REPORT #1 CANADIAN NEUROPSYCHIATRIC WING

B.L.A.

PERIOD 5 AUG 44 - 30 SEPT 44

This report is based on cases seen by this unit while attached to #10 Can Gen Hospital.

1. #1 Canadian Neuropsychiatric Wing arrived in this theatre of war attached as an Increment to #10 C.G.H. and has functioned during the above period in the base hospital area.

2. During the early period of operation the tactical situation permitted us to see acute cases which had been evacuated only a few hours previously. These had been sent down with battle casualties and did not pass through any Extravagance Unit. At other times when #1 Canadian Wing was being moved, acute cases were evacuated directly to this centre. In addition to "Exhaustions" there were referrals for Neuropsychiatric reports from General Hospitals, 2 CBR Op and 3 Reallocation Centre. A number of cases were suspected self-inflicted wounds were also seen and reported on.

4. Benefiting from the observations made by the Canadian Consultants Psychiatrist and psychiatric experiences reported from the Mediterranean Theatre of War, a policy of rapid identification and disposal was instituted. The local situation and the limited bed capacity also influenced this decision. Since the opening of this wing, we have operated as a parasitic unit on #10 Can Gen Hospital. We were allotted 75 bed "W" block in the medical section. Our own ordnance stores having been lost in transit, we were entirely dependent for medical and ordnance equipment. One wishes to record that the assistance given by all departments of #10 C.G.H. has left nothing to be desired.

5. We have had as neighbours until recently No. 32 British General Hospital handling Psychiatric cases and they have been most helpful in assisting us to meet the situation. A local arrangement with Lieut Col. Backus of No. 32 British Psychiatric Hospital was made whereby British Psychiatric cases transferred directly to them and in turn Canadian other ranks, who were psychiatric problems were passed on to us. Canadian Officers were admitted to No. 32 British Psychiatric Hospital for investigation and treatment, and when the occasion arose, transferred to us for disposal. For the past three weeks all the Canadian psychiatric casualties evacuated to this area have been handled through this wing.

6. The past few weeks we have been seeing cases, some of whom were evacuated to other hospitals, 7 to 14 days previously, and at the moment we feel that the war has passed beyond us. It is hoped that we shall be moved in the near future.

7. The functional cases seen at this centre are identical with those described by others and have not presented any new problems. Precipitating etiological factors have varied. A number of cases have been seen in soldiers with short army experience and a minimum of battle training. These are men who have arrived within the past few months or weeks from Canada and were sent to this Theatre of War without the benefit of much training in England. On their arrival here it is necessary for them to adjust to new associates, new units and in many cases they have, within the past the short time, been reassigned to different arms of the service and it is considered that this combination of factors contributes a great deal to the insecurity of the individual. A number of decompressions resulted from bombs falling short, and the man losing faith in his air cover. Another causal factor observed in some units was the prolonged length of time under stress without adequate mental and physical rest. Many of the histories indicated that the most severe stress to which men appeared to be subject was that of being pinned down in one area and under constant mortar and shell fire. In a few instances lack of confidence in NCO's and Officers appeared to be the factor. The asthenic, underweight soldier, who is asked to compete with other men in battle, seems prone to develop psychiatric disability. It is true that in most of these cases there was an existent personality defect, yet a number of these carried on for varying periods and broke eventually under a single severe stimulus such as, a 'near miss', terrific carnage, death of a friend or being partially buried.

9. The treatment of many of these cases did not consist of more than identification of their personality defect and a recommendation to their reclassification and reallocation. The acute symptoms resultant from battle experience had resolved before admission.
A number of cases were treated by a modified continuous narcosis programme using Medinal and Paraldehyde supplement. Most of these cases had 2 to 4 days continuous narcosis, which resulted in the resolution of their acute symptoms. The cases selected for this therapy were those suffering acute anxiety states and hysterias.

Sodium Amytal was used in a number of cases to induce suggestible state and in a few cases to treat major hysteria. Psychotherapy was given to all cases in the nature of explanation, suggestion and reassurance.

It was observed that, when the patient knew that his case was to be reconsidered by a medical and reallocation board his symptoms were further resolved.

Although a convulsive therapy machine was supplied the necessary power was not available and, thus far, we have had very few, if any, cases for which this treatment appeared indicated.

A program of productive occupational therapy was instituted by arrangement with the Commanding Officer and Matron of #10 Cdn Gen Hospital. Approximately 30 to 35 patients were daily employed in the hospital area, making dressings, preparing equipment for sterilization, cleaning supplies and general fatigue duties. This program has been of benefit to the patients and to #10 C.G.H. A minimum of diversional occupational therapy was arranged for.

Sports equipment was supplied by the auxiliary forces, writing material, Library facilities and tobacco were made available by the Canadian Red Cross Services.

Bathing facilities and the opportunity to draw any necessary equipment from quartermaster stores were made available for each patient.

Evacuation to the United Kingdom was necessary in a number of cases. It was the policy to retain in this theatre of war every man, even though only fit for labour duties with employment companies. The number of psychotics admitted have been few and they have not presented any problem owing to the rapid facilities for evacuation to the United Kingdom.

OBSERVATIONS BASED ON TWO MONTHS IN THIS THEATRE OF WAR

The parasitic dependence of a psychiatric unit of this size on a general hospital is of mutual benefit to both units.

In view of the limited war establishment, the facilities provided by the A. and D. Dept. of a general hospital are essential. The availability of medical, surgical, x-ray, laboratory and dental services assist greatly in a better appreciation and treatment of the cases admitted. The Q.M. Dept. of a general hospital is necessary to re-equip men in that a great number are admitted with their equipment deficient.

Thus far the facilities for handling Canadian Officer psychiatric casualties has been inadequate.

We are able to affirm from the observations previously made that the one important factor operative in nearly all psychiatric casualties is the constitutional personality pre-disposition and many of the casualties could have been indentified had adequate screening been possible. In this respect it is true that there is a small group of pre-disposed individuals whose volitional factor is good and they are able to contribute valuable service for a limited time.

As the pressure of cases limits definitely the amount of time available for psychotherapy the resolution of many of these cases depends in large part on Nursing Sisters who have had Neuropsychiatric experience.

It is our impression that the prevention of psychiatric casualties is essentially the responsibility of the combatant officer and the unit medical officer and that once the casualty is evacuated beyond the forward area the likelihood of his return to full duty diminishes rapidly in proportion to the time that he is away from his own unit.

It is considered that a number of the etiological factors could be overcome by a longer conditioning period to battle noises and stress. There appears to be no place for an asthmatic, immature, underweight, timid, unstable individual in the Canadian Infantry Corps.

The number of Neuropsychiatric problems indicates that it is essential to have a competent Psychiatrist attached and the work of Major I.A. Walters in this field has been most helpful to this unit and the General Hospital to which it is attached.

Problems in Physical Diagnosis have been in no way different to those presented to Canadian Neuropsychiatrists in the United Kingdom.

Somatic symptoms of pain such as headache, backache, digestive discom
frequency with Enuresis, præcordial pain and dysphoe8, fatigue, loss of weight and insomnias have required careful investigation of physical, psychological and social factors.

In many cases a general neurotic setting and the pathogenic influence of a hostile environment could be readily established.

In a number of cases patients with obscure complaints and few gross findings came to us as exhaustion and complete examination showed major physical disease. Two brain tumours, Marie Strumpell's arthritis, biliary colic, pulmonary tuberculosis, cerebral emboli fractured ribs and acute poliomyelitis were all encountered thus.

Neurological problems such as the late effects of head injury, vertigo, migraine, obscure low back pain of organic type, and faints and fits and neuralgias have required distinction from the functional nervous diseases.

Neurological problems such as brachial neuritis, sciatica, peripheral nerve lesions, paraplegia, neurosyphilis and epilepsy have been diagnosed and treatment planned.

Such problems have confirmed our experience in the United Kingdom. Any unit which is elected to deal with war neuroses and inadequacies must be prepared to —

(a) Diagnose the difficult problems of medicine and surgery, which present few physical signs and may be erroneously considered neurotic.
(b) Act as consultant authority on problems of medical neurology
(c) Advise on neuro-surgical problems in the absence of a neuro-surgeon.

The value of this broad approach to military neuropsychiatry which has characterized the Canadian Army practice has been again proved in the field. The problems of medicine, surgery, neurosurgery, neurology and psychiatry in military practice overlap and the neuropsychiatrist must be prepared to consider problems of central nervous function, which may arise in any of these fields.

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