MANIC STATES IN THE FAR EAST*

BY

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Shortly after the Japanese capitulation there were observed in South-East Asia a number of cases of interest in several ways: their cause was obscure; their symptoms were elation, overactivity, and fever; their distribution was mostly in young British officers; and, however acute the symptoms, the prognosis was good.

The first appearance of these cases was dramatic. In August, 1945, preparations for the reoccupation of Malaya had been made, and at the last moment the Japanese capitulated. The blow thus, so to speak, fell upon air. A few weeks later four British officers were admitted within a period of 12 days to the psychiatric centre serving the corps concerned. Between the landings and the end of this period no other cases of psychosis—British, Indian, or Gurkha—had been reported in this corps.

Col. T. A. Ratcliffe and Majors J. D. Frazer, D. T. Bardon, and A. A. Martin. Others may have occurred in this theatre at the time, but they cannot have been many, for the psychiatrists—to whom they necessarily came—had been asked to notify me of any cases.

Symptoms

The presenting symptoms were very similar. The patients were overactive, mentally and physically, easily excited to further activity, and exceedingly garrulous; they were elated and had some exaggerated ideas of their own importance, which at times amounted to mild delusions of grandeur, but which were always within the bounds of possibility and not fantastic. In a few cases religious ideas with a vague symbolic content were described; in a few there were ideas of reference and of persecution, and one had auditory hallucinations.

Although it was obvious that their judgment was impaired, most patients were capable of holding moderately logical conversations and showed little loss of comprehension. Only three exhibited flights of ideas, though most were rather easily distracted. The grasp of his surround-

TABLE I.—Summary of Manic and Hypomanic States

No.	Rank	Unit	Age	Previous Service Record	Precipitating Factors	Onset (Days)	Temp.	Symptomatology						Clinical Progress (in 2 Months)
								A	B	C	D	E	Delusions	
1	Capt.	R.I.A.S.C. (staff)	27	Good	Overwork (staff); sudden change	7	10 days intermittent	1	1	1	1	—	Persecution	Recovered
2	Capt.	"	22	Good; schizoid attack, 1944	"	2	—	2	2	1	1	—	—	Recovered after E.C.T. and insulin; later schizophrenia improving
3	2/Lieut.	Seaforths (staff)	24	Good	"	3	—	1	1	1	1	—	Grandeur	Returned to duty
4	Lieut.	R.E.	23	"	Hard work; sudden dull job	3	—	—	1	1	1	—	—	Improving, but hypochondriacal
5	Capt.	P.C. (staff)	?	"	Overwork	2-3	—	1	1	1	1	—	—	Improving, after E.C.T.
6	Lieut.	—	?	"	?	2	—	1	—	1	1	—	—	"
7	Fl.-Lieut.	R.A.F.	?	"	Change from ops. to heavy staff work	2	—	1	—	1	1	—	—	"
	Lieut.	R.E.	25	Good; moody if alone	Overwork; responsibility	2; depressed then excited	101.6° to 99°	1	1	1	1	—	Grandeur	After a week temp. rose, became stuporose, died
9	F.O.	R.A.F.	24	Good	Change from ops. to codes; domestic stress	3; depressed, confused	?	1	1	1	1	—	—	Improving
10	Lieut.	R.E.	22	Excellent	Overwork as Q.M.	?	100°	1	1	1	1	—	—	Improving, but hypochondriacal
11	Capt.	—	24	Good	? fever 2 weeks before	2	99°	2	2	2	1	—	—	Improving
12	2/Lieut.	R.M.	21	"	? Urinary infection	3; fatuous	—	1	1	1	1	—	Grandeur	Improving, but hypochondriacal
13	Capt.	Sigs. (staff)	26	Good; reserved	Domestic stress	2; heavy drinking	99°	1	2	1	1	1	Religious symbolism	Recovered; some amnesia
14	Major	I.M.S.	30	Good; energetic; malaria several times	Overwork; responsibility	3	100°	2	1	2	2	—	—	Improving
15	Sgt.	F.S.S.	19	Excellent; conscientious	"	10; feverish, busy	99°	2	—	2	2	—	Religious symbolism	Improving
16	A.B.	R.N.		Average	Home-sick	3	99°	2	2	2	1	1	Grandeur	Improving on E.C.T.
17	Sgt.	R.A.M.C.	27	Good; one ? hysterical episode	Frustration at work; overwork	3; guilt, inadequacy	100°	1	—	2	1	—	—	Improved; relapsed on boat
18	Cook	H.M.S. Vindex	20	Average	Home-sick; resented lack of welfare	10	—	1	2	2	1	—	Hallucinations (auditory)	Recovered
19	Mne.	"	21	"	Not enough to do	2	99°	1	1	1	1	—	Ideas of reference	"
20	Capt.	Paratroops	25	Good	Missed train on way to paratroop training	2 impatient	—	1	1	2	2	—	Religious ideas	"
21	Mne.	R.M.	18	"	Not enough to do, after busy job in Australia	1	—	1	—	2	1	1	Grandeur	"
22	P.O.	R.A.F.	25	"	Domestic stress	1; rash, ? dengue	102°	1	1	1	1	—	Persecution	Improved but still paranoid
23	Gp. Capt.	R.A.F.	37	Excellent	Overwork; domestic stress	3	—	1	1	2	1	—	Grandeur	Improved

Symptomatology columns: A = Elation; B = Aggression; C = Overactive; D = Garrulous; E = Flights of Ideas; 2 acute; 1 present.

As a result of this experience, investigations were made in other areas and further cases were found: 11 in Singapore (these occurred in the island itself or had been sent from South Malaya, Java, or Sumatra); others were seen in Bangkok and Rangoon, or came from H.M. ships at sea. In all, records of 23 cases have been collected (Table I), of which I saw 16. Details of the remainder (in several different areas) were kindly supplied by Lieut.-

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ings shown by one patient—a senior officer—was such that he had put forward a detailed scheme of operations for some training which was accepted by his superiors; its inconsistencies were not discovered till it was actually put into practice. This was, however, unusual, for in the remainder overactivity and distractibility were enough to send them off duty. Recognition of time and place was generally accurate, but mistakes were sometimes made in identifying passers-by with old acquaintances. Memory for recent events was on the whole good. It is regrettable

that local difficulties as well as the clinical states prevented a more systematic investigation of attention, memory, and comprehension.

When first seen many patients were aggressive, abusive, and sometimes very violent. This symptom disappeared rapidly when skilled cure could be provided; it is probable that it was not so much a primary symptom as a secondary result of the opposition, restraint, and, unfortunately, antagonism occasionally provoked by the patient's behaviour. It is to be emphasized that the most striking symptoms were overactivity and change in mood, and not a disorder of comprehension.

Investigation into the onset of the condition usually revealed a change in behaviour over the last two or three days—in two cases, ten days. Generally this change consisted of overactivity and elation, as described above, and it increased gradually. But several patients had, on the contrary, been morbidly depressed before their excitement began, and two had had feelings of inadequacy and guilt—for which each had had some real cause. One of these two had sought refuge in a day's heavy drinking. One man (Case 18) had been so aggressive and insubordinate as to have been put on 61 charges by an apparently meticulous C.O. in the ten days before admission. In some cases there were records of low fever of 99° to 100° F. (37.2° to 37.8° C.) before admission, and several patients said they had felt feverish for a few days and had been out of sorts and sleeping badly. No focus of infection or any sign of physical abnormality was discovered in any patient except the one whose temperature rose to 102° F. (38.9° C.); he showed an erythematous rash. Blood cultures, blood counts, and examinations for malaria parasites were all negative. Most cases were very resistant to sedatives, becoming less restive only on heavy doses. Little change was seen in their behaviour for a week or so, and careful nursing and supervision were essential.

Previous History

Naturally, the earlier history of these patients was generally dependent on their unsupported statements obtained after recovery; but most showed a singular lack of previous psychological disorder. Only two had had any trouble—one had had a schizoid attack a year before, which cleared up in a few months, and the other had apparently had a hysterical amnesia. Moreover, the Service records of nearly all were good. They were occupying responsible positions and enjoyed a good reputation (among superiors and subordinates alike) for conscientiousness and hard work.

Investigation of the circumstances before the onset showed that fourteen cases had been definitely exposed to increased mental work and increased responsibility for a few months before V.J. Day.

Four of the first five officers had been employed for several months on staff work, involving much planning, minute attention to detail, and severe responsibility for the lives of others; and it is significant that all four were reported to have expressed considerable misgivings about the success of a landing against opposition (whether this was at all justified by the facts as they saw them or was itself a symptom of illness it seems impossible to say). Four other cases had considerable anxiety over domestic problems—two were simply home-sick, and two found themselves "browned off" at lack of work. No mental stress was elicited in the remainder, but two of them had had a history of some infection a few weeks before.

The rank incidence is of great interest: seventeen patients were officers and six were "other ranks." Moreover, two of the latter were holding extremely responsible

jobs. One patient, an officer, was an Indian. The ages ranged from 19 to 37 years, but only one was over 30.

Course of the Illness

During treatment several patients became hypochondriacal and expressed anxiety over minor complaints; others showed considerable anxiety over their future careers. This was not due to realization of the seriousness of their past illness, for few had a full insight into the abnormality of their past behaviour, and several had a complete or partial amnesia for the acute period. When it was partial they remembered their surroundings in hospital but not their own aggressiveness, though a few admitted they might have been "a bit unreasonable." Others had no memory of doctors who had seen them in their acute phase. In two months from the onset seven had made a complete clinical recovery, and thirteen were still improving.

In all these either electric convulsion or insulin treatment had been given. Two had shown improvement described as "recovery," but then relapsed. It is of interest to note that these two were those with a record of previous psychological disorder—one, with a previous schizoid episode, developed a paranoid schizophrenic state which persisted; the other, with a hysterical amnesia in his record, became temporarily confused and aggressive during his voyage home.

Finally, one patient died. A few days after admission with typical symptoms his temperature rose to 101.6° F. (38.7° C.) and he became stuporose; the temperature dropped just before death a week later. A blood count showed 18,000 white cells per c.mm., but no physical abnormality was found clinically and none at necropsy except cerebral oedema and many small haemorrhages. This was one of the cases with a depressive onset.

A full follow-up of all cases after a year is naturally not available, since most were evacuated from South-East Asia to India, and I saw only a few. The details were obtained from Col. R. J. Rosie and Lieut.-Col. A. J. Galbraith, to whom I am indebted.

Rates of Psychosis

The importance of these cases may be thrown into relief if the general rate of psychosis in this period is compared with a sample of cases evacuated from India and Burma earlier in the year (Table II). It will be seen (a) that a

TABLE II.—*Distribution of Types of Psychosis*

Source	Date	Schizophrenics	Manics	Depressives	Others	Total	% of these Psychotics to all Psychiatric Cases
All evacuations from India and Burma	Jan.-July, 1945	64	17	29	11	121	24.2
All evacuations from S.E. Asia	Oct., 1945-Jan., 1946	24	11	1	5	41	44.1
	Feb.-June, 1946	14	1	5	—	20	43.8

much greater percentage of psychoses occurred in cases evacuated from South-East Asia between October, 1945, and June, 1946—unfortunately figures are not available for August and September, 1945, here; (b) that this rise was in part due to an increase of schizophrenics, which persisted till June, and in part to an increase in manics, which was evident only in the winter months.

The grouping by rank (Table III) is of interest. The disproportionate number of officers in the manic states is obvious.

TABLE III.—*Distribution of Psychoses by Rank*

Source	Date	Manics		Schizophrenics	
		Offrs.	O.R.s	Offrs.	O.R.s
Evacuations from India and Burma	Jan.-July, 1945	9	8	9	55
Evacuations from S.E. Asia	Oct., 1945-Jan., 1946	8	3	2	22
	Feb.-June, 1946	—	1	—	14

Review of Literature

No exactly similar series has been found in the literature surveyed; but various writers draw attention to significant points.

Incidence of Psychosis.—A higher rate of psychosis is generally recognized to prevail in the East. From the official figures for admissions to hospital the ratio of psychoses to psychiatric cases can be obtained. In England, between 1942 and 1945, this was as follows:

	All Ranks	Officers	Other Ranks
April, 1942–March, 1943	25.3%	30.1%	15.0%
April, 1943–March, 1944	26.5%	45.8%	25.4%
April–December, 1944	16.3%	19.8%	16.2%
July and August, 1945	20.3%	21.0%	20.2%

(*Bulletin of Army Hygiene*, April, September, and October, 1945.)

For periods in the Middle East, the figures for British troops, unfortunately not separated into officers and other ranks, were:

Oct.–Dec., 1943	19.0%	July–Dec., 1944	23.0%
Jan.–June, 1944	31.3%	Jan.–March, 1945	28.1%

(*Bulletin of Army Hygiene*, October, 1945.)

These figures support the theory that there is generally a higher proportion of psychosis in the East than in England, and also show clearly the higher rate among officers. No explanation of either point is given by the compilers of these figures.

Distribution of Psychosis.—There are various views on how the total of psychotic cases is made up by the various syndromes. Craigie (1944), in the Middle East, gave the ratio of schizophrenics to manic-depressives as over 3:1. Later, James (1945) considered that among 530 psychotics evacuated it was over 4:1.

Aetiology: Physical Factors

It is generally accepted that certain psychoses are directly due to physical causes; confusional states, for instance, may be caused by toxic processes. As the latter are commoner in the East it is possible that this is one reason for the higher incidence of psychosis there. Stungo (1946) suggests this, and also mentions the effects of dehydration.

Malaria was, of course, one of the commonest diseases met with in the East, and it often affected the mind. Its effects were also diverse—so much so that official directives were issued to doctors in the East recommending anti-malarial treatment in all febrile mental syndromes. On the other hand, Merrill (1945) warned us that an aggressive psychopath might seek refuge in the word "malaria" and demand appropriate treatment, when his condition was purely a psychiatric one.

Mepacrine (atebrin) has also been blamed as a cause of psychosis. The evidence for any ill effect from a daily preventive tablet does not seem strong; it would in any case presuppose a rare idiosyncrasy. Larger doses given in treatment of malaria are obviously more likely to be dangerous and need careful consideration.

The largest series of cases of malaria recorded is that of 7,604 treated by Gaskill and Fitzhugh (1944); 35 of

these developed psychoses, which were of two main kinds—confusional states, and states of excitement with delusions. But these authors admit that there is no convincing evidence of a direct effect of mepacrine, or even of malaria.

From Burma several other cases have been reported in which confusion, excitement, and hallucinations followed the use of mepacrine; these improved on its withdrawal but recurred on its renewal (unpublished communications from T. A. Ratcliffe and Kirpal Singh). As these authors admit very readily, however, it is impossible to be sure this was not due to the fluctuations of a psychosis; in fact, in one case an overdose of mepacrine was symptomatic of an incipient psychotic episode. Soysa (1945), in an unpublished communication, reported ten cases which showed toxic effects from mepacrine, but these were drawn from 550 patients treated in Ceylon in two years. Eight of the ten were typical hypomanic attacks and two manic. All recovered when the drug was withdrawn, but one relapsed when it was given again. The responsibility of mepacrine here seems more likely, but an account of the patients' previous personalities and of the psychological stresses they underwent would be of interest.

There are thus, obviously, factors whose full influence is not yet understood, and the exact relation of physical agents to these psychoses is not yet clear.

Mental Factors

These may be grouped under the headings of frustration, change of tempo, and constitutional.

Frustration is a term commonly used to describe a feeling of wasted ability, which may develop into an anxiety state either with depressive features (Gillespie, 1942) or with great tension, irritability, restlessness, insomnia, and a sense of internal unrest—in which state the sufferer is capable of doing considerable work, but at great cost to himself and his subordinates. This has been described elsewhere, as it occurs in base areas overseas (Tredgold, Heffernan, Kelly, and Leigh, 1946), and in this connexion MacCurdy's account (1945) of what is inevitable in departmentalism shows how the lack of aggressive outlet causes irritation to be vented on subordinates, so that a vicious spiral develops. The desire for scapegoats is significant; the next higher formation "they" are always blamed, so that G.H.Q., the apex, invariably becomes a byword.

Change of Tempo.—A more direct effect of the actual work and its pace is described by Curran and Garmany (1944) under the term "change of tempo." They give a series of cases of anxiety which developed in sailors just ashore on leave or, alternatively, in men admitted to hospital for some minor complaint, and consider that this might be due to the persistence ashore of the increased responsiveness developed by tension aloft.

Constitutional.—The importance of constitutional factors in psychoses has been widely accepted, and MacCurdy (1925) claimed that they were always discoverable even in patients whose relatives had not noticed them.

Further, specific types have been regarded as particularly liable to mania—the rigid individual (Freud, 1912), and the over-conscientious obsessional type who develops a sense of injury which prevents him from resting and has on occasion developed a typical manic-depressive cycle (Culpin, 1931), especially if his personality structure is characterized by self-centredness, lack of sociability, and lack of affection (Wittkower and Spillane, 1940).

Discussion

The cause of such conditions is generally considered to be physical, and blame has been laid on malaria and on mepacrine. Both are no doubt often responsible for states of excitement. The rather similar cases quoted by Soysa, for instance, were held to be due to excessive mepacrine, whereas Stungo's cases labelled as "toxic" showed acute

excitement, confusion, and fever, and several died in a way that resembled the fatal case here recorded. In this series, however, there was no record of overdosage of any drug or of the confusion reported in malaria, and no parasites were found; moreover, it is difficult to see any reason why malaria or overdosage of mepacrine should increase suddenly after V.J. Day.

On the other hand, there were mental factors which must have played a part. There was a very sudden and acute change in the tempo of work with a sudden relief of tension. This must have affected most strongly the over-conscientious responsible type of staff officer who had been employed in circumstances (the planning of a major operation) calculated to increase these obsessional tendencies and anxiety. This type formed the majority of the patients.

The restless state which appears in frustration has been described as an underlying unrest which the individual tries to stifle. It is not a great step to the symptoms of mania—where unrest has become overactivity and the attempt to stifle guilt or unworthiness has been oversuccessful and is crystallized out as a delusion of grandeur and elation:

The temperature of these cases suggests a toxic process, but full examination by physicians as well as psychiatrists failed to find any. Perhaps the fever was the result of the overactivity, not its cause. Much attention has been paid to physical conditions because these cases are commoner in the East and commoner in war, where exposure to physical illness is greater. But there are simple explanations, in psychological terms, of both these points. War produces a sense of urgency which is particularly felt by the overconscientious obsessional type. The latter's relaxations, too, are restricted, for he is often home-sick, tries to lose himself in his work, and will not take leave—where, as he says, he has nothing to do but brood and get more home-sick. In forward areas there is a physical outlet combined with the sense of work well done and a feeling of comradeship engendered by danger: relaxation is easier after action. In staff work and base areas there is less sense of achievement. The East thus exerts as much psychological effect—in separation from home and incompatible surroundings—as physical strain.

Summary

A series of 23 cases showing elation, overactivity, and fever occurred in South-East Asia in the months following the Japanese surrender.

The patients were mostly young officers (British) without a history of previous breakdown. The prognosis was good.

Records of psychosis in the East are reviewed.

A discussion of the possible causes leads to the conclusion that they were mental rather than physical, and are thought to be the sudden release of tension and the consequent change in the tempo of work.

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HOMOSEXUAL OFFENCES AND THEIR RELATION TO PSYCHOTHERAPY*

BY

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During 1946 there was considerable correspondence in the columns of the *British Medical Journal* on the subject of homosexuality, particularly concerning the forensic aspect. It was evident that there was a wide divergence of opinion, and in addition some of the correspondents seemed unaware of the extent to which homosexual offences occurred and of the extent of treatment carried out before the offence was committed. It was in fact evident that some regarded the commission of a homosexual offence as a *sine qua non* that the offender was a homosexual and that psychotherapy in some form was indicated. All cases charged with homosexual offences and received into H.M. Prison, Brixton, on remand or committed for trial are investigated as a routine; it was decided, therefore, to analyse those received during the year 1946 in order to ascertain whether the above-mentioned views were justified.

During that year 96 persons were received into the prison charged with homosexual offences; of these 52 (54.2%) were accompanied with a request from the magistrates for a report as to the state of mind of the accused, whereas the remaining 44 were examined owing to the nature of the charge. The total number of remand and trial prisoners received during the year was 5,023, so that the percentage of those charged with homosexual offences was 1.91. For comparison the number of cases charged with heterosexual offences was 198, of which 142 (71.7%) were sent for a report as to the accused's state of mind. Homosexual offences can be divided into four main groups—namely, indecent assaults on boys under the age of 16 years, importuning, buggery, and gross indecency. Of the 96 cases under consideration 39 were charged with indecent assaults on boys, 24 with importuning, 17 with gross indecency, and 16 with buggery. It is interesting at this point to consider the extent to which magistrates asked for reports on the mental state of the prisoner in respect of each of these groups of offences. In the cases of indecent assault reports were requested in 25 (64%), in cases of importuning in 20 (83%), in cases of gross indecency in 5 (29%), and in cases of buggery in 2 (12.5%). It is obvious that the law has much less consideration for medical opinion in cases of gross indecency and buggery than in the other two offences. Of the 96 cases, 57 involved offences against boys (including of course all the indecent assaults) and 39 involved offences against men.

The cases are classified into four groups. Individuals who on investigation were found to have heterosexual tendencies and in whom the homosexual offence was in the nature of a substitution for the normal heterosexual act are classified as "pseudo-homosexuals." The second group consists of the "bisexuals," individuals in whom strong heterosexual as well as strong homosexual tendencies were obvious. Thirdly, there were the "prostitutes," who are individuals who would have fallen into the pseudo-homosexual group but were characterized by the fact that the homosexual acts were carried out for gain. It is of interest that all these cases had previous convictions for the same offence. Finally, there is the group of the "true inverts" which numbered only 13, or 13.5% of the total series.

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