MENTAL ILLNESS AMONG ARMY OFFICERS

A SURVEY OF ADMISSIONS TO A MILITARY PSYCHIATRIC HOSPITAL

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(Received March 15, 1946)

1. INTRODUCTION

The purpose of this communication is to survey psychiatric case material represented by the total number of Army admissions to a Military Psychiatric Hospital (Dumfries) in Scottish Command. The hospital is unique in that its patients are drawn exclusively from those holding commissioned rank. During the period under review—December, 1940, to July, 1945—1,208 Army officers received treatment. This number includes both psychotic and neurotic casualties. Many of them broke down under conditions of service in Home Establishment, or while based on home stations, and many had been invalided from near or remote theatres of war—Normandy, Belgium, Holland, Germany, Italy, the Middle East, India, and Burma. From December, 1940, to April, 1944, almost all such neurotic casualties passed through the hospital. After the latter date, however, treatment of neurotic Army officers was undertaken elsewhere, and the unit under consideration has been primarily responsible for the treatment of psychotic cases. With the exception of the recent, severe and short-lived reactions produced by battle stress, all types of psychiatric illness are present in the case material. It will be seen, however, from the conditions controlling admission since April, 1944, that the sample thereafter contains an excess of psychotics. It refers to admissions from the British Army only. A heterogeneous group of 240 cases consisting of R.A.F., Naval, Foreign, Dominion, and Indian Army Officers has been discarded; but R.A.F. and Naval figures have been drawn on for comparative purposes in a discussion of the schizophrenia—manic-depressive ratio. For purposes of comparing diagnostic distributions, figures of a military psychiatric hospital engaged in the treatment of other ranks have been available.

2. DIAGNOSTIC BREAKDOWN OF SAMPLE

The total number of admissions from December, 1940, to July, 1945, was 1,448. Of this number, 1,208 were British Army Officers. The diagnostic types were classified as follows: (a) *Manic-depressive Psychosis*, (b) *Involucional Melancholia*, (c) *Schizophrenia*, (d) *Paranoid State*, (e) *Psychopathic Personality*, (f) *Anxiety State*, (g) *Obsessional Neurosis*, (h) *Hysteria*, (j) *Chronic Alcoholism*, (k) *Epilepsy*, (l) *Drug Addiction*, (m) *Organic Reaction Type*, whether (i) *Acute* or (ii) *Chronic*. The useful diagnosis of "reactive depression" was dropped in conformity with the Army system of nomenclature. Such cases were distributed between manic-depressive psychosis and anxiety state, with due regard to personality patterns and previous psychiatric history. Schizophrenia here includes the *paraphrenias*—that is, all non-organic cases where hallucinations were present in addition to delusions of a greater or less degree of systematization, of whatever age. By the term "*paranoid state*" is meant all cases showing well-systematized delusions without hallucination, whether transitory, or persistent as in paranoia. The occasional façade type of depressive case, in which the central depressive core is covered by a mask of paranoid or obsessional symptoms, has, we trust, found its correct place in the manic-depressive psychosis group.

TABLE I

Diagnosis	Officers (1,208)	Other Ranks (2,500)	Difference
Manic-depressive psychosis	9.5±0.9	7.8 ±0.5	1.7±1.0
Involucional melancholia	0.6±0.02	—	—
Schizophrenia	7.0±0.8	5.8 ±0.5	1.2±0.9
Paranoid state	0.9±0.03	0.84±0.2	0.1±0.2
Psychopathic personality	11.1±0.9	10.4 ±0.6	0.7±1.1
Anxiety state	54.3±1.4	35.6 ±1.0	18.7±1.7
Obsessional neurosis	2.1±0.4	0.48±0.01	1.6±0.4
Hysteria	10.1±0.9	25.8 ±0.9	15.7±1.2
Alcoholism*	1.3±0.3	—	—
Epilepsy*	0.2±0.01	—	—
Drug addiction*	0.2±0.01	—	—
Organic states	2.8±0.5	5.5 ±0.5	2.7±0.7
Mental dullness	0.1	5.9 ±0.5	5.8±0.5
Reactive depression	—	0.84±0.2	—
Neurasthenia	—	0.52±0.14	—
Physical exhaustion	—	0.44±0.14	—
TOTAL	100.0	100.0	

* Included in the "Organic states" in figures for Other Ranks.

Except in Tables VI-IX, each percentage is followed by its S.E., and each difference by the S.E. of difference.

Figures for officers in Table I show: (a) great excess of *neurotics* in spite of over-representation of psychotics in our material; (b) a great numerical advantage

of *anxiety* over all other diagnoses as a disabling illness. Anxiety state is, in fact, nearly five times as common as psychopathic personality, its nearest rival. Among the psychoses manic-depressive psychosis has a significant lead over schizophrenia. So far as it goes, this tallies with work showing a greater relative prominence of manic-depressive psychosis in the higher income-groups (Slater, 1937; Faris and Dunham, 1939). A comparison of Army cases with those for Navy and Air Force admissions (Table II) discloses a considerable and statistically significant deficiency of schizophrenia among the former.

TABLE II

Diagnosis	Army (250) %	Navy and R.A.F. (90) %	Difference
Manic-depressive psychosis	45.2±3.2	41.0±5.2	—
Involitional melancholia	2.8	—	—
Schizophrenia	34.0±3.0	51.0±5.3	17.0±6.1
Paranoid state	4.4	3.3	—
Organic reaction	13.6	4.4	—

The explanation of this deficiency is not clear. It may be partly attributable to a tendency to reserve manic-depressives of a particular Service, especially depressives, to hospitals under administration of the same Service because of the self-limiting character of their psychosis, while schizophrenics from other Services, if requiring insulin, received treatment in Dumfries, where such treatment was available. It is also pertinent that the nature of combatant duties in the two Services may be both an attractive and a precipitant factor in schizoid personalities.

For comparison of our figures with those of a comparable O.R. hospital (Table I), we have drawn on others published by Torrie (1944), who has reviewed 2,500 consecutive O.R. admissions to a base psychiatric hospital in M.E.F. While greater psychiatric stability for overseas forces may be claimed, and thus (presumably) a lower ratio of neurosis to psychosis than in a corresponding hospital at home, we have to set against this circumstance the greater stresses to which the overseas patient was subjected. The experience of one of the writers, who has worked in psychiatric units both at home and in the Middle East, suggests that much the same material appears to be at risk in both theatres, a slight advantage of the overseas forces with respect to quality being neutralized by battle and separation stress.

The proportion of neurotics in the O.R. hospital is 78.7%, excluding mental defectives from the total. In the officers' hospital, after exclusion of a single defective, the corresponding proportion is 77.6%. The two figures are not significantly different; but the crude percentages for the two main psychoses in the O.R. material are below the level for officers. In both groups manic-depressive psychosis is more common than schizophrenia. Involitional melancholia is absent among

other ranks. The most striking features of Table I with regard to differences between officers and other ranks refer to anxiety state and hysteria, the latter being much more common in other ranks, the former more common in officers.

Anxiety and hysteria combine to make up an equal proportion of the neurotics in both hospitals, 83% of neurotic officers, 82.9% of neurotic other ranks. The central problem of anxiety, therefore, assumes equal proportions in both; but the group with larger responsibilities places less reliance on the primitive method of conversion. In the last war there was also a striking—indeed, a more striking—contrast between O.R.s and the officers in this respect.

3. OCCUPATIONAL INCIDENCE

Distribution of admissions by civil occupation is shown in Table III. The prominence of the four occupations with the heaviest representation is very striking. Doctors, engineers, Regulars, and business men comprise 743 cases, or 61.9% of the total. Teachers and students, the next in order of merit, are together well below the total of doctors, who rank the lowest of the four main occupations, but who nevertheless formed nearly 10% of our Army admissions. Such information

TABLE III
Officers Hospital—Army (1,208)

Occupation	Numbers	Percentages
Clergy	17	1.4±0.3
Lawyers	31	2.6±0.5
Doctors	113	9.3±0.8
Dentists	23	1.9±0.4
Teachers	36	3.0±0.5
Engineers and surveyors	124	10.3±0.9
Architects	29	2.4±0.4
Accountants	21	1.7±0.4
Students	46	3.8±0.5
Journalists	17	1.4±0.3
Artists	16	1.3±0.3
Civil servants	27	2.2±0.4
Bankers	30	2.5±0.4
Stockbrokers	13	1.1±0.3
Actors	12	1.0±0.3
Business men	324	26.8±1.3
Farmers	22	1.8±0.4
Regulars	182	15.1±1.0
Publicity agents	19	1.6±0.3
Miscellaneous	106	8.8±0.8

as is now available puts the percentage of doctors among those of commissioned rank at rather less than six. It would seem, therefore, that they are between 1½ times and twice as numerous in our psychiatric cases as their Army representation warrants. Business men form the largest group. It includes all occupations

related to trading, and the significance of its heavy representation is not easy to assess. There is some reason to think that the figure for engineers is low rather than high relative to the numbers at risk; but the prominence of doctors and Regulars especially calls for elucidation.

Comparison of the proportions of neurotics and psychotics within each of the six occupations most frequently occurring in our material is shown in Table IV.

TABLE IV

Occupation	Psychotic %	Neurotic %	Difference
Teachers (36)	25±7.2	75±7.2	50±10.1
Students (46)	35±7.0	65±7.0	30±9.9
Doctors (113)	34.5±4.5	65.5±4.5	31±6.3
Engineers (124)	25±3.9	75±3.9	50±5.5
Regulars (182)	24±3.1	76±3.1	52±4.5
Business men (324)	16±2.0	84±2.0	68±2.9

Drug addicts, alcoholics, and epileptics are included in the psychotic figures.

In the group as a whole the ratio N.P. (neurotics to psychotics) is approximately 3.5:1. Among students and doctors it is much less, being about 1.9:1, and among business men much greater (5:1).

For more detailed analysis the five main diagnostic types are set out in Table V. To avoid attenuation arising from inclusion of occupational splinter-groups, the list of occupations was divided into six categories of more or less cognate occupations, excluding the miscellaneous group at the foot of Table III, and labelled by literal symbols as follows:

- A. Students, architects, journalists, actors, artists.
- B. Clergy, lawyers, doctors, dentists, teachers.
- C. Accountants, civil servants, bankers, stockbrokers, publicity agents.
- D. Regulars.
- E. Engineers.
- F. Business men.

TABLE V

Diagnosis	A (120) %	B (220) %	C (110) %	D (182) %	E (124) %	F (324) %
Anxiety state	52.5±4.6	45.5±3.4	64.5±4.6	58.8±3.7	58.1±4.5	56.2±2.8
Hysteria	8.3±2.3	6.8±1.7	8.2±2.5	8.2±2.0	9.7±2.6	15.7±2.0
Psychopathic Personality	15.0±3.3	14.6±2.4	6.4±2.3	8.8±2.1	5.6±2.1	8.6±1.6
Manic-Depressive psychosis	4.2±1.8	15.5±2.4	3.6±1.8	10.4±2.3	10.4±2.3	7.4±1.5
Schizophrenia	13.3±3.1	8.6±1.9	9.1±2.6	4.4±1.5	2.4±1.4	6.5±1.4

The third group (C) contains all occupations which may roughly be described as "office activities". A, less sharply delimited from the professional group (B), has, we believe, a unity of its own in that its components are to some extent outside the main stream of activity. Their functions are those of criticism, description, entertainment, or interpretation. Students stand aside also in a somewhat different sense, since theirs is a time of preparation. The *sammelperson*, or type-member, of each section corresponds closely to student, doctor, banker, Regular, engineer, and business man.

It would be tempting to assume that office workers (C) by the nature of their calling contain a large proportion of obsessional individuals with a low anxiety-threshold; but our figures merely show the liability to anxiety within the psychopathic group as opposed to absolute incidence of the condition; and one can say of a member of C group only that if he is to become ill in a psychiatric sense, anxiety is a greater probability for him than it would be for such a member of another occupation. The professional cases (B), on the other hand, show a much lower relative liability to anxiety. Compared with those of others, the casualties of this category show much the highest proportion of manic-depressive psychosis, and an incidence of psychopaths second only to casualties of group A. Hysteria is the least common illness in this group. The student-artist casualties (A) have higher figures for schizophrenia and psychopathic personality than have those of any other group. After exclusion of anxiety state, hysteria is much the commonest diagnosis among business men (F). The low relative liabilities of the office section to manic-depressive illness, and of the engineers (E) to schizophrenia, are noteworthy. Anxiety varies between 44.5% and 64.5% of the casualties—a difference larger than that existing in the other illnesses. Hysteria has the most equal incidence. In the first five groups its uniformity is very striking. There is a close correspondence between Regulars (D) and engineers (E) with respect to their diagnostic distribution. Engineers have an exceptionally low relative incidence of psychopathic states and schizophrenia. Two out of every three casualties of the office occupations (C) are anxiety cases; and psychotic illness is poorly represented in this group. Among professional casualties (B) psychotic illness looms larger than in any other occupational figures. We may thus say that an engineer heading for a psychiatric breakdown is least likely to become a schizophrenic; a professional man least likely to become a hysteric; a student or an office-worker least likely to become a manic-depressive; a Regular or a business man least likely to become a schizophrenic. If we ignore anxiety, always first choice, the next priorities are: hysteria for business men; psychopathic personality for student-artists; manic-depressive illness for the professionals, Regulars and engineers, most prominently for the first-named; and schizophrenia, a very poor second, in the office group. The excess of manic-depressives over schizophrenics, which is true of the officer group as a whole, is reversed for the student-artist and office groups (A and C).

The need for an occupational yardstick for an interpretation of the figures in Table III is evident. However, the actual size of the occupational groups, and the

proportion which each bears to the total of those having commissioned rank, are facts which are not in our possession. In the meantime, we may for our present purpose assume that all occupational groups will develop an equal proportion of anxiety cases, and that the number of anxiety cases in a group will form a rough-and-ready index of its size. Such an assumption enables us to estimate the liability of the different groups to the four principal remaining illnesses, as in Table VI.

TABLE VI

Diagnosis	A	B	C	D	E	F
Anxiety state	100	100	100	100	100	100
Hysteria	15.8	14.9	12.7	13.9	16.7	27.9
Psychopathic personality	28.6	32.1	9.9	15.0	9.6	15.3
Manic-depressive psychosis	8.0	34.1	5.6	17.7	18.1	13.1
Schizophrenia	25.4	18.9	14.1	7.5	4.1	11.6
TOTALS	177.8	200.0	142.3	154.1	148.5	168.0

If these figures are representative of the psychiatric harvest of equal groups, it follows that professional men have by far the greatest liability to psychiatric illness: each group of 100 anxiety cases carries with it 100 cases of other psychiatric illness. Further, the excess occurs in both P. and N. divisions, but especially in the psychotic diagnoses and, *par excellence*, in manic-depressive illness. In numerically equal occupational groups, the lead of the professions in this illness nearly equals the sum of its cases in its nearest rival (engineers). Second to the professional group is the student-artist division, with an absolute liability to schizophrenia clearly exceeding that of the other occupations and a tendency to psychopathic personality exceeded only by the professions. The least vulnerable group is that of the office-workers; engineers come next, and then Regulars. Business men run the student-artists fairly close for second place, chiefly by virtue of their high liability to hysteria. We believe that the figure for Regulars is more significant than it appears. In this group two main stresses—battle- and separation-stress—should fall lightest; and the task of accommodation to military life and to disciplinary ritual is for them a thing of the past. In other words, Regulars should, we believe, be the least vulnerable group, and the fact that they are not needs some explanation. The two psychotic diagnoses now show great and nearly equal swings of incidence; hysteria has the most constant incidence in spite of the number of hysterical business men. The student-artists have six times the liability of engineers to schizophrenia; the professionals have between six and seven times the liability of the office group to manic-depressive psychosis; this latter group is the lowest in hysteria, and nearly lowest in its development of psychopathic cases.

4. RELATION OF RISK TO AGE

Distribution of our cases among the four age groups is shown in Table VII, which also shows, for purposes of comparison, the age distribution of those "other rank" psychiatric casualties who received treatment in home hospitals. We are greatly indebted to Junior Commander Johnstone, of the Directorate of Medical (Statistical) Research, for making available to us relevant figures with regard to the population at risk in each age group.

TABLE VII
Age Distribution of Cases

Age	% Observed Cases		% Relative Incidence	
	Officers	Other Ranks	Officers	Other Ranks
Under 30	37.5	46.6	22.2	11.6
30-39	33.2	41.0	24.0	18.8
40-49	24.3	11.6	35.9	34.6
Over 49	5.0	0.8	17.9	35.0
TOTAL	100.0	100.0	100.0	100.0

The outstanding difference disclosed in Table VII is the relatively higher concentration of liability to psychopathic illness in the younger age groups among officers and in the oldest age groups of other ranks. To get this difference into clearer focus it is necessary to break down the data by diagnostic categories as in Table VIII, which shows the relative incidence of different psychiatric disorders by age group.

TABLE VIII
% Age Distribution by Diagnosis (Officers)

Age	Anxiety State	Hysteria	Manic-Depressive	Schizophrenia	Psychopathic Personality
Under 30 ..	20.3	31.5	14.3	47.6	32.3
30-39 ..	24.8	25.6	20.8	32.0	25.3
40-49 ..	38.2	42.9	42.7	9.3	30.2
Over 49 ..	16.7	—	22.2	11.1	12.2

The main features of Table VIII are in agreement with a more detailed analysis based on a different sample by Hogben and Johnstone (*Social Medicine*, in the

press), in so far as: (a) the highest liability to anxiety state and manic-depressive psychosis is in the fifth decade; (b) the highest liability to schizophrenia is in the youngest age group; (c) there is no conspicuous trend with respect to psychopathic personality.

5. DISTRIBUTION BY ARM OF SERVICE

Five arms contributed 885 out of 1,208 Army cases (73·3%) if we count as one: (a) R.A.M.C. together with the small number of A.D.C.; (b) R.E. together with R.E.M.E., as in Table IX:

TABLE IX

Infantry	..	..	..	..	259	..	..	..	21·4
R.A.	..	..	..	..	245	..	..	..	20·3
R.A.S.C.	..	..	..	..	123	..	..	..	10·2
R.A.M.C. (119) and A.D.C. (23)	..	..	..	..	142	..	..	..	11·8
R.E. (101) and R.E.M.E. (15)	..	..	..	..	116	..	..	..	9·6
TOTAL	..	..	..	..	..	..	..	..	73·3

The high place here taken by R.A.M.C. cases tallies with the prominence of doctors in the breakdown by civil occupation, though R.A.M.C. cases also include a thin layer of non-medical officers—quartermasters, registrars, and company officers. A diagnostic break-up of these five groups yields the following results:

TABLE X

	Anxiety State	Hysteria	Psychopathic Personality	Manic-depressive Psychosis	Schizophrenia
	%	%	%	%	%
Infantry (259) ..	54·5±3·1	9·3±1·8	13·1±2·1	9·0±1·8	8·5±1·7
R.A. (245) ..	57·0±3·2	14·7±2·3	10·6±2·0	7·7±1·7	3·7±1·2
R.A.M.C. (119) and A.D.C. (23) ..	43·7±4·2	4·9±1·8	14·8±3·0	16·2±3·1	9·9±2·5
R.A.S.C. (123) ..	57·7±4·5	8·9±2·6	10·6±2·8	8·1±2·5	6·5±2·2
R.E. (101) and R.E.M.E. (15) ..	53·4±4·7	10·4±2·8	9·5±2·7	12·9±3·1	4·3±1·9
TOTALS (885) ..	53·9±1·7	10·2±1·0	11·9±1·1	10·2±1·0	6·5±0·8

In all arms cited, except Infantry, manic-depressive psychosis has a clear advantage over schizophrenia. R.A.M.C. casualties show the lowest percentage of anxiety but the highest percentage of the psychoses and of psychopathic personality. The prominence of manic-depressive psychosis is especially striking. The most level scoring is shown by the psychopaths, who, in spite of the ill-defined nature of their personality-defect, show surprisingly uniform figures in relation to the other illnesses. Recognition of this condition appears to succeed in the absence of clear-cut definition, and it is difficult to avoid the conclusion that any large sample of the community will contain a fixed proportion classifiable as such.

The two arms with closest measure of agreement are Infantry and R.A.S.C. With respect to its proneness to the several types of psychiatric breakdown, the difference between R.A.M.C. on the one hand and engineers and gunners on the other is spectacular. For comparative purposes, especially with regard to Infantry, the corresponding figures for a small group (57) of R.A.C. cases are worthy of mention, as shown below. Except with respect to anxiety state, there is little correspondence between the scoring of the two arms. The Infantry group as a whole is much more closely allied to R.A.S.C.

TABLE XI
R.A.C. Cases

Anxiety	Hysteria	Psychopathic Personality	Manic-depressive Psychosis	Schizophrenia
56.1 ± 6.5	3.5 ± 2.4	10.5 ± 4.0	5.2 ± 2.9	15.8 ± 4.8

6. DISCUSSION

Since we cannot assess the size of the officer population which provided our cases nor its distribution among the various occupations and arms of Service, any conclusions drawn from this sample must be limited and provisional. The interest of the material lies in the circumstance that cases of the kind are not easily collected in such numbers in peace-time, when they are scattered among the records of private consultants, mental hospitals, and nursing-homes, and shrouded in such secrecy and taboo as surround mental illness in the more prosperous sections of the community. Hence comparable observations are lacking in psychiatric literature. Three themes merit comment:

- (a) the meaning of the relative incidence of schizophrenia in our figures and in Torrie's;
- (b) social implications of the occupational survey;
- (c) the prominence of doctors and Regular officers in the material.

(a) Schizophrenia

Surveys of rates of mental disorder in Chicago and in Munich agree in showing a higher incidence of manic-depressive illness, relative to that of schizophrenia, in the more successful layers of society. In both cities, and in all classes, schizophrenics were more numerous than manic-depressives. But the disparity was least marked among the well-to-do, and in the academic callings. (Slater, E., 1937; Faris and Dunham, 1939.) In our sample of officer patients, manic-depressives are present in greater numbers than schizophrenics; but manic-depressives exceed schizophrenics among Torrie's sample of other ranks as well. It is natural to assume that other ranks contain a larger proportion of individuals.

drawn from homes on or below the margin of economic security. In accordance with the findings cited we should therefore expect that manic-depressives would be considerably less common than schizophrenics; but this is not shown by Torrie's figures. It seems a possible inference that military life for O.R. personnel has features which are not conducive to schizophrenia; but we should not assume that the converse is true of the more prosperous civil groups. It may well be that successful individuals have a greater liability to psychotic illness, and particularly to manic-depressive illness, than the insecure and unsuccessful. It may however be suggested that the physical accompaniments of security are not without importance for the common man, who becomes the average soldier and thereby achieves security without possession of the personality-traits (and possible flaws) which promote success in civil life; and it is possible that the lower relative incidence of schizophrenia in a military population taken as a whole may be partly due to the operation of external influences.

There is, in fact, a tendency for schizophrenia to assume greater prominence among the exposed *action* groups (Navy, Infantry, R.A.F., R.A.C.). We offer the provisional suggestion that this implies a tendency for certain individuals to react to external stress by developing schizophrenia. On the other hand, the prominence of schizophrenia in our Navy and R.A.F. figures may be spurious, in so far as manic-depressives of these Services were more apt to be retained in hospitals of their own Services. We must also recognize that the small R.A.C. group, with its predominantly youthful population, may show a relatively high incidence of schizophrenia through the operation of age alone. Nevertheless, external influences should not be entirely discounted. Though other explanations are possible, Torrie's figures taken with our own permit the interpretation that the soldier who is well fed, clothed, and shod, and—perhaps for the first time in his life—free from economic care, shows greater immunity to schizophrenia, unless exposed to action. We are fully aware that this suggestion is purely tentative.

(b) *Occupational Background*

If our assumption regarding the even spread of anxiety is correct, it is a disquieting thought that professional men have the greatest liability to psychiatric illness and particularly to the psychoses. On the face of it, it is not a satisfactory state of affairs that doctors, lawyers, clergymen, and teachers, the counsellors of society, should have in their ranks such relatively high numbers of manic-depressives, schizophrenics, and psychopaths. It is arguable that this is inevitable, and that personality-traits making for eminence in such occupations carry with them increased risk of breakdown. If this is so, a satisfactory procedure of selection for the professions must take stock of the possibility that elimination of all potential psychotics or psychopaths would lower the standard of the whole. On the other hand, it is hard to believe that such high relative morbidity is inevitable, or that it is impossible to devise some form of initial selection which would reduce later incidence of mental illness without diminishing the quality of the professional group.

Such a selection-method has to be both sensitive and flexible—sensitive enough to detect the pre-psychotic, and flexible enough to admit the perhaps abnormal personality of outstanding ability and promise.

(c) *Doctors and Regulars*

The high place taken by doctors in our material requires detailed elucidation which is not within the scope of the present article. It is hoped to make such an investigation the theme of further study. Here we may indicate circumstances which in our opinion are salient:

- (1) Like engineers and Regulars, but to a greater degree, Army doctors are mainly an unselected group passing direct from civil life to commissioned rank through a single filter of examination for physical fitness. Their method of recruitment, however, does entail a certain degree of selection, which tends to operate against the Army, especially in the later years of war.
- (2) In the psychiatric casualties of the group there is a high incidence of psychosis, a high incidence of manic-depressive illness, and a high incidence of mania.
- (3) Among the relatively smaller number with neurotic illness, two types of break-down were observed: (i) the self-sufficient, anxious, scrupulous, and independent figure, who was often found to have left a one-man practice for the Army; (ii) the young man of dependent habit who had entered the Army immediately after qualifying. After a latent period lasting sometimes as long as two or three years, disabling anxiety developed rapidly in such individuals accompanied by lack of confidence of the most extreme type.

Of the 294 cases in the fifth decade, it is noteworthy that Regular officers contribute 76—i.e. 25·8%, which is five times the mean. If the proportion of cases corresponded to the decade's share of the strength the number would be 203, or 16·8%. Ninety-one cases therefore represent an excess of representation; and excess of Regulars contributes 45 cases, or 49·4%, to this excess. This is greatly above their proportionate representation in the Army as a whole. Against this we have to weigh the consideration that the strength/age distribution of Regulars differs appreciably from that of the whole body of officers. Nearly complete absence of recruitment during the war years and the re-employment of pensioned officers must raise the base-line of the age-pyramid by two or three years and swell the ranks of those over 50 years of age.

In the nature of things Regulars must contribute far more officers of the fifth decade to the Army than any other occupation. The granting of emergency commissions to non-Regular soldiers over 40 was rare, for the simple reason that men over 40 were not called up from civil life. Since no other occupation contributes comparable numbers in this decade, we cannot say with certainty that Regulars of the fifth

decade are more liable to breakdown than members of any other profession of the same age. However, it may be said that in civil life this age-period falls in a trough between the decade of maximum incidence of (male) mental disorder (30-40)* and the periods of involution (50-65) and senility (65 plus), when there is another increase of cases (Henderson and Gillespie, 1944). The casualties of the decade may be regarded as coming under our observation in the mean year of war—1943. This would place the birth years of casualties between 1894 and 1903. Assuming that the average age of commission is 19, we find that the group entered the Army between 1913 and 1922. That is, it consists for the most part of men who were commissioned during or just after the 1914-1918 war, and whose service in the recent war was preceded by the maximum length of peace-time soldiering. In some cases this may have engendered occupational rigidity poorly adapted to meet war-time stresses and responsibilities. Further, it is worth recalling that these men were commissioned at the time of, or just after, the prolonged and murderous battles of the Somme and Passchendaele. Possibly these sombre memories became potent in the precipitation of anxious and depressive states when the subjects were again engaged in war.

7. SUMMARY

(1) 1,208 consecutive admissions of Army officers to a military psychiatric hospital are reviewed; and the diagnostic distribution is compared with that of a psychiatric hospital for other ranks.

(2) Striking differences with regard to the proportional incidence of hysteria and mental dullness are shown. The figure for schizophrenia and its relation to that for manic-depressive psychosis are about the same in both.

(3) Sorting by civilian occupation shows prominence of business men, Regular officers, engineers, and doctors, that of Regulars and doctors being significant.

(4) The age-distribution of the cases shows a maximum relative incidence in the fifth decade.

(5) The distribution of cases among the various arms of Service discloses a striking relative deficiency of psychotics among gunners and an excess, especially of manic-depressive psychosis, in R.A.M.C.

We wish to express our indebtedness to Lieut.-Col. P. K. McCowan, J.P., M.D., F.R.C.P., D.P.M., for his permission to draw on the case records of the hospital which he commands, and also for his friendly interest and criticism; to Dr. W. Mayer-Gross, M.D., M.R.C.P., for much stimulating advice and experienced help; and to Sister Barbara Hickson, A.R.R.C., for her ungrudging and time-consuming labours in the collection, tabulation, and checking of our figures.

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CORRECTION

The reference in the top left-hand corner of the article by Barnet Woolf in the April issue of this journal was erroneously printed *Brit. J. soc. Med.* (1947), 2, 73-125. This should, of course, have been: *Brit. J. soc. Med.* (1947), 1, 73-125. The references on pages 126 and 135 were similarly misprinted.