

Psychological Disorders in Singaporean National Servicemen

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Abstract

Young able-bodied male Singaporeans are required to undergo national service. The majority are able to cope with military training without developing any psychological disorders. A small group, however, are unable to handle the rigours of military training. They are identified, diagnosed and managed appropriately so that they can continue to serve national service within their capability. Three types of psychological disorders are highlighted in this paper. Type I cases refer to those with psychotic and neurotic disorders and they are usually downgraded to serve in non-combat vocations. The severe psychotics are exempted from service. Type II cases refer to those with stress-related disorders which are temporary conditions amenable to treatment. Many of them can return to their previous functioning level once their stress-related problems are resolved. Type III cases refer to those who capitalise on their existing physical conditions by complaining or exaggerating their psychological symptoms hoping to prolong their medical condition so that they can get an easy way out. These cases, which are in the minority, require firm handling, limit-setting and counselling so that they can learn to address their problems appropriately without resorting to psychological symptoms. Emphasis is given to the diagnostic approach and treatment of all 3 types of disorders, particularly the stress-related disorders. The roles of unit personnel and family members in providing a corroborative account of the servicemen's behaviour, work performance and inter-personal relationship are given special emphasis in the management of soldiers with psychological problems.

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Introduction

Each year, a cohort of young, able-bodied male Singaporeans are required to undergo national service. Majority of these servicemen are able to handle their military training without much difficulty. Only a small group will experience psychological problems. This article outlines what sort of psychological problems this group presents with and how these problems are dealt with.

Identification of Psychological Disorders

Pre-identified Psychological Disorders

We distinguish between 2 groups of soldiers with psychological problems. The first group refers to those enlisted personnel who have past records of psychiatric problems (pre-identified group). They are assessed during the pre-enlistment medical check-up at the Medical Classification Centre.

The Singapore Armed Forces' (SAF) psychiatrists will look at their past psychiatric records and do a present mental state examination before recommending the appropriate PES (PULHEEMS Employment Standards) grading. Severe cases of psychiatric disorders such as schizophrenia and manic depressive psychosis are usu-

ally exempted from service. For those found suitable for enlistment, a decision will be made regarding follow-up review during their active period of national service (NS). Some of these pre-identified soldiers are reviewed regularly by the SAF psychiatrists. Others are counselled by the SAF counsellors during their NS stint.

The Unit medical officers (MOs) will also periodically review all these servicemen to ensure that they are coping satisfactorily in the unit. They will liaise with the respective psychiatrists or counsellors to obtain feedback.

Psychological Disorders After Enlistment

This second group involves servicemen who developed psychological problems after their enlistment. They can either go direct to see their camp medical officer or their general practitioners (GPs) or sometimes, even private psychiatrists. The camp doctor will do a preliminary screening and then decide whether to refer the patient to the SAF psychiatrists. For those seen by the GPs or private psychiatrists, a medical report is usually forwarded to the camp doctor who will then decide whether to refer the serviceman to the SAF psychiatrists.

In some instances, they may call the SAF Hotline to

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unburden their problems. Counsellors from the SAF Counselling Centre will counsel these soldiers and if psychological problems are elicited, will refer some cases to the SAF psychiatrists for assessment and treatment.

In a few instances, it is the camp staff who detect that the serviceman is not coping well with his training or is behaving abnormally. They will refer the serviceman to the camp MO who in turn will assess the soldier and determine if he needs to be referred to the SAF psychiatrists.

Figure 1 shows how servicemen with psychological problems are managed in the SAF.

Categories of Psychological Disorders

We divide psychological disorders in the military into 3 broad categories.

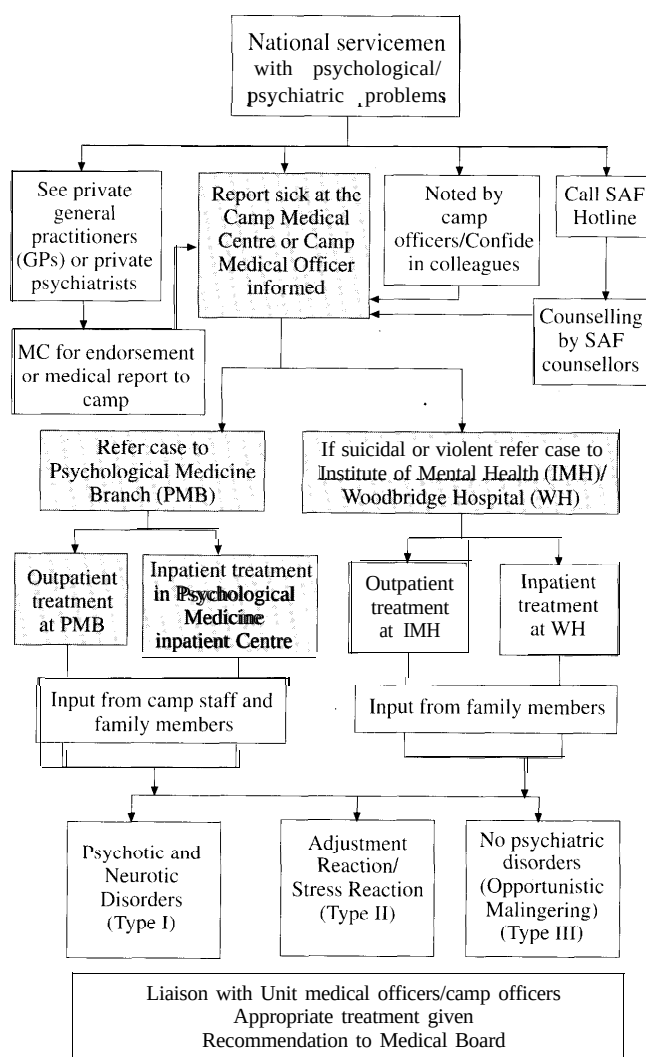


Fig. 1. Management of SAF national servicemen with psychological or psychiatric problems.

Type I psychological disorders consist of clearly-defined psychiatric disorders such as Psychotic Disorders (mainly schizophrenia, delusional disorder and bipolar affective disorder); Neurotic Disorders (mainly panic disorder, generalised anxiety disorder and obsessive-compulsive disorder); Personality Disorders (mainly anxious personality disorder and emotionally-immature personality); Sexual Disorders (mainly homosexuality) and Mental Handicap. About two-thirds of cases seen in the SAF belong to this group.

Type II psychological disorders consist of Stress-related Disorders comprising Acute Stress Reaction (ICD-10's F43.0¹), Post-traumatic Stress Disorder (ICD-10's F43.1) and Adjustment Disorder (ICD-10's F43.2). About one-third of cases seen belong to this group.

Type III psychological disorders refer to servicemen who present with psychological symptoms but mental state assessment do not reveal any psychiatric disorders. Many of them in this group capitalise on existing physical problems (mainly orthopaedic in nature) to complain of psychological symptoms. For instance, they complain of additional psychological symptoms such as difficulty sleeping, poor concentration, feeling low in mood or feeling frustrated easily which do not amount to any psychological disorder. Such cases are termed "opportunistic" malingerers (i.e. taking advantage of their existing physical ailment to complain of secondary psychological symptoms which tend to be exaggerated) in contrast to pure malingerers who feign mental illness in an outright and deliberate manner. Only a handful of cases belong to this group.

The aim of dividing the psychological cases into 3 types is for more effective management and treatment. Type I cases in general will be medically downgraded and assigned suitable vocations. These cases continue to receive maintenance therapy whilst in service. For Type II cases which are stress-related, majority of them do recover and return to their optimal functioning after a period of treatment. Type III cases need to be singled out for firm handling and limit-setting as they are merely taking advantage of their situation to get an easy way out.

Aetiology

Three contributory factors must be considered in considering the aetiology of psychological disorders in the military:

- the nature of the **stressors** (defined as the persons or events which are causing psychological problems for the serviceman);
- the **situation** in the camp and at home (particularly the degree of support the serviceman gets from his peers, officers and family members);
- and the **self** (particularly his personality, his vulner-

ability and usual coping skills as well as his perception of the stressors).

In other words, whether a serviceman breaks down with a psychological disorder depends on the inter-play of these 3 contributory factors. Hence, subject to the same tough training in the same environment and given the same degree of support from the camp and family members, a motivated serviceman sees his training as a challenge and will overcome all odds to do well whilst another less motivated serviceman sees it as a chore and soon develops psychological symptoms.

Moreover, in predisposed vulnerable individuals, the stressors they experience may actually precipitate a psychotic breakdown. Similarly, existing neurotic symptoms of those with Neurotic Disorders may become intensified.

In the military, the following points are often cited as causing stress during the first few weeks of basic military training: (a) abrupt transition from a civilian environment into a military one, (b) separation from family and loved ones, (c) learning to live with strangers and to accept the lack of privacy, and (d) learning to take orders and coping with demanding military discipline.

Fortunately, the majority of our servicemen are able to handle the stress of military life well and they go on to complete their military training without any psychological problems.

Our clinical experience show that those servicemen who are unable to take the rigorous training and who develop psychological problems subsequently invariably have individual vulnerability characterised by an anxious disposition (timid, nervous and introverted), difficulty in getting along with others and emotional immaturity.

Whilst it is neat to consider the 3 types of psychological disorders, some degree of overlap between the 3 types is inevitable. For instance, a serviceman with Type II Disorder, e.g. Adjustment Disorder, may have an underlying severe Personality Disorder (Type I Disorder). Similarly, a serviceman with Opportunistic Malinger (a Type III Disorder) may also have some underlying personality problems.

Clinical Features

Those with Type I Psychological Disorders (e.g. Psychotic or Neurotic Disorders) usually present with clinical features which are similar to those encountered in non-military setting. Instead of highlighting this group, we will highlight the Type II Psychological Disorders.

In Acute Stress Reaction, which usually develops soon after experiencing the stressors, there is an initial stage of feeling dazed and appearing confused with decreased level of attention.² The psychological symp-

toms are mixed and variable ranging from irritability, poor concentration, insomnia, anger, despair, to restlessness. Sometimes, servicemen complain of somatic symptoms such as headaches, indigestion, chest tightness and difficulty breathing. The accompanying autonomic signs include increased heart rate, sweating, and flushing.

At times, the clinical presentation is mainly behavioural in nature. The serviceman may be seen walking around aimlessly, appearing lost and frightened. He may avoid certain places in the camp or refuses to take part in certain camp activities, or he may be socially withdrawn, preoccupied and quieter than usual.

Occasionally, when under acute stress, a serviceman may present with acute hysterical features (either dissociative features such as psychogenic trance state and fugue or conversion symptoms such as psychogenic weakness or paralysis of limbs). Such hysterical features are becoming uncommon (Table I).

Post-traumatic Stress Disorder differs from Acute Stress Reaction in that the onset of clinical symptoms is usually weeks or months after the initial stressful event. What is emphasised is the serviceman's perception of that stressful event and his inability to come to terms with it. For instance, an event such as the over-turning of a truck due to careless driving which resulted in the death of another serviceman may continue to haunt the driver of the truck months later.

The characteristic clinical features include repeated painful re-experiencing of the event, intrusive memories (known as flashbacks), dreams and nightmares. The serviceman may have avoidance behaviour (avoiding the place or activity which would remind him of the trauma) and may be emotionally numbed. There are associated features of anxiety and depression as well (Table II).

Adjustment Disorder, in contrast to Acute Stress Reaction and Post-traumatic Stress Disorder, is associated with adapting to a new situation or a significant change in a serviceman's life. Examples include attend-

TABLE I: MAIN FEATURES OF ACUTE STRESS REACTION

Initial stage:

- In a state of daze, confusion and disorientation
- Emotional detachment and unresponsiveness
- Decreased attention

Later stage:

- Symptoms of anxiety or depression (e.g. difficulty sleeping, irritability, poor concentration, agitation)
- Increased arousal (e.g. hypervigilance, exaggerated startle response, restlessness and overactivity)

Associated autonomic features include increased heart rate, sweating, and flushing. Sometimes, acute hysterical features (e.g. dissociative or conversion symptoms) may be present.

ing a new course, working in a new unit, or handling a new assignment.

The presenting symptoms are varied, ranging from predominant anxiety symptoms (e.g. palpitations, dryness of mouth, and rapid and shallow breathing) to depressive features (e.g. low mood, loss of appetite, and poor concentration) to a combination of both anxiety and depressive features. Sometimes, the main presenting feature may be just disturbance of conduct (Table III).

The main differences between Acute Stress Reaction, Post-traumatic Stress Disorders and Adjustment Disorders are shown in Table IV.

Diagnostic Approach

When a soldier presents with psychological problems, a psychiatric assessment is carried out to determine whether it is a Type I Psychological Disorder. If it is, the appropriate diagnosis (e.g. schizophrenia or neurotic disorder) is made and treatment instituted.

TABLE II: MAIN FEATURES OF POST-TRAUMATIC STRESS DISORDER

- Sense of emotional numbness; detachment from other people
- Recurrent and intrusive recollections of the event (including images, thoughts or perceptions)
- Recurrent dreams of the event
- Episodes of re-living of the trauma (as if the traumatic event was recurring), so-called "flashbacks"
- Avoidance of situation reminiscent of the trauma
- State of increased arousal (e.g. hypervigilance, exaggerated startle response, restlessness and overactivity) and some associated depressive features such as insomnia, irritability and difficulty concentrating
- Impairment of social and occupational functioning

TABLE III: MAIN FEATURES OF ADJUSTMENT DISORDER

- Present with one of the following predominant symptoms:
- with anxiety symptoms such as palpitations, jitteriness, and shallow breathing or
 - with depressed mood such as low mood, tearfulness, and hopelessness, poor concentration, insomnia or
 - with mixed anxiety and depressed mood or
 - with disturbance of conduct such as truancy, vandalism, reckless driving and fighting

TABLE IV: STRESS-RELATED DISORDERS-MAIN DIFFERENCES

Stress-related Disorders	Onset of symptoms	Nature of symptoms
Acute Stress Reaction	Symptoms start within 4 weeks	Usually transient; psychological and somatic symptoms; sometimes behavioural disturbance
Post-traumatic Stress Disorder	Symptoms start more than 4 weeks after stressors or may be delayed longer	Classic symptoms: re-experiencing the trauma ("flashbacks"), emotional numbing/avoidance behaviour, increased arousal and vigilance
Adjustment Disorder	Within 3 months of the change event	Either anxiety or depressed mood (or mixture of anxiety or depressed features) or behavioural disturbance

When a diagnosis of Stress-related Disorder (Type II Psychological Disorders) is made, the following points need to be considered."

Firstly, the stressors must be clearly defined and there must be a temporal connection between the experience of the stressors and the onset of symptoms. Acute Stress Reaction normally starts within a few weeks of the traumatic event (DSM-IV specifies within 4 weeks). For Post-traumatic Stress Disorder, the onset is usually delayed, more than 4 weeks after the traumatic event. In Adjustment Disorder, the onset is usually within 3 months of the significant life change.

Secondly, the symptoms must be clinically significant. In other words, the symptoms are more than what an ordinary person would experience if subject to the same stressors and there must be impairment of functioning both at work and socially.

Thirdly, Type III Disorders (those with Opportunistic Malingering) must be excluded. Time is spent to understand the underlying personality of the serviceman and to check with camp staff/family members regarding his attitude, motivation and work performance or behaviour at home.

Servicemen with Type III Disorders are negative in attitude and usually exaggerate their existing physical or psychological symptoms or unrealistically prolong their symptoms hoping to get a medical downgrading.

What such negative servicemen need is motivation and discipline. Here, the full co-operation of the camp officers, family members, counsellors and camp doctors is crucial to show consistency, firmness and fairness in the handling of such poorly-motivated servicemen. Those who are found to be malingering should be taken to task.

Although such servicemen are in the minority, they are often the most vexing and exasperating cases to handle in terms of time and effort consumed. They also generate a fair amount of counter-transference, often negative, in the therapist and those staff who are trying to help them.

Investigations

Medical investigation will depend on the clinical picture. If there is evidence to suggest an organic brain

pathology (e.g. confusion and disorientation, impaired judgement, poor memory, slurred speech and abnormal gait), the relevant investigations (e.g. computerised tomographic scan or magnetic resonance imaging) should be carried out to rule out a treatable organic condition.

Psychological investigations (e.g. IQ test, personality assessment, and neuropsychiatric assessment) are carried out according to the presenting clinical picture.

Social investigation involves the attending doctor obtaining a corroborative account from family members and immediate camp officers or camp mates so that there is a clearer understanding of the nature of the serviceman's problems and his camp and home situation.

The camp officers can give their inputs regarding the serviceman's attitude, motivation and job performance and family members can help elaborate on the serviceman's pre-morbid personality, his life at home, his relationship with others (friends and family members) and other family-related or personal problems.

Particular attention should be paid to the usual coping mechanisms used by the serviceman in handling past stressful events. It may be useful to know his extra-curricular activities in school as this information will help in sizing up the previous level of personal competence and functioning so that a comparison can be made between then and now.

Treatment

For Type I Disorders, anti-psychotic medication 'is given to those suffering from Psychotic Disorders and anxiolytics and anti-depressants are given to those with severe Neurotic Disorders and Affective Disorders. Appropriate PES grading is recommended according to the level of functioning of these soldiers with Type I Disorders.

For Type II Disorders (stress-related disorders), treatment consists of:

a) Camp / family support: Getting understanding and support from the camp and the family is vital in dealing with Type II Disorders. It is useful for the attending doctor to speak to the camp officers to explain, in layman's terms, the serviceman's difficulties without breaching medical confidentiality. He also may want to elicit the help of family members in providing care and support when the serviceman is recuperating at home. Family members need to know that when a serviceman breaks down, it is often the combination of the 3 S's (stressor, situation and self) and it is erroneous just to put blame solely on any one factor.

b) Recommendation to Medical Board: If the stress-related disorder is likely to take a while to resolve, the camp doctor may need to schedule the serviceman for

a Medical Board to downgrade him temporarily, say for 3 to 6 months, to a less strenuous vocation or recommend posting to a different unit for him to recuperate from his illness. If the serviceman is attending a course, say Basic Military Training, he may be temporarily taken out of his training and allowed to recuperate. He can then be scheduled for another Basic Military Training at a later stage when he has recovered.

c) Symptomatic relief: As a rule, medication is seldom required in the treatment of stress-related disorder. If it is used at all, it is only for a short period of time, often not more than 3 months. Treatment with medication is largely symptomatic; to relieve patients of their distressing symptoms.

Anti-anxiety drugs (e.g. benzodiazepines) are mainly used for the purpose of control of anxiety symptoms (such as palpitations, shallow breathing, feeling tense and tremulous) and for the treatment of insomnia. If depressive symptoms (such as poor appetite, difficulty concentrating, low mood) predominate, anti-depressants may be given. In agitated patients with behavioural problems, a small dose of anti-psychotic medication can be considered.

d) Referral for in-patient treatment: If the serviceman is likely to harm himself (e.g. a depressed serviceman who is suicidal) or harm others (e.g. a psychotic serviceman who is potentially violent), the serviceman should be admitted for urgent in-patient treatment.

e) Supportive counselling/psychotherapy: The main-stay of treatment for Stress-related Disorder is short-term supportive counselling; often lasting 3 to 6 months at a frequency of once or twice a week. The aim of the supportive counselling is to help the affected serviceman re-appraise his stressors and learn new coping skills in handling them.

For a few patients, individual psychotherapy may be indicated as it allows these patients a more in-depth exploration of the meaning of the stressors they are facing so that any unresolved conflicts, earlier traumatic experiences and personality inadequacies can be worked through. The goal of treatment is to remove these obstacles so that successful adaptation and the maturing process can take place.

f) Group counselling can be useful for groups of servicemen with Stress-related Disorder as they can talk about their difficulties in the camp and learn from each other how to overcome some common difficulties.

g) Family therapy: Sometimes, aside from individual counselling or psychotherapy, family therapy is found to be effective for serviceman who shows strong dependency needs and emotional immaturity. The emphasis is shifted from the individual to the system of relationships within the family. The psychiatrist seeks to clarify skewed communication pattern, enmeshed rela-

tionship between the serviceman and his parents, over-protection and rigidity in the hope that personal growth and maturity can take place so that the serviceman is less vulnerable to the recurrence of Stress-related Disorder.

Prognosis

For servicemen diagnosed with Type I Disorders, appropriate management in terms of medication, PES grading, suitable vocation, family and camp support, will mean that they can function well and serve their full stint of national service.

In Type II Disorders, if detected early when the symptoms are mild, most servicemen with Acute Stress Reaction and Adjustment Disorder return to their previous level of functioning after a 3 to 6 months' period of recuperation. However, for the severe cases and for Post-Traumatic Stress Disorder, the prognosis may not be favourable. Some of these cases may need to be medically downgraded and have their vocations changed mainly because of their intrinsic personality inadequacy and their vulnerability to breakdown again if subject to undue stress.

Servicemen diagnosed with Type III Disorders, if dealt with firmly and fairly with proper setting of limits, can also function satisfactorily in NS. However, if not dealt with properly, they can manipulate camp situa-

tions to suit their personal needs and will therefore continue to give problems in the camp. Such soldiers should be exposed quickly and a collective plan of management worked out between the camp doctor, camp officers, counsellor and SAF psychiatrist so that all are clear in handling such soldiers.

Conclusion

This article highlights how psychological disorders in the military are identified, classified and managed in the SAF. About two-thirds of cases seen are Type I Disorders (clearly-defined psychiatric disorders), and one-third are Type II (Stress-related) Disorders. Only a fraction belongs to Type III (Opportunistic Malingering). The timely handling of the patients, especially Type II and Type III Disorders, is crucial for proper recovery and prevention of fixation of psychological symptoms; thus, conserving manpower.

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