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The Prognosis of Psychiatric Treatment in Military Service

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Summary. The author discusses the outcome of psychiatric treatment in the Military. He served as a military psychiatrist in Norway for one year. During this time he personally examined and treated 215 soldiers with psychiatric disorders. The diagnostic composition of the patient group and the treatment given are described. The patient material was again examined at the end of the military service period, when one-third of the patients had been found unfit for service. The remainder were still fit for service. The patients did not differ from soldiers in general from a disciplinary point of view. However, they did not achieve as good grades in personal conduct and military efficiency as the other soldiers. The patients' clinical picture at the follow-up examination had improved when compared to the initial psychiatric examination. The author concludes that psychiatric treatment in the Military is both possible and desirable.

Key words: Psychiatric disorders in military service – Classification – Discharge – Psychiatric treatment in military service.

Introduction

To what extent do soldiers with psychiatric disorders complete their military service? What possibilities are there in the Military for treating young men with psychiatric disorders? These are some of the issues which will be presented in this article. Of the young Norwegian men declared unfit for compulsory military service, psychiatric disorders are the cause in 10%, and these predominate among the medical causes of unfitness (Roness, 1975). Based upon material collected by the author, this article will discuss the possibilities of psychiatric treatment in the Military.

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Military Organisation in Norway

Previously, there was no distinct military psychiatric organisation in Norway. Soldiers needing treatment for psychiatric disorders were admitted to the Psychiatric Clinic in Oslo (Eitinger, 1955). Recently, a military psychiatric organisation has been established. This organisation consists of three mental hygiene teams—each composed of a psychiatrist, two or more psychologists and a social worker—which are located in Northern Norway, Western Norway and Eastern Norway.

The teams operate on an out-patient basis, in close contact with the military environment. In addition, six psychiatrists are employed on a part-time basis in the different geographical areas. The Head of Psychiatry in the Armed Forces Joint Medical Services coordinates these various activities.

Previous Studies

A good deal of research has been done by Norwegian military psychiatrists. Major earlier works of Eitinger (1955) and Sund (1970) ought to be mentioned. In both these studies a considerable amount of the material consists of hospitalized patients. These studies are marked by the presence of the more severe forms of mental disease, as well as by the high number of unfit, in that more than two-thirds are declared unfit for military service. More recent studies of interest are the works of Sund (1973) and Roness (1976). Both these studies are based on out-patient material from military psychiatrists, and here only one-third are recommended to be declared unfit for military service. However, these patients' progress during military service is unknown, since the classification upon completion of service is not available. Other relevant studies in Scandinavia are the work of Kottenhoff (1969), Sihm (1973) and Bliding (1974). In these studies, the percentage of soldiers recommended to be declared unfit is also low, but again the final classification is not available.

Follow-up studies in civilian life of soldiers who have been discharged from military service due to psychiatric disorders show that the prognosis for these men is poor. They function less well than others both socially and mentally (Sund, 1970; Otto, 1974). Simply to discharge soldiers from military service because of psychiatric disorders is therefore not an ideal solution. Not only should they be offered treatment, but the military environment ought to be improved so as to integrate them. A closer examination of the treatment possibilities within the Military is therefore important. This will here be done on the basis of the author's own material, collected while he was a military psychiatrist in one of the mental hygiene teams over a period of 12 months.

Material and Methods

During the period 1970/1971, 215 soldiers with psychiatric disorders were referred to the author for examination and treatment. Of them, 87% were referred by military physicians, 7% by chaplains, 3% by officers and 3% came on their own initiative. These patients were studied closely in relation to two control groups of the same size. The patients differed from the controls

in respect of a number of negative factors in their background and upbringing (Roness, 1975). The diagnostic composition of the patient material was as follows: 69% neuroses, 8% psychopathy, 4% misuse of alcohol, 3% psychoses, 2% oligophrenia, 2% misuse of narcotics, 2% sexual deviation, 1% speech impediment and 7% showing no specific psychiatric disorder. Sixty-six per cent were in the Army, 14% in the Navy and 20% in the Air Force; 36% had been in the service for less than 3 months and were still in recruit school, whereas 64% had been in the service for more than 3 months. The patients came from 41 different units.

The material can be seen as selective, since most of the patients were referred by military physicians. Therefore, the material does not demonstrate the frequency of psychiatric disorders in the military in general, but is nevertheless representative to a certain degree of the types of psychiatric disorders appearing among soldiers. The distribution among the various branches of the service is representative of the normal distribution. It may be noted that only one-third of the soldiers in the material are in recruit school, whereas most of them have been in the service for a longer period. The material is therefore not truly representative of the adjustment process from civilian to military life. The material is marked by relatively milder forms of mental disease, with a high number of neuroses, and a low number of the more severe forms of mental disease. In this way it differs from earlier Scandinavian studies (Eitinger, 1955; Otto, 1966; Sund, 1970). The diagnostic composition aligns well with the material from military psychiatrists (Sund, 1973; Roness, 1976) and more recent studies of Kottenhoff (1969), Sihm (1973) and Bliding (1975).

Treatment. Of the patients, 17% were transferred to another unit, 18% were given another assignment, and 12% received social assistance; 17% received psychopharmacological treatment (8% tranquilizers, 9% ataraxica/anti-depressants), 50% received individual supportive therapy, 10% were recommended group therapy (which was not accomplished due to special circumstances), and 8% were hospitalised (2% in psychiatric institutions and 6% in military hospitals). Motivation towards treatment was evaluated as good/moderate in 19%, poor in 34%, and 37% did not receive treatment. The number found unfit was higher among those who were poorly motivated for therapy than among the rest.

The author's initial recommendations were as follows: It was considered that 180 (84%) of the patients could continue their military service. Thirty-five patients (16%) were immediately exempted from military service as it was clear that they were unfit. These were classified as follows: 27 (13%) as Non-combatant B, 1 (1%) as Temporarily Unfit, and 7 (3%) as Unfit.

It was felt that most of the patients could continue their military service, on the condition that the various recommended measures were carried out. In the following, the progress of the soldiers who continued service will be examined, as well as how many of them completed their first period of service.

The Soldier's Progress

The author interviewed personally 85% of the patients who completed their service at the end of their service. Of 120 patients who completed their service, 76 were interviewed in the unit. The remaining 44 had been transferred to other units, and were interviewed in their home communities from ½ to 1 year after the completion of service. Twenty-six were personally interviewed in their homes, whereas 18 were not personally interviewed. Of these, 4 refused to be interviewed, 3 were out of the country, and 11 lived so inaccessibly that they could not be interviewed. Thus, a total of 102 (85%) were personally interviewed by the author, and the remaining 18 (15%) were not.

The soldiers' final classification will now be examined, as well as the mental condition of those completing service. Whereas 120 patients completed their service, 136 were found to be classified as Fit at the time of the follow-up

according to the military records. This difference is caused by deferment, transfer to civilian duties etc. for a number of soldiers, which did not affect their classification.

1. Classification

Information concerning the soldiers' final classification was obtained from the military records.

Table 1 shows that 45% of the patients were classified as Combatant, 19% as Non-combatant A, 4% as Temporarily unfit and 33% unfit (Non-combatant B and Unfit).

A considerable number of those recommended to continue military service were found unfit at the end of their service. Seventeen per cent were discharged as unfit between the initial psychiatric examination and follow-up examination. It is debatable what this indicates. The cause may be an unrealistic evaluation on the part of the author. The possibility was always present that some of those considered capable of continuing in service would not be able to manage. The author's therapeutic philosophy is that it is better to let marginal soldiers try military service rather than be declared unfit right away. They might manage if given the chance. The fact that so many still did not manage may indicate that the recommended treatment was not carried out. At the time of the follow-up, the author was not able to clarify this point. There is, however, evidence that if these soldiers had received the recommended support and therapy, they would have been able to complete their service. This may indicate that the military system has neither the capacity nor the attitude necessary to provide adequate help to soldiers with psychiatric disorders.

Although 17% of those considered able to complete their military service did not manage to do so, the number of unfit in the author's material is still less than in many other military studies from previous years. The findings in the present study are in accordance with the optimistic prognosis presented by the military psychiatrists (Sund, 1973; Roness, 1976), and also in line with the recommendations of Kottenhoff (1969) and Sihm (1973). In earlier Scandinavian studies

Table 1. Medical classification

	Patient group		Control groups				Statistical significance	
			Matched		Unmatched			
	No.	%	No.	%	No.	%	*P*-MC	*P*-UC
Combatant	96	44.7	186	86.5	166	77.2	+	+
Non-combatant A	40	18.6	23	10.7	40	18.6		
Non-combatant B	54	25.1	3	1.4	5	2.3		
Temporary unfit	9	4.2	2	0.9	1	0.5		
Unfit	16	7.4	1	0.5	3	1.4		
Total	215	100	215	100	215	100		

(Eitinger, 1955; Sund, 1970) the number of unfit was considerably higher. Because of differing diagnostic techniques, it is difficult to compare Scandinavian studies with material from other countries. The impression is, however, that the number of unfit in material from countries outside Scandinavia is quite high (Hauschild, 1966a, 1966b; Plag et al., 1970).

The present study shows that 42% of recruits in the patient group were found unfit, whereas 27% of the patients who had been in the service for a longer period were found unfit. This shows that most of those leaving military service owing to psychiatric disorders do so while still recruits. If they manage to get through the first 3 months, the recruit period, the chance of being declared unfit is less. This indicates that the strongest therapeutic efforts ought to be made in the recruit schools, which is already the practice, for two of the three mental hygiene teams primarily treat soldiers in the recruit schools.

If we look more closely at those found unfit, we see that half of them have been referred for treatment in their civilian life (15 to general practitioners, 12 to psychiatrists and 8 to psychiatric or other institutions). The remaining half have not been referred for treatment in their civilian life. Of these, 8 were poorly motivated for treatment, whereas 27 had no referral since no suitable facilities existed in their home communities. Many are sent home without any realistic treatment facilities being available to them. This, together with the poor prognosis for them in civilian life as described by several authors (Sund, 1970; Otto, 1974), indicates that simply discharging soldiers from military service because of psychiatric disorders is not necessarily a good solution.

2. Evaluation by Officers

At the end of their military service, soldiers are graded according to military efficiency and personal conduct. This information was collected from the military records, and is based upon the officers' evaluation of the soldiers. The following grades are used: Poor, fair, good, very good and excellent.

Table 2 shows the grades for military efficiency, and the patients are here compared with the two control groups. The varying totals in the Table are caused by lack of information, in that these grades did not always appear in the military records.

Table 2. Military efficiency

	Patient group		Control groups				Statistical significance	
			Matched		Unmatched			
	No.	%	No.	%	No.	%	*P*-MC	*P*-UC
Poor/fair	12	10.3	7	4.0	7	4.7		
Good	84	72.4	107	56.3	109	56.8		
Very good/excellent	20	17.3	76	39.7	65	38.5	+	+
Total	116	100	190	100	181	100		

Table 3. Personal conduct

	Patient group		Control groups				Statistical significance	
			Matched		Unmatched			
	No.	%	No.	%	No.	%	*P*-MC	*P*-UC
Poor/fair	10	8.6	9	4.8	10	5.4		
Good	80	69	97	51.6	108	58.7		
Very good/excellent	26	22.4	82	43.6	66	35.9	+	+
Total	116	100	188	100	184	100		

Table 2 illustrates that the patients got poorer marks than the controls, and the difference between the patients and each of the control groups is statistically significant.

A comparison of the patients' marks at the end of their service with the same patients' marks in recruit school shows that there was a clear improvement during their service period (these figures are not included in Table 2). These soldiers, in other words, showed an improvement in military efficiency in the course of their military service. They were, however, not as efficient as the other soldiers.

Table 3 shows that the patients had poorer marks in personal conduct than the controls, and the difference between the patients and each of the control groups is statistically significant.

The patients had better marks at the end of their service than they had at the end of recruit school (these figures are not included in this Table). It is evident that the patients made progress in personal conduct during their military service, although they did not reach the standard of the rest of the soldiers in this category.

3. Disciplinary Actions

Disciplinary actions involving those soldiers with psychiatric disorders who completed their military service were studied. Data on disciplinary actions are found in the military records. The number of disciplinary actions after the initial

Table 4. Disciplinary actions

	Patient group		Control groups				Statistical significance	
			Matched		Unmatched			
	No.	%	No.	%	No.	%	*P*-MC	*P*-UC
One	19	15.8	31	15.2	36	17.9	—	—
Two or more	13	10.9	7	3.4	13	6.5	—	—
None	88	73.3	166	81.4	152	75.6		
Total	120	100	204	100	201	100		

psychiatric examination are registered. Table 4 shows the number of disciplinary actions among the patients and among the controls. The low totals in the control groups is due to lack of information in the military records.

Table 4 illustrates that there is no distinct difference between the pattients and the controls in the matter of disciplinary actions. The patients were disciplined more often than the controls, but the difference between the patients and each of the control groups was not statistically significant.

Therefore, the patients who were fit for duty at the end of their service are not clearly different from the rest of the soldiers from a disciplinary point of view.

4. Patients' Own Evaluation

At the end of their military service, the patients were examined and their mental condition according to their own evaluation was classified as without symptoms, improved, unchanged or worse. Of the 120 patients who completed their military service, 102 (85%) were personally interviewed by the author, and their evaluations are registered in Table 5.

The Table shows that more than one-third of the patients were without symptoms, and over one-half were improved. A small number could be characterized as unchanged and only one was worse.

According to the patients' own evaluation, the progress during military service was positive. More than half of the neuroses in the initial diagnosis consisted of neurotic reactions. That so many patients of this group are without symptoms at the end of their service may be because many of the neurotic reactions were caused by the situation, and therefore transitory.

5. The Author's Evaluation

The author personally evaluated the patients at the completion of their military service. Based on the total clinical evaluation, it was noted whether the patient was without any psychiatric disorder, improved, unchanged or worse. The categories are only general, but can nevertheless give an overall impression of the patient's mental condition.

Table 6 shows that over one-third presented no sign of psychiatric disorder at the follow-up examination, and well over half were improved. Only a few were unchanged, and none had become worse by the author's evaluation.

Table 5. The soldiers' evaluation

	No.	%
Without symptoms	36	35.3
Better	58	56.9
Unchanged	7	6.9
Worse	1	1
Total	102	100

Table 6. The author's evaluation

	No.	%
No psychiatric disorder	35	34.3
Better	60	58.8
Unchanged	7	6.9
Worse	0	0
Total	102	100

Table 7. Use of drugs

	No.	%
Regularly	4	3.9
Intermittently	12	11.8
No drugs	86	84.3
Total	102	100

Table 8. Medical consultations

	No.	%
Regularly	7	6.9
Intermittently	13	12.7
No consultations	82	80.4
Total	102	100

The author's evaluation is in accordance with the soldiers' own evaluation of their mental condition. The progress has thus been positive from a psychiatric point of view for most of the patients.

6. Use of Psychopharmaca

The patients' use of psychopharmaca towards the end of their military service was registered, as well as if they were used regularly, intermittently or not at all.

Table 7 shows that only a few used psychopharmaca regularly at the end of their military service, and a smaller percentage used them intermittently. Most of the patients did not use psychopharmaca at all.

It is also evident that the use of psychopharmaca among the patients was considerably higher at the time of the initial psychiatric examination than at the end of their military service (these figures are not included in this Table).

That the use of psychopharmaca has diminished from the beginning to the end of service also indicates positive progress.

7. Consultation with the Military Physician

Also examined was the patients' consultation with the military physician for psychiatric symptoms towards the end of their military service, and whether this was regular or intermittent.

Table 8 shows that only a small number had regularly consulted the military physician towards the end their military service, whereas a somewhat larger number had consulted him intermittently. Most of the patients had not had any need to consult a physician.

That so few needed to consult a physician towards the end of their military service also indicated that the soldiers' progress during service was favourable from a mental health point of view.

8. Further Referral

Whether the patients have had a need for further treatment after the end of their service was also evaluated. When this was the case, they were referred for further treatment in the civilian environment. Further treatment was recommended for a total of 14 patients (14%). The rest of the patient group had no direct need for continued help.

That so many could be sent home without need for further treatment shows that the patients' condition at the time of the follow-up examination was favourable from a psychiatric point of view.

Discussion

This study shows that many soldiers with psychiatric disorders are found fit for service. In this study only one-third with psychiatric disorders were found unfit for service, as opposed to two-thirds in material from earlier Norwegian studies (Eitinger, 1955; Sund, 1970). The material in these two studies is marked by more severe forms of mental disease, and a large number of the patients studied were hospitalised. However, hospitalisation was the usual practice in treating psychiatric disorders then. The use of a central psychiatric clinic may well have been due to the lack of other treatment facilities at that time. Present military psychiatric treatment is conducted on an out-patient basis, in the military environment itself, and in close association with this environment. The question arises whether the present method is more effective than the earlier practice. That so many of the soldiers in question are able to complete their military service compared to earlier studies, may be caused by the early intervention on an out-patient basis in the military environment. It is possible that fewer are discharged, not only because milder forms of mental disease are involved, but also because modern socio-psychiatric treatment methods are used. Early intervention, in the military environment itself and in close cooperation with it, can prevent symptoms becoming chronic, which could occur if patients were hospitalised in a civilian hospital far away from their base camp. Before the effectiveness of out-patient treatment as opposed to hospitalisation can be verified, these issues ought to be studied more closely.

That nearly half of the patients in the material are classified as Combatant as the end of their service period, and that only one-third are found unfit, shows that being referred to a psychiatrist does not automatically lead to discharge. The study shows, however, that 17% of those considered capable of continuing in the service at the time of the initial psychiatric examination had not been found fit for service by the time of follow-up. This may possibly indicate that the military system is not structured to help marginally functioning soldiers to complete military service.

There is some question as to whether the Military ought to be concerned with helping young men with psychiatric disorders. This may be in conflict with the Military's primary purpose, that is, to create an effective defe ce force in the event of war. However, a classification policy which is too restrictive may also make the establishment of an adequate force difficult.

Treatment of psychiatric disorders in the military environment is not without problems. The psychiatrist may experience a conflict between the soldier's interests and the system's interests. Even though the individual ought to be his primary concern, he must consider the groups's needs as well. There is no easy solution to the psychiatrist's dilemma. However, most will find that they are able to do useful work for both the individual soldier and the Military as a whole.

The patients' general state at the time of the follow-up seems to indicate that most have experienced positive progress. Even though they do not achieve the standard of the other soldiers in efficiency and personal conduct, they do advance beyond their position at the time of the initial psychiatric examination. They do not present any greater disciplinary problem than soldiers in general. Their mental condition at the end of their service period is, for most of them, satisfactory, both in their own evaluation and in the author's. The extent of their need for medical help and their use of psychopharmaca at the end of their service period also supports this. All this evidence seems to indicate that those patients who complete their service have not experienced any damage to their mental health by completing their first period of service.

It is not absolutely clear which of the factors examined have contributed to the patients' positive progress. Their psychiatric disorders may have been caused by the situation, so that there was a gradual improvement. The author has shown in his larger study that psychiatric disorders are probably more often caused by the situation than has previously been recognised (Roness, 1975). The patients' general life situation and their attitude towards the Military may have changed, which would influence their mental state in a positive manner. A change in their military situation may also have contributed. In the treatment recommended for the patients, a change in type or place of service was an important measure for many, which also may have produced positive results. Other psychiatric treatment received by the patients has probably also contributed. The study indicates that the military psychiatric organisation fulfills its purpose, but that the treatment facilities ought to be expanded.

Lønnum et al. (1972) do not believe that soldiers with psychiatric disorders can manage military service. They have shown that most soldiers evaluated by the Special Medical Committee are found unfit for service. Sund (1973) has found the same, but has a more positive attitude to psychiatric treatment in the military. The findings in this present study indicate that the second attitude is the correct one. Follow-up studies of soldiers who have been discharged untreated from service as unfit due to psychiatric disorders show that they do poorly in civilian life. Therefore, treatment in the Military of young men with psychiatric disorders ought to be given high priority.

That so many soldiers with psychiatric disorders are discharged in spite of the military psychiatrist's recommendations that they should continue service, indicates that these soldiers should be followed more closely after the psychiatric examination. It is important that the military psychiatrists follow up their respective patients, to find out why they did not complete service. Further research concerning the various treatment methods practised in the Military is desirable. Newer methods ought to be tried out. An examination of the military environment itself would be of value, to find out what positive and negative elements are present from the psychiatric viewpoint. The author has evaluated the military environment and questions, among other things, whether the distance between the military environment and society in general has not become too large (Roness, 1975). This ought to be a basis for further investigation.

There is evidence that military service must be seen not only as a defence measure, but also in a broader perspective. More than half of the Norwegian

young men of a given age are in the Military for a whole year. The military system ought to be arranged so that this period can be as constructive and positive as possible for them.

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