PSYCHICAL ILLNESS AMONG THE SERVICES IN SINGAPORE.

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THE following 50 cases are presented as representative of psychical illness among the Services in Singapore. The majority are R.A.F. personnel, though a few have been included from Navy and Army sources. There are also in this series six cases of such illness among wives of Service personnel. These last have been included, because nervous illness necessitating repatriation and occurring in wives presents the same quantitative inconvenience to the authorities as such illness in the troops themselves, for in these cases the husband is usually repatriated as escort.

The purpose of this paper is—

(1) To reinforce the opinion expressed in the *Lancet* leader of May 4, 1940. This leader dealt with the advisability of a psychiatric examination of each Service recruit.

(2) To stress the necessity of a psychiatric examination prior to departure for overseas service. (If not a psychiatric examination, then at least a searching inquiry into the previous personal and family history.)

(3) To call attention to the surprising prevalence, in such psychical casualties as do develop, of psychopathy as the dominating clinical picture.

No comment will be made on the precipitating causes and on the implication of the tropical milieu, as the cases now to be described form a small part of a more comprehensive paper (in preparation) in which this aspect is discussed. It may be mentioned in passing, however, that the diagnosis of tropical neurasthenia will not appear, for in the author's opinion this entity as so described in text-books does not deserve a separate nosological designation. To be true, this term is used freely in Malaya, but it is invariably an indication of how far a knowledge of the psychoneuroses lies outside the average medical officer's discernment.

Since the diagnosis "psychopathy" will largely appear, it is perhaps advisable to mention this term briefly. Current views in the practice of psychiatry tend to stress sharply the occurrence of psychopathy—under such terms as psychopathic personality, psychopathic constitution, psychopathic state, psychic constitutional inferiority, sociopath, etc., this entity being distinct

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from, even if in combination with, psychotic and psychoneurotic states. In Britain, Henderson has for some time advocated the need for a clearer appreciation of the importance of such (psychopathic) states, believing that the proportion of these states is very high indeed and that "we do not realize half seriously enough that it is the underlying psychopathic state which constitutes the rock on which our prognosis and treatment in relation to many psychoneurotic and psychotic states become shattered" (Henderson, D. K., *Psychopathic States.* London: Chapman & Hall, 1939). By psychopathy we infer the presence of a pernicious behaviour disorder, an instinctive emotional instability, a continuous or episodically recurring pattern of conduct showing social inadequacy or social deviation, treatment-resistive. There are various subgroupings into which we need not enter. Suffice it to say that here under the term psychopathy are found all the diverse abnormal personalities who cannot be grouped as insane, psychoneurotic or mentally defective.

The 50 case histories are as follows:

(1) (R.A.F.) Referred for suicide attempt (he drank about ℥ij of "Milton"). During interview he was sullen and hostile, and inclined to be evasive and hedge in his replies. Finally he became more expansive and admitted taking the Milton because he was "fed-up" with Malaya. He showed no sign of true depression. On the contrary, considering he was undergoing detention he appeared remarkably cheerful, and later he admitted frankly that being in detention was better than carrying out duties. He showed poor judgment regarding ethical standards, his future and his responsibilities.

Reliable family and personal history not available.

Diagnosis: Psychopathy.

Disposal: Repatriation.

(2) (R.A.F.) Referred for "nervousness." This patient had developed a series of phobias which increasingly restricted all aspects of his life in Malaya. He could not swim because of the danger of "Singapore ear"; he could not walk for fear of snakes and dangerous insects; he could not exercise through fear of dilating veins. He had continual but variable giddiness, lassitude and anxiety. He blamed Malaya for his illness.

Family history negative except for "nervousness" in the mother.

Personal history negative.

Diagnosis: Anxiety hysteria.

Disposal: Repatriation.

(3) (R.A.F.) Referred for opinion on mental state. Patient complained of headache and giddiness and of the atmosphere "closing in" on him. He felt overworked, unable to concentrate and feared he might become insane. At interview he was very emotional, and wept when he mentioned he had a brother insane and also when home (England) was discussed. He felt at the end of his tether, limp and useless, then with sudden vigour, roundly declared Malaya responsible for his state. (He is separated from his wife, who did not come with him to Malaya, and he is old enough to be inelastic in his adaptation to new work and new surroundings—he is 44. No evidence of organic disease present.)

Family history: Father died from brain tumour; mother from cancer; only brother insane.

Personal history: War wounds of head in 1918.

Diagnosis: Anxiety hysteria.

Disposal: Repatriation.

(4) (R.A.F.) Referred for opinion on mental state. At interview patient

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showed evidence of an ecstasy syndrome. His most striking feature was his emotional ecstasy and ambivalence of identity. He was " permeated " with God and had an indescribable feeling of elevation, elation and moral exaltation. He was the sinless man and could solve all the problems of mankind. With this there were feelings of certitude, inspiration and Janet's "sentiment du divin."

Before he joined the R.A.F. (five years ago) he was vaguely persecuted, then had visions of an "illuminated cross." Hereafter became "hurt" the way men acted. Three years later he had a feeling of having died and saw (a vision) a gravestone with "Christ" on it. Since this experience he thinks his mind has been "open" and he has come to realize gradually his omnipotent powers. (It is remarkable that no outward manifestation of this profound qualitative change in his personality was noticed till five years after the onset.)

Family history: Negative.

Diagnosis: Paranoid reaction type psychosis.

Disposal: Repatriation.

(5) (Female.) Referred for erratic behaviour and "fits." Patient herself complained of "depression" and "nervousness" and of increasing irritability and sleeplessness. She was afraid to go out because of reports on her conduct. Throughout the interview she was extremely emotional. The "fits" are episodic fugue states with amnesia, during which she loses all sense of social decorum and acts like a person drunk. The fits apparently started in childhood with great frequency, then decreased to two a year, but in Malaya have risen to one to two per month. She has all her life been "nervous."

Family history: Mother died in (?) *status epilepticus*; father from cancer of the jaw; a sister has had "fits" since childhood; a brother has attacks of syncope.

Diagnosis: Psychopathy.

Disposal: Repatriation.

(6) (R.A.F.) Referred for opinion on mental state. Patient complained of inability to do his job, and bodily weakness. He said his body was ruined through masturbation and as a result he was depressed, felt inefficient and could not assume his responsibilities. With surprising insight (and truth) he declared himself "not mature." However, he went on to relate with some bravado and sang-froid a recent escapade when he deserted, pawned his boots (he had no money), made friends with a Malay and cadged his railway fare from Singapore to Kuala Lumpur (260 miles), fell in with some other Asiatics and borrowed his fare to Penang (another 250 miles) and there appealed to the British Resident for help!

Personal history: A posthumous child brought up in an orphanage; his present symptoms date from five years ago.

Diagnosis: Psychopathy with anxiety neurosis.

Disposal: Full duties (after psycho-therapy).

(7) (R.A.F.) Referred for anxiety symptoms. He was mildly depressed, anxious and could not concentrate. He was obsessed with the fear that he might have syphilis.

Family and personal history negative.

Diagnosis: Mild degree of anxiety hysteria.

Disposal: Full duties (after psycho-therapy).

(8) (R.A.F.) Referred for "nervousness." This patient had two "crashes," neither of them serious. He married some time after the first crash and now, since the second, he is apprehensive lest each succeeding flight be his last. Feels he has too many responsibilities now (i.e. through his marriage). Says his bombing is inaccurate as he "doesn't care"; his only desire is to be on land again.

Family and personal history negative.

Diagnosis: Situational psychopathy.

Disposal: Ground duties.

(9) (R.A.F.) Referred for opinion on mental state. He had recent repeated complaints of tachycardia and eye-trouble—all investigation for physical disease being negative. He says that in some way his thoughts were "inverted" and when

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he is awake he is obsessed with the idea that life is purposeless and wants to end it by drowning. He feels depressed and fears he may go insane as perhaps his "brain is decayed," yet thinks if he "went round the bend" he would be quite pleased. He was disappointed in and disatisfied with the R.A.F. During interview he was frequently at a loss to express himself and gave the impressien of having thought-blocking.

Family history: A maternal aunt insane.

Personal history: An only child—"spoiled."

Diagnosis: Despite a large situational element this case resembled schizophrenia.

Disposal: Repatriation.

(10) (R.A.F.) Referred for opinion on mental state. At the time of interview patient was undergoing treatment for "eye-strain" (from sea-glare). He complained of listlessness and general disinterest. He was mildly depressed, not anxious, and stated his hopes in the R.A.F. were frustrated. He is not in harmony with any of his present messmates and even the M.O's. treatment of him was, he thinks, biased. His mother, too, has recently informed him of his fiancée's unfaithfulness.

Family and personal history not available. Patient gave the impression of having been always inadequate.

Diagnosis: Situational psychopathy.

Disposal: Transfer to another station.

(11) (R.A.F.) Referred for peculiar behaviour. A not over-intelligent but good-natured individual, simple and naïve in his beliefs. He astonished the R.A.F. by chewing and swallowing safety-razor blades (which were identified by X-rays) and licking red-hot irons with his tongue! He acquired this ability five years ago after seeing a negro do likewise. He felt an impulse to try these feats himself and found that with a little practice he could do it easily. He thinks that later he may be able to levitate himself.

Family history negative.

Diagnosis: Psychopathy.

Disposal: Full duties (he carries out his routine duties with efficiency).

(12) (R.A.F.) Referred for opinion. This patient drifted into deep financial difficulties with blameworthy carelessness, after which he became sleepless and complained of lack of drive and general *laissez-faire*.

Family and personal history negative.

Diagnosis: Situational psychopathy.

Disposal: Full duties.

(13) (R.A.F.) Referred for depression. At interview he was in a state of subacute homosexual panic and freely expressed ideas of reference and auditory hallucinations of persecution. He looked deeply depressed and was intensely worried and sleepless. The condition was ushered in a month previously by a (delusional) thought that his messmates called him a "homo" owing to stains on trousers (not his). Seen at a later date, he appeared well and was free from hallucinations and delusions, but he felt, however, the presence of a "change" in his personality.

Family history negative.

Personal history: An idealistic, introspective schizoid type.

Diagnosis: Schizophrenic episode; the retention of affect, insight and (apparent) recovery suggest the situational psychosis of the psychopath but the awareness of a change in his personality is ominous.

Disposal: Repatriation.

(14) (Female.) Referred for depression. At interview she wept freely and easily but showed no sign of a true psychotic depression. She admitted having "hysterical outbursts" of bad temper towards her children and husband; she "could not control" herself and had thrashed the children so much and so vigorously that her neighbours intervened and took the children away. She stated she could not concentrate or occupy herself in any way.

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Family history: Mother "highly strung"; a maternal uncle died insane.

Personal history: Always "nervous," always shown signs of social inadequacy and emotional immaturity.

Diagnosis: Psychopathy.

Disposal: Repatriation.

(15) (R.A.F.) Referred for opinion. A few days ago he was knocked down by a lorry without sustaining hurt; later he became excited. At interview he was in an acute manic state showing much psychic and bodily restlessness, flight of ideas and ideas of misidentification with self-exaltation. Attention extremely distractible, making him only fleetingly accessible.

Family history not available.

Personal history: Similar attack four years ago after convalescence from a motor-car accident.

Diagnosis: Reactive (recurrent) manic state.

Disposal: Repatriation.

(16) (R.A.F.) Referred for committing frequent disturbances (quarrels and fights with his wife). A case of pathological jealousy—his eight years of married life overcast by his morbid emotion. He is unnaturally suspicious, gauche, hostile to society and strongly withdrawn within himself. Indeed, "a gloomy victim of his own fanaticism." Husband and wife both felt that Malaya had greatly worsened their relations.

Family history: Mother "nervous"; one brother a deaf-mute; another brother deserted by his wife.

Diagnosis: Psychopathy.

Disposal: Repatriation.

(17) (R.A.F.) Referred for opinion. At interview patient said he suffered from intense nightmares (of impending doom) with somnambulism, sleep paralysis, obsessional fears of committing suicide and of the walls closing in on him. He had variable anxiety which was, however, ambivalently coloured with bravado and euphoria.

He had his first attack of anxiety at the age of ten years. This recurred again after he joined the R.A.F. and a third attack set in on the voyage to Malaya. He cheerfully stated his only aim in life was "good food and wine" (no Weltanschauung for an aircraftsman in the R.A.F.!). He designated his fellow-airmen as "peasants."

Family history not available.

Diagnosis: Psychopathy with anxiety hysteria.

Disposal: Repatriation.

(18) (R.A.F.) Referred for circumscribed amnesias. Patient had three recent fugues with amnesia (for a period of a few hours each). He himself complained of episodes of depression, "impulses to do things" (stealing cars) and bedwetting—this last since childhood! These symptoms have been variously present for many years but have, he says, been aggravated by coming East. He talks in his sleep, has terrifying nightmares, claustrophobia, nyctophobia and involuntary convulsive "starts." He cannot fly in a plane without intense sickness and has literally to be carried off. Recently he "borrowed" (stole) a car and later entered an expensive hotel where, without even 10 cents in his possession, he ordered a huge meal with champagne costing $24, and when asked to pay the bill he said calmly, "Call the police"! He relates this and similar incidents with evident zest.

Family history: Mother subject to "faints and bus-sickness"; one sister has chorea; one brother stutters badly.

Diagnosis: Psychopathy with mixed psychoneurotic state.

Disposal: Repatriation.

(19) (R.A.F.) Referred for suicide attempt (he had made a few tentative scratches on his wrist with a razor). At interview he showed simpleness and naïveté to a marked degree, with poverty of thought and retardation. Affect was apathetic but labile (he frequently laughed childishly when relating incidents in his history). He said he was obsessed with "the taste of a metal spoon with the

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plating off," and "the feeling of the taste of an electric battery" inside his head.

Family history : Patient states his father "killed" his mother with ill-treatment.

Personal history: ? Concussion two years ago; always inadequate.

Diagnosis: Psychopathy with schizophreniform state.

Disposal: Repatriation.

(20) (R.A.F.) Referred for gross carelessness in his work. Patient presented a widespread loss of interest and emotional indifference following his arrival in Malaya, where he was given a new type of work with increased responsibility and calling for organizing ability (of which he had none).

Family history: Not available.

Personal history: Of mild inadequacy.

Diagnosis: Situational psychopathy.

Disposal: Repatriation.

(21) (R.A.F.) Referred for self-inflicted (minor) injuries to left hand and left foot. This patient had three "spasms" (his own term) within the week prior to interview. In the first of these he went into a daze and stabbed his left hand and foot with a large sewing needle. During the other two attacks he "felt like a baby in a temper," "all clenched up." These were sudden impulsive attacks over which he had no control though consciousness was not lost. He has not felt well since his arrival in Malaya. With a peculiar relish he gave some details about himself—that he was always so "nervous and backward" at school that he never sat examinations or took any certificates; that he is a "funny" fellow and has no friends; that his mother is a "bundle of nerves"; that his father becomes "terribly excited during thunderstorms". The dominant feature in this case was the patient's artlessness and euphoric naïveté.

Personal history: An only child conceived when his father was 52 and his mother 49 years old. Always "nervous."

Diagnosis: Psychopathy (with intellectual defect).

Disposal: Repatriation.

(22) (R.A.F.) Referred for a plethora of nervous symptoms. Since his arrival in Malaya he has felt oppressed, depressed and nervous. He can't sleep, feels like a "wreck" and has already given up all his friends and sports. He is obsessed with the idea that if he remains in Malaya something will certainly happen to his chest and eyes, and he may go mad.

Family and personal history negative.

Diagnosis: Anxiety hysteria.

Disposal: Repatriation.

(23) (Female.) Referred for opinion. This patient had had recent attacks of short-lived but acute schizophrenic episodes during which she was incoherent or mute, refused all food and lay listless in bed, not even attending to her personal hygiene. At interview there was no sign of psychotic disorder. She herself complained of "nerves" and "fainting attacks." She had all her life been "nervous" but the onset of a frank hysteria only made its appearance on her wedding-day when she had a "fit" and lost her voice for 12 hours. The "faints" have increased to four a week since coming to Malaya and last for a few hours, during which time she "behaves like a madwoman and runs about naked or rolls on the floor apparently unconscious." Both she and her husband state that she is completely frigid. She is "like a board" during intercourse and she adds "I guess there must be something wrong down there." However, she naïvely admits rubbing her labia "to give ***him*** his satisfaction" (!) Of her own accord adds she is "terribly attached" to her father and hates to be separated from him.

(The husband is almost as psychopathic as his wife. A small beer makes him "mad," and on a recent occasion when his wife fell to the floor in a fit, he trampled on her body saying "let the bitch lie there" and ran to Sick Quarters, where he was so "roaring mad" that it was he who received the treatment instead of his wife and he was confined in a cell!)

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Family history not available.

Diagnosis: Psychopathy with schizophrenic episodes.

Disposal: Repatriation.

(24) (R.A.F.) Referred for "scattered" reponses in his air-fitness tests. This patient was rather reticent and coldly unco-operative. Finally he admitted to some depression, insomnia and anxiety dreams. He appeared afraid to enter into a discussion of his difficulties lest he be boarded out of the Air Force. Apparently he had had a crash a few weeks prior to interview (not at all serious), since which he has lost confidence in himself.

Family history: Father "nervous."

Personal history: Two previous air crashes, ? attended by mild concussion.

Diagnosis: Situational psychopathy.

Disposal: Ground duties.

(25) (R.A.F.) Referred for a mild attempt to injure himself. Patient had complained of being sleepless and depressed and he cut his forearm with a razor, reporting his action almost immediately. At interview he was not at all depressed and admitted feeling quite well (one day after the suicide attempt!). On arrival in Malaya he was posted to a department somewhat different to the one he was in in England and he felt that this new job was too much for him. He had also some home worries.

Family and personal history negative.

Diagnosis: Situational psychopathy.

Disposal: Full duties (to a post within his capabilities).

(26) (R.A.F.) Referred for suicide attempt. (A few tentative razor cuts on his neck.) At interview he was mildly depressed and retarded with some difficulty in thinking. He stated he had three previous attacks of depression three years and one year ago respectively, each lasting for approximately ten days. On the first occasion he drank some "Brasso." He appeared to be a moody, withdrawn and intellectually dull individual.

Family history negative.

Diagnosis: Apart from the quick recovery and the woefully inadequate suicide attempt this would appear to be a true endogenous recurrent depression. There was an entire absence of situational factors.

Disposal: Repatriation.

(27) (R.A.F.) Referred for mental opinion. At interview this patient appeared to be recovering from an attack of sun-traumatism characterized by a history of a few hours' exposure to the mid-day sun, followed by nausea, vomiting, then exhaustion-collapse with signs of cerebral irritation and mild deliria (athetoid movements of fingers, amnesias, headaches, restlessness and marked irritability). The condition lasted for two weeks.

Prior to this, however, he admitted being in a "keyed-up" state since his mother's death eight months ago. He is recognized by his messmates as having been always self-absorbed, moody, irritable and withdrawn. When seen, too, at a later date, he showed many signs of psychopathy, being sullen and truculent by turns, voicing a general grievance against the world and behaving in an erratic impulsive manner. He admitted this was his usual frame of mind.

Family history not available.

Personal history: He had a similar episode of deliria after a works accident four years ago.

Diagnosis: Psychopathy with sun-traumatism.

Disposal: Repatriation.

(28) (Female.) Referred for obstinate insomnia and nervousness. At interview this woman appeared to be in a state of anxious depression attended by distressing agitated nervousness and accompanied with mild dissociation episodes when she feels suddenly disorientated and "lost," can't think why she is "there" or of what she has been talking about.

She has always been "nervous," always afraid of the dark and of being alone in

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a house (sees "figures and things" going upstairs), and she has an extreme loathing for all the "crawly things" in Malaya. She is separated from her only child, to whom she is over-attached. She blames Malaya for the accentuation of her symptoms.

Family history not available.

Personal history: As above, she is an only child (her father died when patient was three years old).

Diagnosis: Psychopathy with anxiety hysteria.

Disposal: Repatriation.

(29) (R.A.F.) Referred for chronic invalidism. This patient had a crash five months prior to interview. He was in the (shark-infested) sea with a tropic sun overhead, clinging to 'plane wreckage for a period of nine hours and undoubtedly underwent much physical and mental torture. He recovered from this but never really felt well, and has gradually drifted into a state of anxious depression attended with insomnia, nightmares, sleep-paralysis and mildly obsessional thinking with a feeling that his "nerves" are not right.

Family history not available.

Personal history: An only child conceived when both parents were over 40 years old; he appears a weak facile type.

Diagnosis: Situational psychopathy.

Disposal: Repatriation.

(30) (R.A.F.) Referred for opinion. Patient complained of acute depression (when he could have "shot" himself) about a year prior to interview. This cleared up partly, but since that time he has been subject to episodic attacks of a syndrome with headache, insomnia and irritability. These attacks alternate with periods when he is fairly well. (All examinations for physical disease negative.)

The patient is aged 45. A warrant officer promoted to flying officer and, *ipso facto*, in a difficult (social) position in the mess. His age, too, isolates him. So does his job, which is stores officer—he has nothing in common with the younger flying officers. He is accordingly abnormally restricted in his contacts. Added to this, his wife is in England.

Family and personal history negative.

Diagnosis: Situational psychopathy.

Disposal: Repatriation.

(31) (R.A.F.) Referred for somnambulism. This patient had five episodes of somnambulism within the previous six months. These were apparently situational in response to several factors. Though quite obviously an eccentric he was otherwise well adjusted. He himself stated he had a "one-track mind." There were certain words (i.e. anger) which he could not bear to hear. His wife (who, he says, is a "handful") is uncontrollably bad-tempered and thrashes him with slippers, he being afraid to retaliate, for he thinks if he lifts a hand against her it will be to kill her.

Family history: Father also addicted to automatic behaviour. Other siblings eccentric.

Diagnosis: Psychopathy.

Disposal: Full duties (after therapy).

(32) (R.A.F.) Referred for "fainting attacks" and fear of high-altitude flying. He had three such attacks, 7 years, $2\frac{1}{2}$ years and 3 weeks ago respectively. All occurred on the termination of a period of mental strain, i.e. after a (successful) forced landing. Dislike for flying above 6,000 ft. developed first ten years ago, but is overcome by practice (by forcing himself to fly daily above 6,000 ft.). He showed much evidence of a psycho-neurotic character—too long to relate here—but apparently he had himself well in hand. He describes himself as "highly strung" and suffering from a marked inferiority complex, which latter he thinks he has now in great part conquered. He appeared serious, conscientious and intelligent. He is at present in an administrative post, which he fills with efficiency.

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Family history: Mother " nervous," a brother nervous of physical effort (games).

Personal history: Head injury aged 8 years, concussion after rugby (age ? 17); long involved history of psychoneuroticism.

Diagnosis: Psychoneurotic personality.

Disposal: Full duties.

(33) (R.A.F.) Referred for a general and widespread neglect of his duties, obligations and responsibilities. He was stated to be seclusive, erratic and impulsive in his behaviour and neglectful of his personal appearance. He " borrowed " (stole) cars for joy-rides. During interview he was not so psychotic as his history might suggest and impressed rather as being an easy-going facile individual. He realized the presence of some defect in his personality, while not being able to account for it. He admitted his conduct was remiss and himself cannot understand why he has not " pulled himself together " after the repeated warnings given to him. He was fed up with Malaya.

Family and personal history negative apart from the fact that he is an only child.

Diagnosis: Psychopathy.

Disposal: Repatriation.

(34) (R.A.F.) Referred for opinion. This patient was admitted to the general hospital with a complaint of dysphagia and anorexia. There, he was first diagnosed " neoplasm " and later " gastric neurosis."

Patient said he had always been " nervous " and to combat this he took up sport and boxing. On arrival in Malaya (six months ago) he received a kick in the testes while playing football. He thought then that " something snapped." Later he had backache and awakened one night with dyspnoea and " heart-spasm." He complained repeatedly to his M.O. and said he felt something like a " muscle " coming down his rectum and interfering with defaecation; later he had a feeling of something like " two balls " coming up his throat and stopping his food from going down. At interview he was greatly perturbed as the doctors had not been able to find organic disease.

Family history: Mother in a mental hospital, maternal aunt " queer."

Personal history: Anxiety at adolescence.

Diagnosis: Mixed psychoneurotic state.

Disposal: Repatriation.

(35) (R.N.) Referred for opinion. This patient had transient attacks of a *petit mal* nature, together with longer attacks of an inhibitory epilepsy. The *petit mal* episodes began at the age of 18, and have only recently increased sufficiently to interfere with his work and make him seek help.

Family and personal history negative.

Diagnosis: Epileptic variant.

Disposal: Repatriation.

(36) (R.N.) Referred for opinion. At interview a naïve individual, simple in his outlook, lacking judgment and discrimination. He is emotionally unstable and is forced into states of morbid depression by not unusual situations. These states in turn actuate impulsive conduct.

Family history not available.

Personal history : Moodiness, uncertain behaviour, inadequacy.

Diagnosis: Psychopathy (with intellectual defect).

Disposal: Repatriation.

(37) (R.N.) Patient certified insane and hospitalized. He was in an acute psychotic state with fleeting hallucinations and delusions of a persecutory nature and clouding of consciousness. Later he improved, became free from symptoms, showed insight, and, at the time of repatriation, was apparently well.

Family history negative.

Personal history: Evidence of inadequacy.

Diagnosis: Schizophrenic episode.

Disposal: Repatriation.

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(38) (R.N.) Referred for a plethora of vague complaints, so many and so variable that he was described simply as "unhappy." He complained of impaired powers of concentration, vague fears and apprehensions, psychic restlessness and "impulses" to behave in a "hysterical" manner and also of a flight into increasing introversion. The majority of his symptoms set in when he knew he was being posted abroad (he became "hysterical" when he saw a film in London called "Yellow Jack" dealing with the perils of yellow fever). He feels he is a misfit in the Navy as he was, too, in civil life.

Family history negative.

Personal history: Attack of "hysteria" aged 15.

Diagnosis: Psychopathy with anxiety hysteria.

Disposal: Repatriation.

(39) (R.N.) Referred for continued delinquency. His longest period of normal behaviour during his three years' stay in the Navy was four weeks. His dossier is a continuous record of offences and punishments (absences from duty, disobedience, obscenity, drunkenness and impulsive conduct—he finally assaulted the Captain!). He frankly admitted that from as early as he could remember he had no control over his emotions and that he flies into tantrums and acts impulsively, but he blames others for starting trouble. He shows no real appreciation of his vicious anti-social propensities.

Family history: One brother has similar propensities and was dismissed from the Army.

Diagnosis: Psychopathy.

Disposal: Repatriation.

(40) (R.N.) Referred for opinion. Patient is obsessed with the idea that he may have cancer of the throat, that his eyes are failing and his chest falling in. These fears have been present vicariously for the past three years with an acute exacerbation 14 months ago—the present panic of a few weeks' duration. (He has a slight fullness in the neck with an unduly rapid pulse. Appears extremely "nervous" and anxious.)

Family and personal history negative.

Diagnosis: ? Anxiety state due to thyrotoxicosis.

Disposal: Repatriation.

(41) (R.N.) Referred for peculiar ideas and behaviour. Patient has a simple treatment-resistive acne which he thinks obsessedly may be syphilis. He had expressed an idea that all people may have (latent) syphilis. He arrived at this opinion from various discussions in the mess and from seeing anti-V.D. films. He appeared an obviously simple individual, inclined to be obsessed and preoccupied by ideas but showing a mental state within average limits.

Family and personal history not available.

Diagnosis: Psychopathy.

Disposal: Full duties.

(42) (R.N.) Referred for withdrawn, moody behaviour and a "blind fury" when he broke up furniture during confinement for disciplinary purposes. This later catathymic crisis was a reaction out of all proportion to the circumstances. His behaviour generally appears to be a continuous protest against the life-long restrictions under which he has laboured—first in an orphanage and now in the Navy.

Family history not available.

Personal history: An orphan; history of difficult behaviour.

Diagnosis: Psychopathy.

Disposal: Full duties (he responded to sympathetic handling, which is unusual in the pure psychopath).

(43) (A.) Referred for abortive suicide attempt (a futile, exhibitionistic attempt at strangulation on a busy thoroughfare). He said he disliked Malaya and was depressed, but at interview he appeared euphoric if anything, and showed a lack of appreciation of his obligations and responsibilities and an inability to be affected

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by the consequences of his conduct. He impressed as being a weak, easily influenced individual.

Family history negative.

Personal history: Numerous petty infringements of discipline.

Diagnosis: Psychopathy.

Disposal: Repatriation.

(44) (Female.) Referred for suicide attempt (she swallowed about 20 tablets of aspirin). This patient was apparently having an extra-marital love affair with Case 43 in this series. Her husband became cognizant of the affair and patient's suicidal attempt was the result. There was no collusion, however, with Case 43 regarding any suicide pact. There was evidence of severe marital maladjustment with other environmental factors. Patient said she was indifferent rather than depressed, as she had long passed the end of her tether.

Family and personal history negative.

Diagnosis: Situational psychopathy.

Disposal: Repatriation.

(45) (A.) Certified insane and hospitalized. On admission to hospital he showed much psychic restlessness with great incoherence of speech and thought. Fleeting hallucinations with absurd ideas and fantastic delusions were present. He had a history of "strange" behaviour one week prior to admission. Within a few weeks he returned to a normal state.

Reliable family and personal history not obtainable.

Diagnosis: Schizophrenic episode.

Disposal: Repatriation.

(46) (A.) Referred for opinion on mental state. At interview he was apathetic and disinterested, speech toneless, gaze vacant and fixed. His emotional indifference was greatly at variance with his thoughts for he felt that all Singapore revolved around him, and that Asiatics and Europeans alike revered him for his exceptional abilities, his actions and astuteness. People listened outside his room to pick up his remarks, and there were daily references to him in all newspapers.

Family and personal history not available.

Diagnosis: Schizophrenia.

Disposal: Repatriation.

(47) (A.) Certified insane and hospitalized. On admission there appeared to be much slumping of his whole psychic life. He was sunk in a state of apathy from which he could only be roused with difficulty, and there was so much perplexity and groping in trying to formulate his thoughts that it was impossible to obtain any connected ideas from him. He remained in this grossly retarded state with his interests and activities reduced to the barest minimum for about six weeks, then fairly suddenly began to show more appropriate emotional responses with less difficulty in thinking; insight present.

Family history: Mother died in a mental hospital.

Personal history: Always unduly timid and of a nervous disposition.

Diagnosis: Schizophrenic episode.

Disposal: Repatriation.

(48) (A.) Found by the police wandering in a dazed state dressed only in shorts. At interview he appeared to be in a fugue-state and behaved like a mute automaton. His movements were wooden and grossly retarded. He took a few weeks to pass out of this condition, while remaining amnesic regarding his name and previous life for a few more weeks. This, too, resolved. Later, he stated he had had an Army examination (extremely elementary) to pass and had been very worried as he "couldn't take it in." He showed congenital mental dulling and impressed as being probably always inadequate. While it was not suspected that he was malingering, yet his automatic state did not impress as being a genuine fugue.

Family and personal history not available.

Diagnosis: Psychopathy (with intellectual defect).

Disposal: Repatriation.

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(49) (A.) Certified insane and hospitalized. For a month prior to hospitalization he had been "nervous" and unable to concentrate. More recently he became acutely hallucinated and delusional, and appeared to be in a state of panic, thinking he was about to be shot. Later he passed into a dull dazed state with failure of affect while freely voicing delusions of persecution. Gradually these disordered thoughts left him and he returned to a more normal condition with insight.

Family history negative.

Personal history: Syphilis 14 years ago, "heat-stroke" 11 years ago.

Diagnosis: Schizophrenic episode.

Disposal: Repatriation.

(50) (Female.) Referred for opinion. At interview she was agitated and emotional, her face swollen with weeping. It was only with difficulty that she composed herself sufficiently to enter into a discussion of her condition. She declared that for the past year (the duration of her residence in Malaya) she had become increasingly irritable, loses her temper and is "hysterical," could not work, concentrate, sleep, or "stick it any longer." Some months ago she meant to jump out of a second-floor window, but a mental picture of her children prevented her. Three days ago she made a few tentative scratches on her throat with a table-knife.

She is 49 years old and has menopausal difficulties. She "hates" Malaya. Admits she has always been "nervous and hysterical."

Family history: One sister "worse" than patient.

Diagnosis: Psychopathy.

Disposal: Repatriation

COMMENT.

I.

(1) Despite the fact that a reliable family and personal history was not always obtainable, a study of the cases presented shows the need for caution in permitting the individual to serve overseas, and, to some extent, was an indication for non-acceptance as a recruit. There is a history of this kind in 32 of the 50 cases (in the way of previous psychic anomalies and constitutional loading).

When a recruit is examined, therefore, there is an obvious need for a closer scrutiny of the family and personal history for assessment of morbid trends in these, and particularly (in the author's opinion) for evidence of psychopathy. Especially is this examination necessary when overseas service is in view, as this drastic change in milieu is sufficient to bring disaster to a personality which only just manages to hold its own in home surroundings. Logically, wives of Service personnel should also be subjected to this scrutiny should they accompany their husbands abroad.

II.

(2) In the 50 cases reviewed, the disease grouping is as follows:

A. (*a*) Psychopathy (purely so), 15 cases (Nos. 1, 5, 11, 14, 16, 21, 31, 33, 36, 39, 41, 42, 43, 48, 50). Here are typical examples of various psychopathic types: inadequate, poorly adjusted, immature and emotionally unstable

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individuals showing marked behaviour disorders; with explosive diatheses as in Cases 39 and 42; fugue states and hysteroids as in 5, 14, 21, 48, 50; pseudo-suicides as in 1, 43; eccentrics as in 11; schizoids as in 33; cycloids as in 36, etc.

(*b*) Psychopathy plus an apparently well defined psychoneurotic state, 5 cases (Nos. 6, 17, 18, 28, 38); usually the psychoneurotic episode was one of anxiety hysteria. In such a (favourable) case as 6, the engrafted episode easily yielded to psychotherapy, and in Cases 28 and 38 it was expected that repatriation would resolve the psychoneurotic crisis.

(*c*) Psychopathy with a definable psychotic episode, 3 cases (Nos. 19, 23, and 27), of which No. 19 (apparently schizophreniform) might possibly be schizophrenia. In No. 23 (a staggering mixture of psychopathy, conversion hysteria and schizophrenic episodes) and No. 27 (psychopathy with sun-traumatism) the psychotic episodes impressed as being transient reactive incidents in the profound permanence of the psychopathy.

The remark, of course, may be valid for the cases in (*b*) and (*c*) that these engrafted phases are merely an expression of the underlying psychopathy and not a separate disease entity. The subdivision, however, was made, since in the author's opinion the psychoneurotic episode (like the psychotic) is not treatment-resistive and appears to have its own definite and separate aetiological (reactive) agents—unlike the psychopathy itself which is treatment-resistive and (? invariably) constitutional.

(*d*) Situational psychopathy, 9 cases (Nos. 8, 10, 12, 20, 24, 25, 29, 30, 44). This diagnosis was made where prior to the illness little or no evidence of psychopathic personality was elicited. Here the illness did not amount to a massive psychotic or psychoneurotic state. The majority were mild (reactive), depressed, apathetic or anxious states; comprehensible expressions of inadequacy in adjustment, mostly in response to unusual situations. Cases 10 and 20 in this group may possibly be true psychotics.

In all, 32 cases in which the dominating picture is psychopathy (while admitting that in some cases the diagnosis was by no means final). As a point of interest, among these cases of psychopathy were 7 cases referred for suicide attempts—none of them convincing attempts and indeed most of them laughably inadequate actions; all of them impressing merely as a token-suicide, a theatrical gesture. In other words, the action of psychopaths and containing nothing of the melancholy of the true manic-depressive; a tacit admission of failure in adjustment out of all proportion to the situational factor. Possibly such attempts are related to Kretschmer's "short-circuit reactions." Of this 32, 8 were returned after adjustment to full duties and 2 to ground duties.

B. Psychoneuroses, 6 cases (Nos. 2, 3, 7, 22, 32, 34), of which 4 cases were anxiety hysterias and 2 were mixed states. Two cases were able to return to full duties (Nos. 7 and 32). Cases 2, 3, 32 it was felt would resolve readily after repatriation with or without therapy.

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C. (*a*) Psychoses (purely so), 5 cases (Nos. 4, 9, 15, 26, 46), of which 2 were schizophrenias (Nos. 9 and 46); No. 4 a paranoid reaction type; No. 15 a recurrent reactive manic state; No. 26 a recurrent endogenous depressive state. All were repatriated.

(*b*) Schizophrenic episodes, 5 cases (Nos. 13, 37, 45, 47, 49). These were psychotic phases of sudden onset resembling schizophrenia, but having a benign course and characterized by fleeting hallucinations and delusional formations —fantastic as in 45, panic-stricken as in 49 and 13, massive slumping as in 47. There was retention of affect in all except No. 47.

The present-day tendency is to look upon such schizophrenic episodes as being divorced from true schizophrenia and being rather the expression of a psychopathic (or other) state. They are here left in an open group, as in the absence of a reliable history a situational (emotional) factor could not with certitude be postulated, and the course of the cases was not followed up after immediate resolution and repatriation. Case 13, for instance, impressed as being a true schizophrenia despite the retention of affect and (apparent) resolution.

D. The final two cases (Nos. 35 and 40 respectively) are an epileptic variant and an anxiety near-psychotic state, probably due to a thyrotoxicosis.

Of these 50 cases, then, 32 are psychopathies with or without an engrafted definable psychotic or psychoneurotic state; 6 are psychoneurotic states; 10 are psychotic states; and 2 as in para. D. Depression was the complaint most frequently met with and occurred in 28 cases. Regarding disposal, 10 were returned to full duties, 2 to partial duties, and 38 were repatriated to England. It was expected that in about 10 cases in this last group the crisis would automatically be resolved by repatriation, so the repatriated group by no means infers total casualty.

Although generally the patients were referred merely for opinion, in a few cases wherein the outlook seemed favourable, treatment on the lines of a distributive analysis was given. It was felt that psycho-analytic treatment would possibly have conserved a few others, but this was too time-consuming to be considered.

It is not suggested that the small numbers here given (50) can be stressed statistically, the cases being merely a cross-section of one individual psychiatrist's experience as consultant. In the main, however, the figures agree with Grelinger's results in Holland (reported in the *Lancet*, May 4, 1940). Grelinger found that the majority of service psychiatric casualties were psychopathies (51 per cent.) and were mostly reactive depressions; that manic-depressive states were rare; and that a strong predisposition to mental disorder existed in nearly every case. In the disposal of his cases 22½ per cent. were returned to full duties, 7½ per cent. to garrison duties, and 70 per cent. were found unfit for any form of service.

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SUMMARY.

1. The presentation of 50 cases of psychical illness among the Forces in Singapore (mostly R.A.F. personnel), showing that in the majority of cases there existed a strong indication for caution in permitting overseas service.

2. The astonishingly high percentage of psychopathy as the dominating clinical picture (in contra-distinction to psychoses or psychoneuroses) is pointed out.

3. It is suggested that psychical casualties overseas could be easily and greatly reduced by an efficient weeding-out of such susceptible individuals at recruiting-time or prior to transfer abroad.

For permission to publish, the author is obliged to the Director of Medical Services, Malaya, and to the various Principal Medical Officers of the Forces concerned.

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