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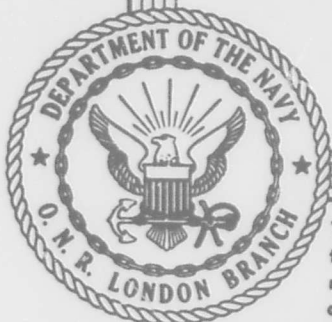
PSYCHIATRY IN THE NORWEGIAN DEFENSE FORCES

BY

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PSYCHIATRY IN THE NORWEGIAN DEFENSE FORCES

The Norwegian armed forces are relatively small, numbering less than 35,000 men. For some years they have operated an integrated tri-service medical department, although each branch of the service has its own surgeon-general and medical officers who wear the uniform of and are primarily identified with the given service. Thus, the integration actually is more apparent in the administration, budgeting, and broad policy than it is in the actual practice of military medicine. Historically, the Army and Air Force have never developed full-scale neuropsychiatric (NP) programs. The Navy, however, at one time had a substantial NP effort.

From approximately 1950 to 1963, Dr. John Greve-Brun was the Surgeon-General of the Norwegian Navy. Greve-Brun was extremely interested in the problems of military neuropsychiatry, although he himself was not trained in this discipline. A man of independent means, he devoted his full time to the Navy rather than maintaining a private practice as is customary for Scandinavian military medical officers. Under him, the first psychiatrists were brought into the Norwegian Navy, and a group of clinical psychologists were commissioned and served in uniform. In many respects this was a golden era of Norwegian military neuropsychiatry. The psychologists and psychiatrists formed a closely-knit unit and embarked upon a rather extensive program of research, assessment, and therapy. None of this work has been published in English, although some of it is of sufficient interest to warrant summarizing.

In 1952 Commander Per Joren, chief psychologist of the Royal Norwegian Navy; Dr. Johan F. Thaulow, the senior Navy psychiatrist; and Commodore Ole A. Mortensen, the present Surgeon-General, embarked upon an extended study of selection procedures in the Navy. The primary aim of the research was to institute a selection procedure which would decrease the disciplinary difficulties experienced in the Navy.

Parenthetically, it should be noted that nearly all enlisted men in the Norwegian armed forces are conscripted through a national service system which requires 16 months of active duty in one or another branch of the services from every able-bodied Norwegian male. All conscripts for the Navy are drawn from the Merchant Marine service. Traditionally, the Norwegian Merchant Marine has in turn drawn its recruits from individuals who have had difficulty in adjusting at home. Thus, the enlisted input into the Norwegian Navy contained an inordinately large proportion of character disorders, and for many years disciplinary rates in the Navy were far in excess of those

found either in the Army or the Air Force. A program was developed which included both a basic test battery and a clinical evaluation. In addition to ability and manual dexterity tests, and a biographical questionnaire, background information was obtained on each man from public registers maintained by the police, school system, and labor bureaus. All incoming recruits received individual interviews by psychologists and problem cases were referred to consulting psychiatrists.

Prior to the introduction of the selection program in 1956, approximately ten percent of new conscripts were rejected for NP reasons on the basis of their records. By 1960 the NP-rejection rate of recruits had been increased from 10 to 15%; however, the disciplinary offense rate had been reduced by 60%. That is, in 1960 there were 60% less offenses than in 1955, the last year before the program was introduced. During the same period there was no reduction in disciplinary rates of the other two branches of the service, so it is not possible to attribute the change to a difference of personnel input or service management.

During the early stages of the above program, another investigation was initiated by Thaulow to determine the post-service adjustment of 593 men discharged from the Navy for psychiatric reasons. It was found that the discharged group had a record of approximately five times as many legal offenses before reaching the age of 25 as a control group which completed their naval service, and they had twice the rate of offenses beyond the age of 25 as the controls. Data of this sort led Thaulow to the conclusion that psychiatric separation produced a significant emotional trauma. Thus, a third research program was initiated to reduce the number of men separated from the Navy on psychiatric grounds. Here an attempt was made to develop a treatment program along the general lines of a therapeutic community; however, the focus of management responsibility was placed on line officers and petty officers rather than on medical department personnel. Basically, Thaulow and P.S. Albertsen, a Navy psychiatrist who collaborated with him, consider the tendency of line personnel to shift responsibility for management of such problem cases to the medical department to be one of the primary problems in dealing with character disorders in the military service. Their approach to handling problems of this nature was to shift the responsibility back to the line and help the Navy officers and petty officers to develop techniques for dealing with the immature sailor.

The study was carried out at a Norwegian Navy base located on a small island in the Oslo fjord. This facility had existed for some time and was staffed by men randomly

assigned to the duty of repairing antisubmarine nets. It was ideal for the study because it was reasonably isolated and all of the individuals working at the command were in close contact. It was anticipated that men would be assigned to the therapeutic community program until they demonstrated an adequate service adjustment. At that time they would be transferred to other units. Periodic group therapy sessions were conducted by the psychiatrists; these included the line officers and petty officers as well as the seamen who served as subjects. As might be anticipated, considerable difficulty was encountered through resistance on the part of the line officers. In spite of the fact that these men had been specially selected for this assignment, their training and experience as sea-going line officers were such as to make it extremely difficult for them to engage in the group therapy situation. Generally speaking, no startling results were obtained with the subjects, but the study was considered to be successful because the investigators learned how programs of this nature might be conducted. Unfortunately, before the study could be replicated major changes took place within the Norwegian Navy medical department and all of the psychiatric work came to a standstill.

The Navy NP program as established by Commodore Greve-Brun was an almost autonomous segment of the Norwegian military medical department. There was little or no contact with the Department of Defense Military Psychology Institute, the Army, the Air Force, or other related groups. Both the Navy psychologists and psychiatrists were responsible solely to Greve-Brun. A multitude of unrelated but coinciding events brought the program to a rather complete and final termination.

Greve-Brun resigned from the Navy and became Executive Secretary of the Norwegian Medical Association. The chief psychologist, Johan, who had been one of the major motivating forces in the program, also resigned at about the same time as Greve-Brun. Thaulow began to devote full time to his private practice and Albertsen left the Navy.

In 1962, as a result of a Norwegian Defense Department study, both the Air Force and the Navy psychology programs were disbanded; and the responsibility for all personnel selection was assigned to a central military psychology institute. At the same time, the psychiatrists working with the Navy found it impossible to continue their research program without the assistance of their psychological collaborators. Essentially, the role of psychiatry in the Norwegian Navy was reduced to one of almost complete nonexistence. Thaulow remained as a consultant to the Surgeon-General but was not clinically active. In fact, his consulting was restricted primarily to giving

advice on the handling of difficult administrative problems.

In retrospect, particularly to one who is familiar with the program, its termination was extremely unfortunate in many respects. First, the Norwegian Navy is small enough to permit one to conduct carefully-controlled NP research projects which would not be possible in the US Navy because of the sheer size of the organization. Secondly, a highly effective and well-trained team had been developed. Moreover, this team had the full support of the Navy medical department. Finally, and most important, the program had actually produced results, particularly in selection, which might well be the envy of many military psychiatry groups throughout the world.

Within the past few months there has been renewed activity in Norwegian military psychiatry, although the focus of this activity is at the Department of Defense level. Dr. Arne Sund recently has been appointed as Chief Psychiatrist for the Norwegian forces. Sund, who has experience as an army medical officer, is a young, extremely pleasant, and energetic individual who obviously is quite challenged by the task of building a meaningful psychiatric program within the forces. During the few months Sund has been in office he has accomplished a great deal -- at least in the primary stage.

As in the case of almost all military medical officers in the regular forces of Norway, Sund's appointment in the Department of Defense is half rather than full time. The remainder of his time is spent on the staff of the University of Oslo Psychiatric Clinic, where he is engaged in a rather extensive follow-up study of men separated for psychiatric reasons from the Norwegian forces.

Fortunately, Sund relates well to the surgeons-general of all three services and reportedly has their support. There are no psychiatrists identified with a given service in the Norwegian forces beyond individuals, such as Thaulow, who may serve as consultants to a surgeon-general. As in most countries, military psychology is not looked upon as being particularly rewarding by Norwegian clinicians, and recruiting has proved to be an extremely difficult problem. For the most part, the practice of psychiatry in the Norwegian forces now is confined to a limited diagnostic service. In isolated cases, the psychiatrist does spend time with the military commanders, acting in a role of a mental hygiene consultant. The only military hospital in Norway has been closed and all psychiatric treatment of armed forces personnel is carried out in civilian hospitals. Both Sund and Thaulow consider this to be a distinct handicap to the practice of military psychiatry. In

fact, Thaulow has a generally pessimistic view about the future of military psychiatry in general as far as the Norwegian forces are concerned. Sund is far more optimistic, and it is entirely possible that the future may be brighter than Thaulow is inclined to believe. In talking to the two men, one obtains the impression that Thaulow might be considered an excellent example of everything the clinician should be, and Sund is an individual whose particular talents are in the field of psychiatric administration.

At present there are six psychiatrists directly affiliated with the military service, in addition to Thaulow, who still does not see military patients but serves as a consultant to the Surgeon-General of the Navy. The psychiatrist at Stavanger, which is primarily a naval training center, spends half time with the Navy and probably is more active than any other single individual. He spends each morning at the training school consulting with the staff officers when he is not working with the Defense Department psychologists in screening recruits.

The psychiatrist at Trondheim has been retained on a half-time basis to provide services for what amounts to essentially the northern half of Norway. This doctor works in the Trondheim hospital and is not available to make trips out of town. Accordingly, it is necessary for all military patients to be referred to his office. In many cases this involves sending a man some 500 miles for a psychiatric consultation. Parenthetically, it should be noted that the difficulties of transportation in northern Norway are almost inconceivable. The Trondheim psychiatrist serves Army, Navy, and Air Force units without distinction.

A third psychiatrist is located in the town of Lillihammer in central Norway. This doctor works primarily with Army personnel and is responsible for psychiatric service at ten different commands, most of which are training units. In carrying out his work he routinely visits the units to meet with company commanders in the role of a mental hygiene consultant. On the other hand, because of the requirements of his civilian practice, the visits to the military stations often are at lengthy intervals. Thus, it is frequently necessary for the station medical officers to refer patients to his office in Lillihammer. Again this practice involves lengthy travel on the part of the patient.

The psychiatrist at Bergen works primarily with naval personnel, but again he is available mainly on a consultation basis. In Oslo, Sund occupies his full time in the Department of Defense with administrative matters and does not see military

patients, although -- odd as this may seem -- he does see civilian patients at the University clinic. There is a half-time psychiatrist who works in the central military dispensary in Oslo.

The strategically important northern part of Norway is guarded by a brigade of 5000 men. At the present time there is no provision for psychiatric care of this group of men and consultations must be referred to Trondheim.

Sund has formulated plans which will result in a somewhat drastic change in the picture outlined above. In fact, if he is successful in implementing his plans the ratio of psychiatrists to active duty personnel will be greater than in the US forces. In the fall of 1966 there will be a review of medical care in the Norwegian forces and Sund has prepared a plan for expanding neuropsychiatry. Norway is divided into 15 military districts. Sund, in cooperation with the Director of the Military Psychology Institute, has developed a plan for staffing each of the 15 areas with a mental hygiene team. At the minimum, this team will consist of one psychiatrist and one psychologist. Wherever possible there also will be a psychiatric social worker. There are no clinical psychologists working with the military forces at the present time, and this specialty is probably in greater shortage than psychiatry in Norway. Thus, the proposed expansion constitutes an extremely optimistic program. However, one suspects that the plan may be successful if Sund and the chief psychologist of the Norwegian Forces are persistent enough in their recruiting efforts. In fact, it is entirely possible that the lack of an active NP program may be attributed primarily to the fact that no-one there before Sund was in a position to accept the responsibility for administration of the program and for recruiting.

The program, as conceived, would be directed primarily toward a mental hygiene unit model of the US Army. The first additions to the psychiatric program definitely are planned for the northern brigade. In order to implement the effort, doctors who have completed only part of their residency training will be utilized as psychiatrists. Here, the idea is to use doctors with three of the required five years of specialized training required in Norway for certification as psychiatrists. Actually, when compared to US military psychiatry programs, even this reduced level of training would result in an exceedingly high quality of professional attention.

Inasmuch as he is relatively new at the job, Sund has not formulated plans for psychiatric programs extending beyond the mental hygiene consultation unit. It is quite likely,

however, that the basic assessment program, and selection for stressful duties, will remain a responsibility of the Military Psychology Institute.

A problem which obviously is unresolved to date is that of the extent to which military psychiatrists should provide treatment for patients. As indicated earlier, almost all enlisted men in the Norwegian Forces are conscripts. There is a rather sharp dichotomy of opinion as to the role of the military psychiatrists and clinical psychologists. On the one hand there is a rather vocal group which advocates providing treatment wherever possible, inasmuch as facilities in most civilian communities for such care are quite lacking. Another group takes the position that it is not the function of the military to provide care for the general population; rather, this group is of the opinion that the military psychiatry program should be focused solely on maintaining an effective fighting force. After hearing advocates of both positions, one is left with the feeling that it may be some time before this issue is fully resolved. Obviously there are numerous political as well as professional considerations involved.

In his recent activity at the Oslo University Clinic, Sund has been engaged in a rather extensive follow-up study of military personnel separated from the Norwegian armed forces during the period 1950-1955. Somewhat over 400 men were separated during this time, and he has selected a sample of 220 who were inducted into the service from the southern half of Norway. After eliminating four subjects who are dead, four who have emigrated to the US, and nine who were unavailable for various reasons, the final number of subjects in the study is 203. These include men treated either as in-patients or out-patients in the military service during the period reported above. Of the sample currently being studied, approximately 50% were returned to duty after their psychiatric treatment. After the 16 months of primary service required of every male, he has an obligation of nine additional years of reserve service. Every third year the reserve military man is required to spend three weeks on active duty. Of the sample studied, approximately 25% have remained in the reserve and have fulfilled their military obligations.

Two control groups are being utilized in the present study. One group consists of 200 men selected at random from conscripts in the Engineer Corps. Eighty percent of the control group completed their reserve service as compared to 25% of the psychiatric patient group. At the present time Sund is working up data on a control group which has been matched with the patients for age, education, social and economic status, etc.

Of the patients sampled, 20% had their service deferred for either one or two years because of their psychiatric symptomatology. Thus, they were called to active duty, examined, and returned home for recall at a later date. On the basis of available data, approximately one man in 20 of those sent home was able to return and complete his normal period of service. Thus, Sund does not believe that the Norwegian policy of deferring character disorders for service at a later date, rather than discharging them as in the US forces, is a particularly worthwhile procedure.

Analysis of the follow-up data has not been completed. However, among the patients who were returned to duty and served effectively through the remainder of their military service, 60% demonstrated adequate postservice adjustment, 29% slight impairment, and 10% marked difficulty in adjustment. Among the ineffective soldiers who were separated from service, 34% showed an adequate postservice adjustment, 35% exhibited a slight impairment, and 32% a marked impairment. The criteria for effectiveness included factors such as time unemployed, duration of unemployment, hospitalization, and conflict with civilian authorities. Because of the Scandinavian procedures for maintaining statistical records on the total population of the country, it is possible to obtain extremely accurate follow-up data. In addition to interviewing each subject, Sund has information from at least one relative, the individual's employer, and his family physician. In addition, data are available from the Central Penal Register, the Register of Fines (a central file of traffic violations, etc.), the Labor Exchange Register, and the Alcoholic Register. Data on performance after return to duty and breakdowns by diagnosis have not yet been analyzed; however, the information regarding disciplinary difficulty has been. Approximately 20% of the 203 men in the patient sample have been in trouble with the police since their release from active duty. This is opposed to approximately 5% of the randomly selected control group. Sund hopes that it will be possible to use data obtained from this study to refine the selection standards for military service.

At the present time one might safely say that there is relatively little in the present-day Norwegian military psychiatry program which would be of interest either to civilian or military psychiatrists in the US. On the other hand, some of the work done in the Navy prior to 1962 well might be worthy of detailed study by the US Forces. The program for deferring active duty in the case of selected character disorders has proved to be less successful than anticipated. However, one obtains the feeling that this was not a rigidly administered program. Although the present picture is not particularly

bright, it is likely that the Norwegian military psychiatry program will become increasingly interesting and important. In particular, the research possibilities offered in the Norwegian forces are unexcelled. The forces are small enough to carry out well-controlled studies and large enough to make the studies meaningful.

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