Treating and Preventing Trauma: British Military Psychiatry during the Second World War

Nafsika Thalassis

European Studies Research Institute
Centre for Contemporary History and Politics
University of Salford, Salford, UK

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ABSTRACT

This is a study of military psychiatry in the Second World War. Focusing on the British Army, it recounts how the military came to employ psychiatrists to revise recruitment procedures and to treat psychiatric casualties. The research has shown that psychiatry was a valued specialty and that psychiatrists were given considerable power and independence. For example, psychiatrists reformed personnel selection and placed intelligence testing at the centre of the military selection of personnel. Psychiatrists argued that by eliminating the 'dull and backward' the tests would help improve efficiency, hygiene, discipline and morale, reduce psychiatric casualties and establish that the Army was run in a meritocratic way. However, it is probable that intelligence testing made it less likely that working-class men would receive commissions.

Still, the Army had no consistent military doctrine about what the psychiatrists should be aiming for –to return as many psychiatric casualties to combatant duties as was possible or to discharge men who had found it impossible to adapt to military life. In the initial stages of the war, the majority of casualties were treated in civilian hospitals in Britain, where most were discharged. This was partly because the majority were regarded as constitutional neurotics. When psychiatrists treated soldiers near the front line most were retained in some capacity. The decision on whether to evacuate patients was influenced by multiple factors including the patients' military experience and the doctors' commitment to treatment or selection.

Back in Britain, service patients were increasingly more likely to be treated in military hospitals such as Northfield –famous for the 'Northfield experiments'. These provided an alternative model of military psychiatry in which psychiatric intervention refocused away from individuals and their histories and onto social relationships, and where the psychiatrists' values were realigned with the military rather than with civilian general medicine.

Introduction

This is a study of military psychiatry in the Second World War. Focusing almost exclusively on the British Army, it recounts how the military came to employ psychiatrists (and a few psychologists) to reform its recruitment and promotion procedures and to treat its psychiatric casualties. In addition, it explores how psychiatrists responded to these challenges with new selection procedures and therapeutic regimes. The military purpose in employing psychiatrists and psychologists was to reduce manpower wastage and this was the principle that underscored psychiatry in the different military contexts in which it was practiced. Nevertheless, this principle was interpreted differently in different military contexts – sometimes emphasis was placed on retaining staff who were still of some use to the forces and other times on discharging unsuitable personnel who were thought of as "consumers of manpower."[1]

A variety of sources has been used for this work. Among them are psychiatric, military and government reports, and the minutes from Army Council meetings found in the National Archives. Further psychiatric reports, army memoranda as well as unpublished medical articles located in the Royal Army Medical Corps Collection and the General Collections of the Contemporary Medical Archive Centre, Wellcome Trust, have been widely used. Research for this dissertation has benefited greatly from access to the personal papers of the Adjutant-General Ronald Adam, Dr John Rickman, Dr William Sargant and Dr S. H. Foulkes, some of which have included soldiers' medical records from the Second World War, which have never previously been written about. Of great advantage have also been the parliamentary papers, and the official medical histories of the First and Second World Wars. Contemporary articles published predominantly in *The Lancet*, *The Journal of the Royal Army Medical Corps*, *The Army*

[1] J.R. Rees, (1945) *The Shaping of Psychiatry by War*, London: Chapman & Hall, p. 43.

Quarterly, *The Journal of Mental Science*, *Proceedings of the Royal Society of Medicine, The British Medical Journal*, as well as other journals have been frequently used, as have contemporary psychiatric monographs and textbooks.

In recent years, shell-shock has been rediscovered. This newfound popular interest can be traced to the publication of Pat Barker's *Regeneration*[2] in 1991, the first novel in what came to be known as the *Regeneration Trilogy*. The trilogy capitalised on the British public's familiarity with the First World War poets to recount the experiences of Siegfried Sassoon and Wilfred Owen in a military psychiatric hospital –and it succeeded in attracting a huge readership as well as literary acclaim. Since then, a number of historical volumes on military psychiatry have been published, though mostly covering the more commercial end of the market, there have also been scholarly works.[3] While some of these

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[2] P. Barker, (1991) *Regeneration,* London: Penguin Books. Prior to the Regeneration trilogy, the most widely-read pieces on shell-shock were E. Leed, (1979) *No man's land: Combat and Identity in World War I,* Cambridge: Cambridge University Press, chapter X, and E. Showalter, (1985) *The Female Malady, Women, Madness and English Culture,1830-1980,* New York: Pantheon Books, chapter 7. Nonetheless, both these texts found a much wider readership once they became known as the acknowledged sources for *Regeneration*. Other works published in this period are: T. Bogacz, (1989) 'War Neurosis and cultural change in England 1914-22: The work of the War Office Committee of Enquiry into shell-shock', *Journal of Contemporary History,* 24, pp. 227-256; M. Stone, (1985) 'Shellshock and the psychologists', *The Anatomy of Madness, Vol. II, Institutions and Society,* (eds) F. Bynum, R. Porter & M. Shepherd, London: Tavistock Publications.

[3] A. Babington, (1997) *Shellshock, A history of the Changing Attitudes to War Neurosis,* London: Lee Cooper; A. Becker, (2000) 'The Avant-garde, madness and the Great War', *Journal of Contemporary History*, 35, No 1, pp. 71-84; H. Binneveld, (1997), *From Shellshock to Combat Stress, A comparative History of Military Psychiatry,* Amsterdam: Amsterdam University Press; J. Bourke, (2000) 'Effeminacy, ethnicity and the end of trauma: the sufferings of 'shell-shocked' men in Great Britain and Ireland, 1914-39', *Journal of Contemporary History,* 35, No 1, pp. 57-69; W. Holden, (1998) *Shellshock,* London: Channel4 books; D. Kaufmann, (1999) 'Science as cultural practice: psychiatry in the First World War and Weimar Germany', *Journal of Contemporary History*, 34, No 1, pp. 125-144; A. Kunka, (2001) *The inward scream: shell-shock narratives in twentieth-century British culture*, PhD Thesis: Purdue University; E. Leed, (2000) 'Fateful memories: industrialized war and traumatic neuroses', *Journal of Contemporary History,* 35, No 1, pp. 85-100; P. Leese, (2002) *Shell-shock, Traumatic neurosis and the British soldiers of the First World War,* New York: Palgrave; P. Lerner, (2000) 'Psychiatry and casualties of war in Germany, 1914-

volumes have touched on military psychiatry prior to, or after, the First World War, nonetheless popular interest remains firmly rooted in shell-shock, the disorder which was discovered, established and abandoned within the Great War.

In contrast, military psychiatry in the Second World War remains a hugely under-researched area. The scholarship consists mainly of two publications written in the 1950s by psychiatrists who had been personally involved in military psychiatry during the war[4] and a recent monograph by the historian Ben Shephard[5] that describes military psychiatry in the whole of the twentieth century, dealing mainly with the British and American Armies, but touching also on other European Armies. The histories which were written by psychiatrists provide immense information and fascinating detail, but are best treated as primary rather than secondary sources; the authors were not writing from a perspective of distance and their accounts are on the whole very similar to the articles and reports written during the war. Ben Shephard's book on the other hand is enormously well researched

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18', *Journal of Contemporary History,* 35, No 1, pp. 13-28; P. Lerner, (2003), *Hysterical men: war, psychiatry, and the politics of trauma in Germany, 1890-1930,* New York: Ithaca; C. Merridale, (2000) 'The collective mind: trauma and shell-shock in twentieth-century Russia', *Journal of Contemporary History,* 35, No 1, pp. 39-55; M. Micale, & P. Lerner, (eds), (2001), *Traumatic Pasts, History, Psychiatry and Trauma in the Modern Age, 1870-1930,* Cambridge: Cambridge University Press; G. Mosse, (2000) 'Shell-shock as a social disease', *Journal of Contemporary History,* 35, No 1, pp. 101-108; M. Roudebush, (2000) 'A patient fights back: neurology in the court of public opinion in France during the First World War', *Journal of Contemporary History,* 35, No 1, pp. 29-38; B. Shephard, (2000) *A War of Nerves*, London: Jonathan Cape; J. Winter, (2000) 'Shell-shock and the Cultural History of the Great War', *Journal of Contemporary History*, 35, No 1, pp. 7-11.

[4] The official medical history of the Second World War discusses psychiatry mainly in two sections. The first section was composed by the Directorate of Army Psychiatry, F.A.E. Crew (ed), (1955), 'The army psychiatric service', *The Army Medical Services,, Administration, Vol. II,* London: HMSO, pp. 467-497; the second was based on the memoirs of the G.W.B. James, Consultant in Psychiatry in the Middle East and can be found in F.A.E. Crew (ed), (1957), 'The Army Psychiatric Service. The Middle East Force 1940-1943', *The Army Medical Services, Campaigns,* Vol. II, London: HMSO, pp. 440-513. A similar but more extensive account can be found R. Ahrenfeldt, (1958), *Psychiatry in the British Army in the Second World War*, London: Routledge & Kegan Paul.

[5] B. Shephard, (2000).

and provides a wealth of information and bibliographical detail but as it covers a huge span and is intended mostly for a commercial market it necessarily tends to be descriptive and to reproduce the perspectives of the main players unchallenged. Other works on this topic tend to be short, commercial volumes that span the entire twentieth century[6] or explore very specific aspects of military psychiatry only.[7]

The absence of scholarly interest in this field does not mean, however, that military psychiatry in this period was an insignificant part of military medicine. On the contrary, military psychiatrists were given unprecedented new powers that were unheard of in previous conflicts. These included powers to revise the recruitment and promotion procedures in all three services, and a separate administrative department devoted to Army Psychiatry in the Army Medical Department –an honour given only to three other medical specialties.[8] With regard to actual treatment, an elaborate network of forward psychiatric treatment centres was developed, the principles of which had been established at the end of the Great War, but which were much expanded in the Second World War, while back in Britain radical new social treatments were created and put into practice for the first time. Nonetheless, psychiatric casualties were huge –psychiatric

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[6] Such as A. Babington, (1997), H. Binneveld, (1997), W. Holden (1998).

[7] For example, Sydney Brandon has written about the diagnosis of *lack of moral fibre* in the RAF during the Second World War, S. Brandon (1996) 'LMF in Bomber Command 1939-45: diagnosis or denouncement?', *150 Years of British Psychiatry, Volume II, The Aftermath*, (eds) H. Freeman & G. Berrios, London: Athlone. The psychiatrist Tom Harrison has written a book on Northfield military hospital. T. Harrison, (2000), *Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front*, London: Jessica Kingsley. The following discuss aspects of personnel selection: J. Crang, (2000) *The British army and the People's War*, Manchester: Manchester University Press; N. Rose, (1989) *Governing the Soul, the Shaping of the Private Self*, London: Free Association Books; P.E. Vernon & J.B. Parry, (1949) *Personnel Selection In The British Forces*, London: University of London Press. Joanna Burke discusses aspects of the treatment of civilian psychiatric casualties caused by air raids, J. Bourke, (1998) 'Disciplining the Emotions, Fear, Psychiatry and the Second World War' in *War, Medicine and Modernity* (eds) R. Cooter, M. Harrison & S. Sturdy.

[8] The other 3 specialties were Hygiene, Pathology and Dentistry. The importance of this point can be illustrated by considering the specialties that did not get their own department: for example surgery or infectious diseases.

illness remained, throughout the war, the primary cause of medical discharge, accounting for between 30 and 40% of all discharges due to disease (not wounds).[9]

This dissertation focuses on three major areas: the relationship between psychiatrists and the military, the rationalisation of recruitment and promotion through psychological techniques and the different forms of psychiatric practice in different military settings.

With regard to the relationship between psychiatry and the military this work has found that the evidence from the psychiatric military experience gives support to the works of Mark Harrison, David French and David Edgerton who have argued that the British Army in the Second World War held a doctrine in support of medical, scientific and technological innovation.[10] While this doctrine did not translate into practice in all fields at the onset of the war, it certainly did in most instances by the latter part of the war, especially from 1943 onwards. In the field of psychiatry, the primary examples of such developments are the psychiatric involvement in the selection of officers and in the testing of other ranks and the establishment of forward psychiatry. Some of these developments are paralleled in other fields of medicine, which, for

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[9] W. Mellor, (1972) *Casualties and Medical Statistics,* London: HMSO, p. 439. Actual figures for the number of psychiatric casualties are difficult to compute, however Mellor states that in the years 1943, 1944, and 1945 the rate of discharge for mental diseases was 6.24, 8.55 and 9.42 per 1000 troops respectively. This computes to approximately 68000 men having been discharged in the last 3 years of the war from the Army alone. In addition, the *Report of an Expert Committee on the work of psychologists and psychiatrists in the services* states that approximately 118,000 men were discharged from all three services between September 1939 and June 1944 (HMSO, 1947), while the medical officer H. L'Etang, gives the figure of 109,000 as the number of men discharged from the army during the entire war, H. L'Etang, (1951) 'A criticism of military psychiatry in the Second World War', *Journal of the Royal Army Medical Corps,* 96, p.192. Figures between 10% and 20% were generally reported as the proportion of psychiatric casualties to general battle casualties after a battle.

[10] D. French, (2000) *Raising Churchill's Army; The British army and the War against Germany 1919-1945,* Oxford: OUP; M. Harrison, (2004) *Medicine and Victory, British Military Medicine in the Second World War,* Oxford: Oxford University Press; D. Edgerton (forthcoming), *Warfare State: militarism, expertise and twentieth century Britain.*

example, contemporaneously established forward treatment centres. Among the reasons for this shift are the therapeutic benefits of early treatment but also the reduction of the overall time patients spent away from their units, which in turn decreased incentives for malingering. Significantly, many new developments were not technical but organisational –for example, there were changes in how hygiene regulations were enforced which placed the onus on combatant officers, the evacuation of the wounded was speeded up, and medical units became more flexible and easy to transport.[11] Such changes, of which there are many examples, point to a great degree of cooperation between specialists, regimental medical officers and combatant officers, and to an army keen to listen to the advice of experts.

One unique example of what has been shown to be a positive relationship between psychiatrists and the military is the involvement of psychiatrists and psychologists in the Army's procedures for recruitment and promotion. Protected and promoted by the Adjutant-General Ronald Adam and his staff, psychiatrists and psychologists established new practices organised by the new Directorate for the Selection of Personnel. New developments included the IQ testing of all recruits and the posting of recruits along the lines indicated by test results, the by-passing of commanding officers' opinions about which soldiers would make good officers and the re-allocation of this task to psychologically trained officers, and entirely new procedures for testing officer cadets which included several psychological components. While such measures were not uncontroversial or unopposed, the fact that they were established indicates the degree to which the military was willing to cooperate with psychiatrists. However, this happy relationship indicates also that, while many of these changes appeared to run counter to traditional military values, in fact they did not really challenge the establishment. In most instances, military

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[11] M. Harrison, (2004).

psychiatrists and combatant officers shared very similar views about the qualities that made a good soldier and a good officer. For example, there was widespread agreement that men of low intelligence caused a series of medical and disciplinary problems (a link which had been more or less non-existent during the Great War) while high (but not necessarily very high) intelligence was a positive quality for an officer. In fact, psychiatrists involved in selection demonstrated their ability to select good officers by showing that, on the whole, their views agreed with those of regular officers. In addition, statistics show that while the new War Office Selection Boards (WOSBs) were held up as meritocratic and democratic, they still massively favoured the middle and upper classes and in fact were less likely to select elementary school boys for Commissions than were Commanding Officers and their traditional Unit Selection Boards.[12]

Of course the majority of psychiatrists during the Second World War were not involved in personnel selection, but in therapy. Interestingly, however, the principles of selection played a very significant role in therapy as well, as patients frequently went through a selection procedure of sorts before being allocated a treatment regime. The significance of this selection procedure varies in different contexts and was more significant in environments where there was the possibility of evacuating patients back to base or to Britain and where treatment facilities were limited and therefore rationed. This dissertation has examined the therapeutic regimes in one civilian and one military hospital in the United Kingdom and the work of ten different practitioners in theatres of war. It found that what particular psychiatrists regarded as the main task of their work (either therapy or separating those who were easily treatable and would return to duty from those who had to be evacuated) influenced how much emphasis they placed on their patients' family and personal histories at the expense of their

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[12] See Chapter Three of this dissertation. Statistics from the following publication demonstrate this point. Office of the Adjutant-General, (1943) *Selection of Personnel,*

patients' accounts of war time experiences and their symptoms. This difference between history-based practice and symptom-based practice often resulted in quite different experiences for patients, as symptom-based regimes were optimistic and usually more likely to return soldiers to duty although in some cases, therapies were also dangerous and coercive.

Two theoretical issues that need to be clarified here are the positions that this work takes with regard to the nature of intelligence and psychiatric breakdown. With regard to intelligence, historical scholarship has shown that this is a concept that has changed significantly over time. In the early twentieth century the view that people had multiple "virtues and talents", or a genius for one thing, but not for another, was discarded for what Charles Spearman termed *g* –a theory of general intelligence.[13] Thus, in the early twentieth century, intelligence obtained ontological validity, and became a trait of limitless importance (all abilities and even potential abilities, in whatever field were thought to be influenced and to a large degree determined by it). In addition, it became an easily measurable trait as confidence in intelligence testing abounded.

This is the perspective that is shared unquestioningly by every early twentieth century psychiatrist and psychologist mentioned in this work. However, the view taken in this thesis is that there is no need to regard intelligence as a physical or cognitive entity, but rather as an historical concept. The implication of this is that the way intelligence was conceptualised during the Second World War, and the policies that this lead to are viewed not as necessary and inevitable but as one possible option among many. It is *not* the aim of this thesis to prove that the policies adopted were wrong or inefficient. However, it does not aim to prove that they were right or effective either. Instead, this work hopes to show how and why they came about and what were some of their consequences.

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p.14, Liddell Hart Centre, Adam 3/4/2.

Similarly, in the case of psychiatric breakdown, while this work acknowledges the very real suffering experienced by many of those deemed to be having a psychiatric breakdown during the Second World War, it does not accept that there are precise demarcations between health and breakdown under which soldier-patients can be classified. For example, medical and lay descriptions of psychiatric patients during the Second World War vary significantly in how they describe the conditions, symptoms and suffering of patients. Whereas some descriptions portray men who are no longer able to function, others are described as quite normal, but very afraid, and others as merely unwilling. Therefore, with no widely applicable standards there is no sense in evaluating psychiatric treatment in terms of efficacy. The statistics that are on offer were compiled by psychiatrists who had different standards about when a man was fit for duty and whose standards naturally varied according to the pressures under which they and their units served. This difficulty in comparing and evaluating practices was acknowledged during the Second World War and there was particular concern about the lack of 'relapse' statistics, which made evaluating treatment accurately impossible. Overall, therefore, the efficacy of psychiatric practices is not a subject within the scope of this work.

Chapter One outlines the history of trauma in civilian and military contexts from the 19th century until the Second World War. Influenced by Allan Young's analysis of Post-Traumatic Stress Disorder,[14] it aims to provide the reader with an understanding of how psychiatrists and the military found themselves in the position of close cooperation and similar outlook during the Second World War. This chapter explores how armies have previously dealt with the proportion of men who in each war have

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[13] J. Carson, (1994) *Talents, intelligence, and the constructions of human difference in France and America, 1750-1920*, PhD thesis: Princeton University.

[14] A. Young, (1995) *The Harmony of illusions: Inventing Post-Traumatic Stress Disorder,* Princeton: Princeton University Press.

been incapacitated yet showed no visible organic lesions. It relates how the psychiatric profession came to own these *functional* disorders and how, in order to explain and treat them, psychiatrists hypothesised an alternate consciousness in which lay pathogenic, traumatic memories.

In the First World War, cooperation between psychiatrists and the British Army began in earnest. This meant that debates that had puzzled the psychiatric profession for years such as whether particular people are predisposed to neurosis, possibly because of a hereditary taint, whether neurosis can be prevented by stigmatising or by other means, and where the line should be drawn between organic and mental disorders, became issues of national importance and the subject of a national enquiry. However, ultimately what influenced Second World War psychiatry were not just the experiences of the First World War but also the hardening of attitudes towards the mentally deficient who were thought of as the root cause of every kind of social and medical problem, and a political need for promoting meritocracy in all spheres including the Army.

In Chapter Two, the successes and failures of psychiatrists in establishing a power base within the military are discussed. By taking advantage of the prevailing mood that supported medical specialisation and preventive medicine, psychiatrists succeeded in establishing the Directorate of Army Psychiatry in the War Office and an associate Directorate for the Selection of Personnel that revised selection methods according to their advice. In addition, the numbers of psychiatrists employed by the military overseas increased considerably thus making it possible to establish forward psychiatric treatment centres. Nonetheless, the Army Council resisted the Adjutant-General's proposals to give psychiatrists the Staff status, (instead of Consultant/Adviser), that had been given to Hygiene specialists, arguing instead that, unlike Hygiene, Psychiatry was part of curative rather than preventive medicine. The argument that psychiatrists were unable to predict human behaviour and thus prevent mental

breakdown was also put forward when it was suggested that psychiatrists should be removed from the Selection Boards that selected officers for regular commissions.

Overall, the profession's achievements in infiltrating the military at the levels of policy, selection and treatment were immense –however their success was determined by the extent to which they convinced others that psychiatry was the equivalent of mental hygiene and thus, like the Hygiene specialty, ought to be part of all medical strategic decisions.

The new selection procedures are the subject of Chapter Three. In this chapter, the aims of the selection methods and the circumstances that enabled them to happen are analysed. It is shown that while psychiatrists have argued that intelligence testing was recommended by the Southborough committee which enquired into the incidence of shellshock after the First World War, the reverse is the case, as the Committee explicitly stated that such tests were unnecessary –although they did recommend that doctors dealing with recruitment should exclude mentally deficient people from service. It is argued that what instead enabled the introduction of intelligence testing was a social climate in which borderline mental deficiency was seen to be the root cause of a number of social problems ranging from criminal behaviour to infectious diseases. Furthermore, it is argued that while the purpose of these procedures was to promote meritocracy they did not contribute to changing the social background of officers, as the new procedures were less likely to promote boys from elementary schools than would have been promoted if selection had been based on the recommendations of commanding officers alone. The most likely explanation for this is that emphasis on IQ test results precluded those less educated from being accepted. While the Adjutant-General argued that this was necessary as a good education was necessary for an officer, other officers including an officer responsible for training officer cadets, argued that elementary school boys made the best officers.

Chapter Four is a case study of the civilian hospital Sutton and the soldiers who were treated there between 1940-1942. It appears that overall the patients who were treated in Sutton were treated like civilians and almost three quarters were discharged. In addition, the majority received no treatment while they were hospitalised. This was probably because the ethos of the hospital dictated that treatment should be reserved for those more likely to recover whereas the majority of military patients were thought of as constitutional neurotics. The decision about who to treat was guided to some extent the patients symptoms –particularly loss of weight, and hysterical loss of function. On the whole, however, the judgment was made on the basis of whether the patient had been a worthwhile person prior to his breakdown –whether he had a good job record, no family history of mental illness, appeared intelligent, industrious and keen to get better and whether he had suffered severe mental and physical stress prior to breakdown.

In Chapter Five, different kinds of psychiatric practice in the theatres of war are explored. This chapter focuses on several psychiatrists practising in Egypt, Tripoli, Algiers, Burma and Italy and examines links between approaches to psychiatric aetiology and psychiatric practice. It is shown that psychiatrists who believed that in many cases the patients' breakdown had been caused by inherent constitutional deficiencies rather than the stresses of war or physical exhaustion, did not invest in psychiatric treatment but in selection. These psychiatrists published articles explaining how they examined the patients' personal and family histories in order to establish whether their problems were longstanding. Patients who were thought of as constitutionally inadequate (because they had a history of unemployment for example) were evacuated back to base or to the UK and were downgraded. These psychiatrists promoted the idea that psychiatry's main function in wartime was preventive –mental hygiene— and that this would have been best achieved by a thorough psychiatric examination at

recruitment, which would have stopped men with long-term psychological problems from enlisting. On the other hand, psychiatrists who were interested in new treatments and published accounts of how they experimented with therapy tended to regard all their patients as treatable. These psychiatrists placed a lot less emphasis on patients' histories and instead focused on the patients' symptoms and morale. So, for example, instead of classifying patients according to 'types' they classified them according to the symptoms they displayed.

Chapter Six is a case study of Northfield Military Hospital –the site of the most radical contemporary therapies practiced in Britain. The social therapies initiated by Wilfred Bion and John Rickman and pursued by Michael Foulkes, Tom Main and Harold Bridger have left a lasting legacy in psychiatric practice. Interestingly, however, these social therapies did not contravene military values but encapsulated them. Therapy in Northfield was explicitly based on the principles of duty, high morale and unit cohesion –whereas the traditional values of civilian medicine that encouraged the medicalisation of emotional problems and the separation between patients and doctors were rejected. Furthermore, a positive relationship between psychiatrists and commanding officers was one of the explicit aims of the institution.

In an appendix, there is an analysis of 20 questionnaires filled in by Northfield patients who give an account of their life and the experiences that led to their breakdown. It provides a singular opportunity to examine psychiatric breakdown from the perspective of the soldier-patients rather than their doctors.

By covering the subject of military psychiatry from the angles of administration, selection and treatment, and exploring a number of different settings –War Office, forward psychiatry, a civilian hospital for service patients and a military hospital, this dissertation aims to provide a close

analysis of how the military enlisted psychiatrists to help Britain to victory in the Second World War.

Chapter 1: Trauma, Psychiatry and the Military c.1860-1939

Introduction

Throughout the twentieth century, psychiatrists and psychologists have played an important role in warfare. Although their most important task has been to treat psychiatric casualties, psychologists and psychiatrists have also contributed in a number of other ways: by advising on how to prevent casualties, by implementing preventive policies, by examining recruits, and by advising the army on how to maintain the morale of the troops and destroy the morale of the enemy. However, psychiatrists and psychologists have not always had such a wide remit. They have carved out this role for themselves over a number of years and a number of conflicts.

The most significant starting point for the involvement of psychiatrists in warfare is the First World War and the shell-shock epidemic. The First World War established that all modern conflicts would result in psychiatric casualties which would significantly drain manpower, and that the Army needed to make extensive provisions for psychiatric casualties, preferably near the front line. Importantly, it also established that all men had a breaking point, and while psychiatrists, doctors, army officers, ordinary soldiers and the general public, thought that many shell-shocked soldiers were 'halfwits', 'criminals', 'cowards', 'homosexuals' or simply 'inadequate' men, it was generally accepted that some shell-shocked soldiers at least, were brave men with excellent war records who had survived unbearable levels of stress.[15]

Psychiatrists at the onset of the Second World War were much more prepared than had been their colleagues, 25 years previously. Many, had first hand experience of military casualties and the others had relevant monographs and case histories from all over the world available to them.

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[15] P. Leese, (2002) Shell-shock, Traumatic neurosis and the British soldiers of the First World War, New York: Palgrave.

However, they also had different experiences and in some cases different training than their predecessors, as the fields of psychiatry and psychology had changed significantly since the First World War. In addition, the death penalty for military offences (apart from treason) had been abolished, and inhumane, overtly disciplinary treatment of psychiatric casualties was no longer tolerated. Attitudes towards the working class had become more benign, and psychiatric diagnoses were no longer as polarised as in the First World War in which officers and men were, to a large extent, diagnosed with different disorders. Simultaneously, there were efforts to end the class prejudice in the selection of officers and democratise rank. Other changes were less benevolent: as intelligence became an increasingly valued quality, and the technologies which measured it increasingly well respected, the position of those thought to be at the bottom of the intelligence spectrum became more untenable. Innovations in physical treatments that claimed to cure hitherto incurable mental illness encouraged the conception of mental illness in biological terms and permitted some doctors to practice increasingly experimental, dangerous and unpleasant treatments on their patients. Furthermore, the rise of social medicine encouraged psychiatrists and psychologists to expand their remit into all areas of life: family, education, employment, politics and every other area in which government planning was involved.

In order to elucidate the perspective of psychiatrists who faced the Second World War, it is important therefore to examine both the psychiatric involvement in the First World War and the history of institutional psychiatry and academic psychology, which psychiatrists and psychologists brought with them and applied to the very different military setting. This chapter will begin at the end of the nineteenth century and briefly explore five disorders that shaped the views of doctors who in the First World War were confronted with shell-shock. These disorders are: *nostalgia, soldier's heart* (both military disorders), *railway spine* (the result

of railway accidents), *hysteria* and *neurasthenia* (both functional disorders).[16] These particular disorders have been selected because they highlight questions that are intrinsic to the topic of twentieth century military psychiatry: Are dilapidating conditions which are not accompanied by any sign of injury or infection, organic or psychosomatic? How should the Army deal with soldiers who have not adapted to military conditions without wasting manpower? Which people are more vulnerable to mental illness? Should mental illness carry a stigma?

Changes in how these questions have been answered provide an insight to the intellectual and practical choices available to military psychiatrists and psychologists in the Second World War. Furthermore, this medical history highlights the matrix of circumstances that eventually gave rise to particular decisions and practices taken by the Armed Forces and the psy-professions during the Second World War.

Five disorders of the 19th century

In the aftermath of the First World War, when shell-shock had been accepted as a psychological disorder, the medical histories of the American Civil War were revisited with a view to gauge the incidence of shell-shock. For example, Dr F. Peterson, writing for a journal specialising in the history of medicine described the disorder known in the Civil War as *windage,* a disorder caused by the nearby explosion of a shell, which without actually impacting on the body could cause paralysis.[17] The disorder appears to have enjoyed an ambiguous reception by the medical authorities of the civil war, who on the one hand claimed that it was impossible that a shell could cause damage without actual contact yet at the

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[16] Functional disorders are disorders where the physical symptoms (paralysis, mutism etc) cannot be traced to an organic cause. The cause of functional disorders was disputed –theories about their cause cited both psychological and neurological explanations as well as the possibility that an organic cause did exist but had not yet been found.

same time explained the mysterious paralyses caused by this disorder in terms of invisible injuries to the spine.[18] Dr Peterson believed windage to be shell-shock and the paralyses to be hysterical.[19] Furthermore, he believed the same to be the case of a number of other disorders:

> Scattered throughout these volumes are undoubtedly many cases of war-neuroses, to which other names were given at the time. It is highly probable that there were some war-neuroses among the 7200 cases registered as "sunstroke" to judge from reading over a few of the histories. In the discussions on loss of vision, deafness and epilepsy there is some suggestion of effects out of proportion to the trauma. Very likely most of the cases reported as nostalgia, numbering some 5200, were war-neuroses and psychoses, and the proportion of cases of epilepsy, some 9,000 cases, or four annually per thousand of strength, is extraordinary. As I find among abdominal injuries cases referred to that are suspiciously neurotic, so I infer that among the 1,213,685 cases reported as malaria there must have been a considerable number that we would now-a-days classify among the war neuroses.[20]

Of these disorders mentioned, the most significant from the point of view of the history of psychiatry in the civil war, is Nostalgia,[21] as this was

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[17] F. Peterson, (1919) 'War Neuroses in the civil war', *The Proceedings of the Charaka Club, vol. V,* pp. .9-15.

[18] U.S. War Department, Surgeon-General's Office, Circular No. 6: U.S. Government Printing Office: Washington. *Reports of the extent and Nature of the Materials Available for the Preparation of a Medical and Surgical History of the Rebellion,* 1865, Lippincott: Philadelphia. Cited in F. Peterson, (1919); A. Babington, (1997) *Shell-shock, A history of the Changing Attitudes to War Neurosis*, London: Lee Cooper.

[19] In this context, hysterical means psychogenic; i.e. the patient is only paralysed because he believes himself to be paralysed. The belief, however, is genuine and the patient therefore is not lying or malingering.

[20]F. Peterson, (1919) pp. 14-15. A similar outlook is shared by Eric Dean who also noted the importance of insanity, Nostalgia, sunstroke, and irritable heart as diagnostic categories which stand in for shell-shock and result in discharge. See E. T. Dean, (1997), *Shook over hell, Post-Traumatic Stress, Vietnam, and the Civil War,* Cambridge: Harvard University Press, p. 116.

[21]The origins of the word *nostalgia*, have been traced back to the physician Johannes Hofer who in 1678 translated the disorder *heimweh* as nostalgia by combining the Greek words *nostos* meaning the return home and *algos* meaning pain. Nostalgia was therefore originally known as a medical disorder rather than as a sentiment. The disorder Hofer described was not particular to soldiers, however over the years it became included in treatises of military medicine such as those by De Meyserey and Gerard Van Swieten as a disease likely to be found among troops fighting far away from home. J. Hofer,

a disorder that unlike sunstroke, malaria, deafness etc, was contemporaneously acknowledged as a mental disease. In contrast, if soldiers without organic lesions were diagnosed with the aforementioned organic disorders this was done under error.

During the civil war, nostalgia was a recognised medical disorder that merited medical discharge. In the Union manual issued to army medical officers it is written that:

> Nostalgia is a form of disease which comes more frequently under the observation of the military surgeon ... Considered as a mental disease, –and there can be no doubt that the primary phenomena of this state are mental, it belongs to the class of Melancholia. ... As Nostalgia is not unfrequently fatal, it is ground for discharge if sufficiently decided and pronounced.[22]

In 1863, it was described by Assistant Surgeon-General De Witt C. Peters as a 'species of melancholy or a mild type of insanity caused by disappointment and continuous longing for home.'[23] Thought of as particularly likely to affect young soldiers, Nostalgia was according to the official medical history of the war, responsible for a total of 5213 cases among the white troops of the North during the first year of the war, as well

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(1678) *Diss. de Nostalgia,* Basel; De Meyeserey, (1754) *La Médicine d' Armée, Contenant des Moyens Aisés de Préserver de Maladies, sur Terre and sur Mer, dans Toutes Sortes de Pais, and d'en guérir sans beacoup de Remédes ni de Dépenses, les Gens de Guerre, and autres de quelque Condition qu'ils soient,* vol.1, Paris: Veuve Cavalier; G. van Swieten, (1758) *Kurze Beschreibung und Heilungsart der Krankheiten welche am öftesten in dem Feldlager beobachtet werden,* Vienna, cited in G. Rosen, (1975), 'Nostalgia: a 'forgotten' psychological disorder', *Psychological Medicine,* 5, pp. 340-354.

[22] *A manual of instructions for enlisting and discharging soldiers,* quoted in E. T. Dean (1997), p.129.

[23] De Witt C. Peters, (1863) 'Remarks on the evils of youthful enlistments, *American Medical Times,* 6, 75-76, quoted in A. Babington, (1997).

as 1 death in 1862 and 12 deaths in 1863[24] and for making the policy of evacuating the sick an impossibility.[25]

One disorder that the aforementioned Dr Peterson did not consider to be shell-shock in disguise, is Soldier's Heart. This is because during the First World War, Soldier's heart, known also under the names of *Da Costa Syndrome* (named after Dr Jacob DaCosta who first identified the syndrome), *irritable heart*, *disordered action of the heart (DAH)*, and *effort syndrome*, formed a category of its own separate from shell-shock and war neurosis, and only began to be integrated with war neurosis during the Second World War.[26] In 1871, Dr Jacob Da Costa evaluated soldiers referred to him for a syndrome principally characterized by shortness of breath, palpitations, and sharp or burning chest pain, particularly on exertion. Other symptoms included fatigability, headache, diarrhoea, dizziness, and disturbed sleep. There was no consistent sign of physiological disease, and most patients appeared to be in fair overall health. Because symptoms had included diarrhoea and respiratory problems, Da Costa concluded that a proportion of patients could be suffering the aftermaths of an infectious disease. Da Costa also identified hard field service, rheumatism and sunstroke as the chief causal factors in some of the cases and furthermore argued that tobacco, and frequent

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[24] U.S. War Department, Surgeon-General's Office, Circular No. 6: U.S. Government Printing Office: Washington. *Reports of the extent and Nature of the Materials Available for the Preparation of a Medical and Surgical History of the Rebellion,* 1865, Lippincott: Philadelphia. Cited in G. Rosen, (1975), p. 351.

[25] P. Bourne, (1969) *The Psychology and Physiology of Stress,* New York: Academic Press, quoted in A. Babington, (1997) p. 15.

[26] Some psychiatrists now argue that soldier's heart or effort syndrome is the precursor to Gulf War syndrome although the disorder also shares similarities with chronic fatigue syndrome. See K. C. Hyams, F. Stephen |Wignall, Robert Roswell, (1996) 'War Syndromes and Their Evaluation: From the U.S. Civil War to the Persian Gulf War', *Ann Intern Med,* 125, 398-405; S. Wessely, 1990, 'Old Wine in New Bottles :Neurasthenia and 'ME'', *Psychological Medicine,* pp. 35-53; S. Wessely, C. Nimnuan & M. Sharpe (1999) "Functional Somatic Syndromes: One or Many" *Lancet*, vol. 354, pp. 936-39; J. Wheelwright, *The irritable Heart, the medical mystery of the Gulf War,* New York: W.W. Norton & Co.

seminal emissions were likely to aggravate the problem. In terms of a cure, Da Costa prescribed mainly rest and sometimes drugs such as Digitalis.[27]

Heart problems among soldiers had been identified contemporaneously in Britain, among soldiers attending the newly opened Royal Victoria Hospital, Netley, in 1863. A government committee appointed to study heart conditions in the Army lay the blame for the excessive numbers of heart disease in the Army to the soldier's kit which weighed over 60 lb and was therefore thought to restrict the heart's action. Other contemporary explanations were that excessive rifle drills obstructed cardiac outflow and that uniforms were too restrictive.[28]

Both nostalgia and irritable heart were disorders specifically affecting soldiers, particularly the young, but only nostalgia was thought of as a mental disorder. As a subcategory of melancholia, nostalgia was nonetheless also an organic disorder that took its toll on the body, ultimately causing death. Like insanity, (also a cause for medical discharge), disorders with mental manifestations were thus considered to be organic diseases albeit sometimes with some psychological origins (such as feelings of homesickness in the case of nostalgia or enduring a tragedy in the case of insanity). The acceptance of these disorders by the military authorities as legitimate causes of discharge suggests that armies have for a long time found ways of discharging those who failed to adapt to the conditions of warfare, but also that this leniency was conceived in the terms of life-threatening disease or madness. Furthermore, possibly because both soldier's heart and nostalgia were thought to be life-threatening and therefore not within the patient's control, neither appears to have carried a significant stigma. High incidents of nostalgia appear to have been blamed on the forceful conscription of soldiers sent to fight in a distant land.

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[27] J.M. Da Costa, (1871), 'On irritable heart', *American Journal of the Medical Sciences,* 61, pp. 17-52.

In the same period, a very different disorder was affecting healthy people, frequently men, who were the seemingly uninjured victims of railway accidents. *Railway spine* sufferers displayed a variety of physical disorders, frequently some time after the accident. Symptoms included giddiness, loss of memory, pains, local paralysis, and intellectual deterioration.[29] Railway spine developed particular significance in the second half of the nineteenth century because it became the subject of heated debate in the courtroom: victims of railway accidents were suing the companies for compensation. When these victims were not able to display burns and wounds, but only the more subjective symptoms of Railway Spine, the railway companies contested the claims and a controversy with regard to the veracity and nature of this disorder ensued.

The first full-length medical text on railway spine and related conditions appeared in 1866.[30] Its author was John Erichsen, a well-respected surgeon with considerable experience as a medical witness in railway compensation cases who generally gave evidence for the plaintiff.[31] Like the doctors who attempted to explain the symptoms of windage, Erichsen argued that the symptoms of railway spine were caused by imperceptible damage to the spinal cord, in this case resulting from concussion and inflammation during a railway accident. Erichsen's formulations on railway spine were based on a twofold strategy: first he explained a point through analogy and then he illustrated his case by putting forward a number of fascinating case studies: For example,

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[28] J.D. Howell, (1998) 'Soldier's heart, the redefinition of heart disease and speciality formation in early twentieth century Great Britain' *War, Medicine and Modernity,* (eds R. Cooter, M. Harrison, S. Sturdy), Thrupp: Sutton Publishing, pp. 85-87.

[29] *The Lancet,* 8 February 1862, pp. 156-157. Quoted in R. Harrington, (2001) 'The Railway Accident', *Traumatic Pasts: History, psychiatry and trauma in the modern age, 1870-1930,* (eds) M. S. Micale & P. Lerner, Cambridge: Cambridge University Press.

[30] J.E. Erichsen, (1866) *On Railway and other injuries of the nervous system*, London: Walton & Maberly.

[31] R. Harrington, (2001) p. 43.

Erichsen theorised that victims of railway accidents, suffer from nervous shock, but he offered no actual causal explanation for this:

> We do not know how it is that when a magnet is struck a heavy blow with a hammer, the magnetic force is jarred, shaken, or concussed out of the horse-shoe. But we do know that it is so, and the iron has lost its magnetic power. So, if the spine is badly jarred, shaken or concussed by a blow or a shock of any kind communicated to the body, we find that the nervous force is to a certain extent shaken out of the man.[32]

Furthermore, Erichsen explained the fact that seriously injured patients rarely suffered from *railway spine* or any other nervous conditions by an analogy with a watch:

> It would appear as if the violation of the shock expended itself in the production of the fracture or the dislocation, and that a jar of the more delicate nervous structures is thus avoided. I may give a familiar illustration of this from an injury to a watch falling on the ground. A watchmaker once told me that if the glass was broken, the works were rarely damaged; if the glass escapes unbroken, the jar of the fall will usually be found to have stopped the movement.[33]

Erichsen's claims were supported by his case studies in which the most dilapidating illnesses were found to occur in patients with minute injuries, such as the case of a woman sufferer who acquired her illness after tripping on her way down the stairs, even though she did not actually fall over or sustain any injury.

Erichsen's arguments were refuted in the mid 1880s by Herbert Page, a railway company surgeon who asserted that it was very unlikely that the spinal cord could be injured without the spinal column showing signs of damage. Page rejected the watch analogy, arguing that it was irrelevant as the watch possessed no nervous system, and he focused

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[32] J.E. Erichsen, (1866), p. 95.
[33] Ibid, p. 94.

instead on the mind and on the emotions, particularly fear, for his explanations.[34] He said:

> Medical literature abounds with cases where the gravest disturbances of function, and even death or the annihilation of function, have been produced by fright and by fright alone. It is the same element of fear which in railway collisions has so great a share –in many cases the only share— in inducing immediate collapse and in giving rise to those after symptoms which may be almost as serious, and are certainly far more troublesome than those which we meet with shortly after the accident has occurred.[35]

While Page acknowledged that the nervous disorders associated with railway spine may involve some organic change (possibly a chemical one), Page saw fear as the primitive causative element and he pointed out that a nervous disorder could result from autosuggestion.[36] Page, in fact, equated railway spine with hysteria, although he said he used the term 'without a shadow of reproach'[37] towards the sufferers. Erichsen, however had firmly rejected that possibility:

> Hysteria, ... is a disease of women rather than of men, of the young rather than of the middle-aged and old, of people of an excitable, imaginative, or emotional disposition rather than of hard-headed, active, practical men of business. ... In those cases in which a man advanced in life, of energetic business habits, of great mental activity and vigour, in no way subject to gusty fits of emotion of any kind— a man, in fact, active in mind, accustomed to self-control, addicted to business, and healthy in body, suddenly, and for the first time in his life, after the infliction of a severe shock to the system, finds himself affected by a train of symptoms indicative of serious and deep-seated injury to the nervous system – is it reasonable to say that such a man has suddenly become "hysterical" like a love-sick girl? ... To me, I confess, the sight of a

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[34] H. Page, (1888) *Injuries of the Spine and Spinal Cord without Apparent Mechanical Lesion, and Nervous Shock, in their Surgical and Medico-Legal Aspects,* London: J.& A. Churchill.

[35] Ibid, p. 62.

[36] Autosuggestion was thought to be the process by which a person who has experienced a situation that could have caused him or herself an injury or infection becomes convinced that he or she is indeed suffering from it.

[37] H. Page, (1888) p.191.

> man of forty-five, rendered 'hysterical,' ...would be a novel and a melancholy phenomenon ... and could such a condition actually be induced, it would certainly be to my mind an evidence of the most serious and disorganising disease of the nervous system.[38]

Page argued further that contrary to Erichsen's views, men did suffer from hysteria:

> ... even if in every-day life women more commonly than men show signs of being emotional, excitable and hysterical, it is nevertheless true that as a direct outcome of the nervous shock of a railway collision men become no less emotional than they. We are much inclined to agree with Mr Jordan* that "the frequency of hysteria (if such a term may be used) in men is not fully recognised;" but if the manifestations thereof, as we may admit, are absent or but rarely seen in ordinary men, a condition closely allied to the "hysteria" of women is very common, or is commonly developed, in men, after the great psychical shock of a railway accident.[39]

Page argued further that the knowledge of the possibility of compensation unconsciously caused victims of railway accidents to develop or exacerbate symptoms.[40]

The legal situation was that railway companies were obliged to pay compensation only to those suffering from a nervous complaint rather than a mental one.[41] Interestingly, both Erichsen and Page accepted that railway spine affected the nervous system organically in some way –but Page thought the organic change had been brought about by the patients' feelings of fear. Therefore, both Page and Erichsen would have agreed that the symptoms of 'railway spine' were 'nervous'.[42] Arguably, the fact that Page accepted that a nervous change had taken place but nonetheless opposed

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[38] J.E. Erichsen, (1866), pp.126-7.
[39] H. Page, (1888) p.188. Page quoted J. F. Jordan, (1873) *Surgical Inquiries,* London: J. & A. Churchill.
[40] A. Young, (1995) *The Harmony of illusions: Inventing Post-Traumatic Stress Disorder,* Princeton University Press, p. 17.
[41] A. Parsons, (1813) *The Liability of Railway Companies for Negligence towards Passengers,* London. Cited in R. Harrington, (2003) 'On the Tracks of Trauma: Railway Spine Reconsidered', *Social History of Medicine,* Vol. 6, No. 2, p. 213.
[42] R. Harrington, (2003) p. 213.

the idea that patients should receive compensation implies that the crux of the debate was not the nature of the symptoms but their causation. Page, by claiming that the symptoms were psychogenic, argued that they were the patients' responsibility. Accordingly, the reason why some of the victims of railway accidents developed 'railway spine' while others had not, is that they were more susceptible to the effects of fear –and this is what disqualified them from compensation.

The railway spine controversy is frequently seen by historians as the precursor to the controversy over the nature of shell-shock as many of the arguments postulated are the same: one side was arguing that the illness is caused by minute damage to the nervous system and the other that it is in fact hysteria caused by fear and fuelled by desire for compensation. In both debates, the reputation of the patients involved hang in the balance, as hysteria was one of the most stigmatising illnesses. Unlike shell-shock, the railway spine debate was not resolved within the lifetime of the participants and all sides maintained medical legitimacy as the diagnosis of railway spine gradually disappeared in the twentieth century.

The background to Page's psychological model is the contemporary understanding of hysteria. The work of Herbert Page was read and admired by Jean-Martin Charcot, the influential director of La Salpêtrière; a vast asylum housing between five to eight thousand women –one per cent of the entire population of Paris.[43] Charcot is significant to the history of shell-shock because he developed the two ideas implicit in Page's writings; that hysteria could develop in men as well as women, and that it could be caused by autosuggestion after a traumatic experience, the "hystérie traumatique". Charcot also interpreted *railway spine* to be *hysteria* and argued that it was brought about by autohypnosis caused by the extreme fear felt at the moment of the accident. Charcot argued that similar symptoms to those exhibited by railway accident victims could be induced

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[43]L. Appignanesi & J. Forrester, (2000) *Freud's Women,* London: Penguin Books, p. 63.

in his own hysterical patients if they were told under hypnosis that they had suffered an injury.[44]

Charcot however believed hysteria could only develop in those suffering from hereditary taint. In those cases where the hysteria developed after a traumatic event, the trauma was merely the trigger for the illness, not the ultimate cause. Furthermore, according to Charcot it was only those people who suffered from this hereditary taint that could be hypnotised. The state of hypnosis was therefore similar to that of hysteria and could be used to add or remove symptoms and had no therapeutic effect.

In the 1880s, Sigmund Freud began studying under Charcot. From this experience, Freud formulated his own views about both the prevalence of male hysteria but also about the aetiology of hysteria. With regard to treatment, he was at first eclectic, as the *Studies on Hysteria* show, using electrotherapy, hydrotherapy, massage, and the rest cures.[45] In this respect, he was no different from other Viennese specialists in the nervous diseases. By the end of 1887 however, Freud was becoming an enthusiast for the cures produced by hypnotic suggestion.[46]

Furthermore, Freud rejected Charcot's doctrine of hereditarian degeneration. Freud did accept that dispositional hysteria did exist, but he did not think it applied to most hysterical patients.[47] In its place, Freud, in his work with Breuer, elaborated the seduction theory which proposed that all instances of psychoneurosis can be traced back to a sexual trauma occurring in infancy –the seduction (or what we would now refer to as rape or sexual assault) by an older relative, usually the father, nanny or older

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[44]J.M. Charcot, (1889) *Clinical Lectures on Diseases of the Nervous System Delivered at the Infirmary of la Salpêtrière*: London: New Sydenham Society. Cited in A. Young (1995) p.19.

[45] J. Breuer & S. Freud, (1893-1895) 'Studies on Hysteria', *The Complete works of Sigmund Freud,* Vol. II, (trans & ed. J. Strachey, 1955), London: The Hogarth Press.

[46] L. Appignanesi & J. Forrester (2000) p. 71.

[47] A. Young, (1995) p. 37.

sibling.[48] During the early 1890s, Freud had discovered that hysterical and obsessive patients had invariably experienced a sexual seduction before the age of eight. In the views he then developed, the experience of a seduction became the necessary precondition for the ability to *repress*, a pathological defence mechanism, a process of forgetting which then guided the patients' reaction to moderately or mildly traumatic experiences later on in life.[49] Generally, patients suffering from hysteria had *recently* experienced some mildly traumatic events which had given rise to symbolic, hysterical symptoms, as well as a traumatic seduction as young children –and it was the memory of the distant sexual experience deep in the unconscious that caused their pathological reaction to the recent traumatic events. Their pathological, hysterical reaction therefore was not due to hereditary degeneration but due to a repressed memory of a seduction that had taken place in childhood. Freud argued further that patients suffering from obsessional neurosis, had also experienced a similar sexual experience but had later on decided to re-enact the experience with another child and had thus experienced sexual pleasure precociously, which in turn lead to guilt and repression and the symptoms of obsessional neurosis. According to Freud what appeared sometimes to be a familial disposition to neurosis was in fact a case of widespread abuse; in one example the nanny had seduced a little boy who then went on to seduce his sister; the little boy grew up and developed obsessional neurosis while the little girl became a hysteric; but what appeared as hereditary degeneration was only a cycle of abuse. Freud argued further that women were more likely to develop hysteria because

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[48]J. Breuer & S. Freud, (1893-1895); S. Freud, (1896) 'Heredity and the Aetiology of the Neuroses', Vol. III, *The Complete works of Sigmund Freud* (1962); S. Freud, (1896) 'The Aetiology of Hysteria', Vol. III, *The Complete works of Sigmund Freud* (1962); S. Freud, (1896) 'Further Remarks on the Neuro-Psychoses of Defence', Vol. III, *The Complete works of Sigmund Freud* (1962).

[49] J. Breuer & S. Freud, (1895); S. Freud, (1896). As Young has so lucidly described, the original traumatic experience became thought of as a 'pathogenic secret' which then determined the victim's behaviour in all future traumatic experiences, A. Young, (1995) pp. 36-37.

they were more likely to be seduced as children while men were more likely to develop obsessional neurosis because if they were seduced as children they were more likely to try and re-enact the seduction. Furthermore, Freud insisted that while the reactions of hysterics to mild irritations or slights appear to others to be extreme, they are in fact perfectly proportional reactions –not to the irritation of the present but to the distant trauma the memory of which is reawakened by the current situation.[50]

Freud originally procured the memories of sexual seduction by hypnosis but this method proved unsatisfactory and so he turned to the pressure technique. With this method, patients lay on a couch facing away from Freud while he pressed his hand on their forehead while asking questions. Patients then mentioned words and thoughts which Freud linked into a narrative. Freud made it clear that patients had no memory of the experiences of seduction before they began analysis; however, by analysing their words and behaviours he demonstrated to the patients what these experiences were. Patients did not always agree with Freud that these events had taken place, and if they did, they nonetheless frequently did not come to *remember* them but merely to accept they must have occurred.[51]

The treatment for hysteria, at this stage of Freud's career was abreaction –a process by which the patient re-experienced the traumatic experience together with its accompanying emotions. This process was brought about by hypnosis, narcosis (drug-induced abreaction) or through persuasion.[52]

Soon after publishing *Studies on Hysteria*, Freud's views began to change; he rejected the seduction theory and the pressure technique and turned to free association and psychoanalysis. He concluded that hysteria

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[50] S. Freud, (1896) 'Further Remarks on the Neuro-Psychoses of Defence'.
[51] R. Leys, (2000) *Trauma, a genealogy,* Chicago: Chicago University Press, pp.102-103.
[52] A. Young, (1995) p. 37.

was not caused by a traumatic sexual experience but by abnormal fixations occurring through the early years of childhood while children go going through the oral, anal and phallic stages and resolving the Oedipus complex.[53] Abnormalities in these stage were caused by an interplay of minor traumas and chance occurrences which may give rise to fantasies of seduction with as much force as a genuine experience of seduction, which is then repressed. Freud also acknowledged that constitution and heredity could play a significant role in the development of hysteria and other neuroses[54] although he continued to pay little attention to this issue.

After 1896, Freud also distinguished between psychoneuroses that originate in experiences in early childhood and actual or traumatic neuroses that are produced by traumatic events that occur later on in life. However, Freud was not particularly interested in traumatic neuroses and would only deal with them in the aftermath of the First World War, when there was a surge of interest in war neuroses. Even then, however, Freud had no first hand experience of treating patients with war neuroses.[55]

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[53] S. Freud, (1900) 'The Interpretation of Dreams', Vol. IV, *The Complete works of Sigmund Freud,* (1953); S. Freud, (1905) 'Three Essays on the Theory of Sexuality', Vol. VII, *The Complete works of Sigmund Freud,* (1953).

[54] For example, when discussing the patient 'Dora', Freud wrote: "I do not, it is true, adopt the position that heredity is the only aetiological factor in hysteria. But, on the other hand, - and I say this with particular reference to some of my earlier publications, e.g. 'Heredity and the Aetiology of the Neuroses' (1896a), in which I combated that view -I do not wish to give an impression of underestimating the importance of heredity in the aetiology of hysteria or of asserting that it can be dispensed with. In the case of the present patient the information I have given about her father and his brother and sister indicates a sufficiently heavy taint; and indeed, if the view is taken that pathological conditions such as her mother's must also imply a hereditary predisposition, the patient's heredity may be regarded a convergent one. To my mind, however, there is another factor which is of more significance in the girl's hereditary or, properly speaking, constitutional predisposition. I have mentioned that her father had contracted syphilis before his marriage. Now a *strikingly high* percentage of the patients I have treated psycho-analytically come of fathers who have suffered from tabes or general paralysis ... syphilis in the male parent is a very relevant factor in the aetiology of the neuropathic constitution of children." S. Freud, (1905[1901]) 'Fragment of an Analysis of a Case of Hysteria', Vol. VII, *The Complete works of Sigmund Freud,* (1953), pp. 20-21, note 1.

[55] A. Young, (1995) p. 37 & p. 78.

Freud's ideas developed throughout his life and were themselves re-interpreted by Freud's followers. British psychiatrists felt that it was possible to mix and match from Freud's theories rather than accept the whole Freudian doctrine. Among the ideas that gained popular acceptance were the notions of unconscious motivation and the pathogenic effects of repressed memories of childhood trauma. Overall, Freud's writings on hysteria went some way to remove the stigma from hysteria as Freud shifted its aetiology from a biological degeneration to traumatic life experiences which to some extent exonerated victims. Furthermore, Freud introduced the idea that neurotic symptoms were meaningful representationally; paralyses, stammers, tics, and dreams were now the patient's way of communicating to the psychiatrist what their innermost desires were.

The fifth disorder that is of relevance is *Neurasthenia*. Neurasthenia was first established in the United States by the neurologist George Miller Beard in the late nineteenth century. Meaning literally 'weak nerves' it was thought of as an organic disorder caused by a lack of nervous force and encompassed many of the symptoms that became associated in the late twentieth century with chronic fatigue syndrome.[56] Symptoms of Neurasthenia included anxiety, despair, phobias, sleep disturbances, difficulties in concentrating, extreme fatigue, palpitations, migraine, indigestion and sexual dysfunction. Beard thought that this depletion of nervous force was usually caused by the fast pace of urban life. Neurasthenia was generally regarded as an ill-defined disorder, encompassing many of the symptoms of the disorders previously known as 'nervousness' but also 'vapours' or 'spleen'.[57] Nervousness, in the 18th

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[56]M Gijswijt-Hofstra, (2001) 'Introduction: Cultures of Neurasthenia from Beard to the First World War', *Cultures of Neurasthenia from Beard to the First World War* (eds) M Gijswijt-Hofstra & R. Porter, Amsterdam: Rodopi

[57] R. Porter, (2001) 'Nervousness, Eighteenth and Nineteenth Century Style,' *Cultures of Neurasthenia from Beard to the First World War,* p. 36. Apparently, 'vapours' was generally a disease of women while 'spleen' was the equivalent disease of men.

century was frequently regarded as a disease of the well-educated, civilised upper classes. In the 19th century, while neurasthenia was still associated with the well-to-do, it became linked to hard work rather than luxurious living.[58]

Some historians have argued that neurasthenic patients tended to be more affluent than patients diagnosed with hysteria and were more likely to be men rather than women.[59] Certainly, the formulation of neurasthenia by Beard points to the middle-classes as more likely sufferers. However, the situation is complicated by the fact that different doctors had different notions of neurasthenia and therefore different epidemiological accounts. Overall, it seems that neurasthenia affected both men and women, unlike hysteria, which affected women almost exclusively. However while men were a little more likely than women to be diagnosed with neurasthenia, some doctors specialised on female patients and linked neurasthenia to gynaecological disorders. In terms of class, in America neurasthenia was closely associated with the affluent, but in Britain some doctors went out of their way to prove that it affected people of all classes –partly as a way of proving the validity of the disease.[60]

Significantly, neurasthenia, unlike hysteria, was not always thought of as a hereditary disease but also as an environmental disease –although that began to change towards the end of the 19th century. While some historians have stressed that neurasthenia like nervousness was a stylish disease, it could also be an embarrassment, particularly for patients for whom it signified that there was nothing really wrong with them[61]. Towards the end of the century, neurasthenia began increasingly to lose its location in the body of the patient (the nerves) and began to be treated as a

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[58] R. Porter, (2001).

[59] For example E. Shorter, (1992) *From Paralysis to Fatigue, A history of psychosomatic illness in the modern era,* New York: The Free Press pp. 220-227.

[60] M. Thomson, (2001) 'Neurasthenia in Britain', *Cultures of Neurasthenia from Beard to the First World War.*

[61] R. Porter, (2001).

mental disorder under the remit of psychiatrists rather than neurologists.[62] Simultaneously, it was considered in an increasingly negative and hereditarian light.

The most significant treatment for Neurasthenia was the Silas Weir Mitchell rest cure. Mitchell originated his cure on soldiers from the civil war whose health seemed to improve when due to other injuries they were forced to rest.[63] The Mitchell cure consisted of complete seclusion and rest, a fattening diet, initially composed of milk only, massage and some light electrotherapy. The cure took place in a nursing home, away from the patient's home, while the patient was forbidden to leave the bed sometimes not even to defecate. Patients were not allowed to wash themselves, feed themselves, read, sew, or see family and friends. After a period of overfeeding once the patient had improved sufficiently more and more privileges were permitted until the patient was permitted to return home.

Hysteria and Neurasthenia later became the main subcategories of shell-shock. In other European countries where a term like shell-shock was never invented these formed the diagnostic categories of the psychiatric casualties of the First World War.[64]

Nostalgia, soldiers' heart, railway spine, hysteria and neurasthenia are all disorders which informed the understanding of the psychiatrists who in the First World War dealt with shell-shock Also important however is the context of institutional psychiatry and academic psychology in which the majority of psychiatrists and psychologists were trained and practised. This will be explored next.

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[62] M. Neve, (2001) 'Public views of Neurasthenia' *Cultures of Neurasthenia from Beard to the First World War.*

[63] T. Lutz, (2001) 'Varieties of Medical Experience: Doctors and Patients, Psyche and Soma in America', *Cultures of Neurasthenia from Beard to the First World War,* p. 56.

[64] M. Roudebush, (2001) 'A battle of Nerves: Hysteria and its treatments in France during World War I', *Traumatic Pasts: History, psychiatry and trauma in the modern age, 1870-1930,* (eds) M. S. Micale & P. Lerner, Cambridge: Cambridge University Press, p. 254.

Psychiatry, Psychology and Social Medicine 1900-1918

The British mental health service at the turn of the century consisted of large asylums with an increasing population where all inmates were certified. The process for certification was that established by the Lunacy Act 1890 whereby fee-paying patients could be admitted to an asylum or a private licensed house on the strength of a magistrate's order and two medical certificates or through the poor laws whereby a magistrate's order and only one medical certificate was necessary. Treatment for inmates consisted of occupational therapy, mild faradisation and baths (the technique varied from benign hot baths to extremely unpleasant, successive full-length plunges in cold water). More commonly, patients were sedated or received no treatment besides the hospital routine. This was a period of therapeutic pessimism and mental illness was generally gauged in a degenerational, hereditarian way. The main purpose of the mental health services was custodial; to protect the sane from the insane rather than to cure.[65]

In contrast, general medicine in this period was undergoing a change where increasing emphasis was being placed on social medicine. While the notion that social science combined with medicine could improve future society was well founded in the nineteenth century,[66] during the early part of the twentieth century, British medicine became more social and more pervasive. David Armstrong has shown that the difference between nineteenth and twentieth century social medicine lies in the latter's focus on 'interpersonal hygiene' which identified the relations between people rather than the relationship between people and the natural environment as

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[65] K. Jones, (1993) *Asylums and After, a Revised History of the Mental Health Services: From the Early 18th Century to the 1990s,* London: The Athlone Press, pp. 112-125.
[66] D. Porter, (1997), 'Introduction,' *Social Medicine and the Medical Sociology in the Twentieth Century*; Amsterdam: Rodopi.

the cause of disease and the locus of medical intervention.[67] Twentieth century social medicine, therefore, focused for the first time on the psychological and the social rather than the environmental. This intellectual climate brought with it an interest in social psychology, sociology and preventive medicine. In this period, the British Psychological Society, the Eugenics Education Society and the National Council for Mental Hygiene were founded, and a number of influential sociological works were published.[68]

For the evolution of mental health care, the most significant developments of social medicine were the increased interest in preventive medicine, the widespread acceptance of eugenic concerns, and the development of psychometric psychology. The Eugenics Education Society, formed in 1907 by among others, the psychiatrist James Crichton-Browne, based its intellectual foundation in the works of Francis Galton concerning mental deficiency and national efficiency, which claimed that the mental and physical fitness of the nation depended upon the proper understanding and management of heredity.[69] Simultaneously, innovations in statistical analysis and the application of the new statistical methods in psychological testing allowed psychologists to make a significant contribution in the measurement of normal psychological functioning, particularly intelligence. During the first decade of the twentieth century, the Binet intelligence scale, originally to be used in the detection of 'dull' children, whose mental age was lower than their chronological age, was published. It eventually gave rise to the term Intelligence Quotient or IQ (mental age divided by the chronological age).

The perceived eugenic need to prevent the problem of mental deficiency becoming a racial disaster, combined with a widespread belief

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[67] D. Armstrong, (1997), 'The Social Space of Illness', *Social Medicine and the Medical Sociology in the Twentieth Century*;

[68] R. Porter, (1996), 'Two Cheers for Psychiatry!', *150 Year of British Psychiatry, Volume ii, The Aftermath,* H. Freeman & G. Berrios (eds) London: Athlone.

that intervention would benefit mental defectives as well as society in general, and a new technology which was felt could measure intelligence accurately and reliably, led to the Mental Deficiency Act (1913). The Act, partly responding to the administrative difficulties caused in schools and prisons by the 'weakminded' on whom usual disciplinary procedures proved unfruitful, put in practice the Eugenic Society's demands for the segregation of the mentally deficient.[70] The Act made it the responsibility of every local authority to ascertain who were the defectives living within their catchment area, whether in the community, workhouses or asylums, and house them in specialised institutions.[71] Cyril Burt thus became the first educational psychologist to be appointed by a government body in the UK when he became the official psychologist of the London County Council responsible for the administration and interpretation of mental tests in London's schools. For the first time, the entire nation was surveyed for mental deficiency and those found to be defective were placed in specialised colonies.[72]

In the United States, the Binet intelligence scales had been disseminated by Henry Herbert Goddard, an influential psychologist working for a small private institution for mentally handicapped children. Goddard used the tests in a number of epidemiological studies the results of which he felt confirmed their validity and reliability and also made the

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[69] R. Porter, (1996).

[70] M. Thomson, (1998) The problem of mental deficiency; Eugenics, Democracy, and Social Policy in Britain c.1870-1959, Oxford: Clarendon Press.

[71] M. Thomson, (1996) '"Though ever the subject of psychological medicine": psychiatrists and the colony solution for mental defectives' *150 Years of British Psychiatry.*

[72] Before this Act, mental defectives could be placed in asylums under the Lunacy Act, in poor-law workhouses or in voluntary Idiot Asylums but they could also live in the community. See M. Thomson, (1998), p. 130. In practice, the implementation of the Act proved difficult as there were insufficient facilities to house all those who were mentally deficient and conflicts arose between the priorities of local governments and those of the institutions that housed the mentally deficient. See P. Dale, (2003) 'Implementing the 1913 Mental deficiency Act: Competing Priorities and Resource Constraint Evident in the South West of England before 1948', *Social History of Medicine,* Vol. 16, No. 3, pp. 403-418.

public aware of the widespread problem of mental deficiency. According to Goddard, many more children than was previously known were mentally deficient and furthermore the majority of these children looked perfectly normal; it was only through use of the intelligence tests that their abnormality could be detected.[73]

In the 1910s, Goddard expanded his studies from children to adults, particularly socially undesirable adults such as paupers, prostitutes and criminals. His conclusion was that the problem underlying the majority of socially undesirable behaviour was not evil, as had been previously argued, but mental deficiency. The majority of the undesirables were people who were unable to care for themselves and who had no real awareness of the difference between right and wrong and who therefore became easy prey for those wishing to corrupt them. Had these people been raised in a kind, specialised institution instead of being left to their own devices, Goddard argued, the best use would have been made of whatever skills they did have, and they would have grown to have happy, useful, and more significantly, childless lives.[74]

However, in Goddard's view, even a specialised education would not improve the abilities of the mentally defective by very much; mental defect was formulated to be an incurable inborn genetic disorder brought about by a single recessive gene. The dysgenic effect caused by the feebleminded, who had no ability to use contraception nor the morality to restrict procreation within marriage was huge. This was demonstrated in

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[73] L. Zenderland, (1998) *Measuring Minds, Henry Herbert Goddard and the Origins of American Intelligence Testing,* Cambridge: Cambridge University Press.

[74] For example, H. Goddard, (1912) 'Sterilization and Segregation', *Bulletin of the American Academy of Medicine,* 13, pp. 210-219; H. Goddard, (1912) 'Feeble-Mindedness and Crime', *Proceedings of the American Prison Association,* 12, pp. 353-357; H. Goddard, (1913) 'Feeble-Mindedness as a Source of Prostitution', *Vigilance,* pp. 3-11; H. Goddard, (1914) *Feeble-Mindedness: Its Causes and Consequences,* New York: Macmillan. Cited in L. Zenderland, (1998), chapter 6.

Goddard's hugely influential and popular *The Kallikak family*,[75] in which Goddard and his assistants traced the family of one institutionalised girl back to Martin Kallikak, a young soldier in the independence wars. Martin Kallikak came from a good family, but one night, he thoughtlessly slept with a feeble-minded tavern girl. She later bore a feebleminded son, from whom, a vast progeny of other feebleminded criminals, prostitutes and other social inefficients came about causing destruction for the next century and a half. By contrast, Martin Kallikak later married an intelligent girl from a good family and together they founded a line of good and worthy citizens. This 'natural experiment' was thought to prove that the uncontrolled breeding of the mentally deficient was responsible for bringing about much of society's social problems.

In the 1910s, Goddard continued his work with intelligence testing on incoming immigrants at Ellis Island. The very poor performance of the majority of immigrants forced Goddard to reconsider his views and question whether a poor environment was to some extent responsible for low scores.[76]

This emphasis on mental deficiency as a source of great social inefficiency would have long–term implications on how Armies chose to prevent a variety of problems ranging from psychiatric casualties to lack of discipline. But first, the First World War and the accompanying epidemic of shell-shock began.

Shell-shock 1914-1918

The story of shell-shock is mostly a British one, since in France and Germany the psychiatric disabilities of war were assimilated into the existing psychiatric nosology of hysteria and other functional disorders

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[75] G. Goddard, (1912) *The Kallikak Family: A study in the Heredity of Feeble-Mindedness,* New York: Macmillan. The name 'Kallikak' was created by Goddard to indicate that the family had a good and a bad strand.

without the invention of a new term.[77] It is unclear how this term became established in Britain[78] but it has been argued that it contributed to (and was the result of) a comparatively less stigmatising approach to the problem of war neurosis. Shell-shock was originally thought of as a form of concussion, and its name gave the illness a distinctive military feel and distanced it from the negative and feminising connotations of hysteria[79]. Even once the psychological nature of shell-shock had been confirmed, the term 'shell-shock' was still preferred amongst troops. For that very reason however, the army eventually abolished the term, to replace it with Not Yet Diagnosed (Nervous) or NYDN.

Regardless of the different approaches of the nations involved, historians agree that the phenomenon of mass psychiatric casualties took by surprise all belligerent armies and preparations to deal with the phenomenon were delayed and only fully implemented in the final stages of the war. Statistics about the numbers of soldiers affected are very inadequate, but historians seem to have settled on the figure of 200,000 for each of the main participants Britain, France and Germany.[80] The problem was identified as early as December 1914, when an official report stated that 7-10 per cent of all officers, and 3-4 per cent of all men admitted to hospitals in Boulogne, were sent home suffering from the effects of nervous and mental shock, due to strain, stress and exhaustion.[81] In 1915, the psychologist (and qualified doctor although he had not previously practiced) Charles Myers, who had already published an article on shell-

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[76] G. Goddard, (1917) 'Mental Tests and the Immigrant' *Journal of Delinquency*, 2, pp. 243-277. Cited in L. Zenderland, (1998).
[77] For the French case, see M. Roudebush, (2001).
[78] For an interesting interpretation of the term, see P. Leese, (2002).
[79] E. Showalter, (1985) *The Female Malady, women, madness and English Culture, 1830~1980,* New York: Pantheon Books, p.172.
[80] For example, P. Leese, (2002), M. Roudebush, (2001), P. Lerner, (2001) 'From traumatic neurosis to male hysteria: the decline and fall of Hermann Oppenheim', *Traumatic Pasts: History, psychiatry and trauma in the modern age, 1870-1930.*

shock, was appointed as Specialist in Nervous shock to the British Army in France and became responsible for the treatment and prevention of shell-shock.[82]

The psychiatrists who were confronted with shell-shock in the First World War were bewildered by it. Their patients' symptoms were extremely varied. There were men who were obviously anxious, who could not sleep, and were troubled by nightmares as well as men who stammered and twitched uncontrollably, men who were paralysed or who could not bend their joints, men who could not speak, could not hear or could not feel pain. While some of these symptoms seem obviously psychological, others seemed quite obviously organic. This soon lead to a controversy over the nature of shell-shock and on whether it was an organic disorder -caused by the nearby explosion of a shell, or a psychological one –caused by fear and anxiety.

Psychiatrists encountering shell-shock were well aware that there was a psychological disorder which could account even for the most spectacular of physical symptoms namely Hysteria. In the literature, there were numerous case studies of patients exhibiting the most dilapidating physical symptoms, for which there was no organic cause. When, in 1915, Charles Myers, published the first medical article that used the diagnosis shell-shock, he noted: 'The close relation of these cases to those of "hysteria" appears fairly certain.'[83] The patients that Myers described had all been blown up by shells and their symptoms were amnesia, impaired vision, hearing, smell and taste, severé constipation, and urine retention.

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[81] W. Johnson & G. Rows, (1923) 'Neurasthenia and war neuroses', *History of the Great War based on official documents, Medical Services Diseases of the war,* W.C. Macpherson, W.P. Herringham, T.R. Elliott & A. Balfour (eds) Vol. II, HMSO, pp. 1-2.
[82] B. Shephard, (2000) *A War of Nerves,* London: Jonathan Cape; W. Johnson & R. Rows (1923).
[83] C.S. Myers, (1915) 'A contribution to the study of shell-shock. Being an account of three cases of loss of memory, vision, smell, and taste admitted into the duchess of Westminster's war hospital, Le Touquet', *The Lancet*, vol. I, pp. 316-320.

These patients were treated by hypnosis and suggestion[84] and gradually improved.

Elaine Showalter has argued by reference to Myers' memoirs[85] that Myers was convinced that the cause of shell-shock was organic.[86] However, a careful reading of the original article suggests instead that Myers believed that it was very likely that shell-shock would turn out to be hysteria, but was reluctant to say so.

Back in Britain, the first hospitals for military psychiatric casualties opened in late 1914 while concurrently the law changed to permit the treatment of service patients without certification.[87] A number of specialist hospitals opened during the war however at the same time soldiers were also treated in specialist wards of regular military hospitals, such as the famous D Block at Netley as well as in regular wards in ordinary non-specialist hospitals.[88]

Towards the end of 1915, the Army officially recognised shell-shock as a distinct disorder and attempted to assimilate it within the military tradition which distinguished between wounds acquired in battle and sickness. Reflecting the debate among psychiatrists as to whether shell-shock was organic or psychological, shell-shock acquired during battle was assumed to have been caused by the enemy's shellfire; and therefore to be organic concussion. Patients diagnosed with (W) shell-shock as it was called were able to wear a wound stripe and were eligible for a pension. Shell-shock not acquired in the midst of battle on the other hand, was

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[84] Broadly speaking, treatment by suggestion meant that once a doctor was able to convince a patient that his symptoms would go away, the symptoms vanished. Suggestion is the basic principle on which hypnosis is based.

[85] C.S. Myers, (1940) *Shell-Shock in France*, Cambridge: Cambridge University Press.

[86] E. Showalter, (1985) pp. 167-168.

[87] The Act permitting this was the Mental Treatment Act 1915. See P. Leese, (2002) p. 59.

[88] According to Leese, this was the worst alternative for psychiatric patients who were ridiculed by the other patients, but a preferred option for the Ministry of Pensions which wanted to reduce the 'special' status of the psychiatric casualties and argued that the other patients would help 'cheer up' neurasthenic patients, P. Leese, (2002) pp. 64-67.

thought of as a mental breakdown and therefore as sickness and although the soldier was entitled to treatment he was not eligible for a pension or wound stripe.[89]

The problem of shell-shock became particularly acute for the Army during the battle of the Somme. According to official figures (generally thought to be underestimating the incidence of shell-shock) between January and June 1916 there were 3,951 cases of shell-shock, the highest figure so far, yet in the following six months the number rose to 16,138.[90] This forced the Army to create even more facilities for treatment including the Craiglockhart hospital for officers. After the Battle of the Somme, the Army began to take the issue of shell-shock and particularly the manpower wastage caused by it more seriously. C.S. Myers was promoted to 'Consulting Psychologist to the Army' and in that capacity produced a memorandum arguing that it was important that special treatment centres near the front were created to ensure that treatment was prompt, that the environment was such as not to encourage soldiers to think that they have found a way out from the horrors of warfare (ideally they should be close enough to still hear the noises of fighting), and treatment should consist of simple psychotherapy. Possibly helped by the fact that submarine warfare had begun constricting the movement of ships across the channel, Myers's advice was followed and the specialist treatment centres were set up by the Army Medical Services.[91] Unfortunately, for Myers, the Army also employed more psychological staff in senior positions and Myers was sidelined. He returned to England on sick leave and his work was largely taken over by the neurologist Gordon Holmes.

Soon after the Army recognised shell-shock, medical opinion concurred that shell-shock was mainly a psychological disorder and was

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[89] C.S. Myers, (1940) *Shell-shock in France* quoted by B. Shephard (2000) p. 29; W. Johnson & G. Rows, (1923) p.11.
[90] W. Johnson & G. Rows, (1923), p.4, quoted in P. Leese, (2002) p. 104.
[91] P. Leese, (2002) p. 69.

rarely the result of a concussion. The medical advice was that the term altogether should be abolished. The Army's response was initially to abolish shell-shock (S), and adopt NYDN instead. Furthermore, it was decided that the old category of shell-shock (W) had been applied to too many soldiers who had not in fact been blown up by a shell. It was decided that all shell-shock cases should be accompanied by a new form (AH 3436) in which their commanding officers would confirm whether each soldier had been blown up by a shell.

One consequence of including front line officers in the bureaucracy of psychiatric treatment was that the treatment which had meant to be immediate was much delayed: patients had to wait until their forms caught up with them. Secondly, it was shown that the vast majority of cases had not been blown up by a shell. Halfway through the Passchendale battles, policy was further changed and it was decided that it was no longer necessary to send all cases to the special casualty clearing station; if a doctor felt that a man was just temporarily shaken he could keep him even nearer the front. A lot of the treatment of shell-shock cases fell therefore to the regimental medical officers rather than to psychiatrists and neurologists. The result of the new procedures, the new powers of regimental medical officers and the new treatment centres was that a lot fewer psychiatric cases were lost to the Army in Passchendaele than had been in the Somme.[92] Of course, it is impossible to tell whether that was a clinical or a bureaucratic success; whether soldiers were less likely to become sick, or more easily cured or merely more easily persuaded to return to the Army. In any case, in September 1918, shell-shock was abolished altogether as a medical diagnosis.[93]

Overall, the majority of shell-shock patients were treated in Britain. Most hospitals were segregated by rank, and in the few that were not,

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[92] B. Shephard, (2000) pp. 54-55.
[93] Ibid.

accommodation for officers and men was always separate. One in fifty of all war cases of war neurosis were treated in Maghull –one of the best war-time psychiatric hospitals even though conditions were overcrowded and uncomfortable and adequate food supply was a constant problem. The most distinguished aspect of Maghull was its staff –run by R.G. Rows, Maghull attracted at one time nearly all the shell-shock specialists.[94]

Only about 20 per cent of Maghull patients were returned to military service. By civilian standards however, Maghull was a model shell-shock hospital where soldiers received specialist care from leading experts. It was also probably the most humane of the British centres for the other ranks with its emphasis on re-education, persuasion and careful attention to the individual. Treatment in Maghull was mainly 'the talking cure'. Men were encouraged to talk about their experiences in the frontline and were absolved from feelings of guilt and shame over their illness. The psychiatrists also interpreted the soldiers' dreams and tried to bring back forgotten memories but did not hypnotise patients. Towards the end of the war, a series of short courses in analytic techniques and abreaction training were offered to RAMC officers.[95]

As shell-shock became medically discredited as a nosological category, it was replaced with Concussion, Hysteria and Neurasthenia. These categories were not wholly distinct however but tended to overlap. Concussion was supposed to apply only to patients who were known to have received a head injury, but that was something that could not always be verified; many patients traced their symptoms to an incident involving loss of consciousness, which they related to an injury. Furthermore, while hysteria was supposed to apply to cases of functional paralysis and neurasthenia to cases of anxiety and nervousness in practise the diagnostic process was a lot more complex, and the two disorders were sometimes

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[94] P. Leese, (2002).
[95] Ibid.

(just as it had been prior to the war) used interchangeably. During and after the war, it was noted that officers were far less likely than the men from the ranks to be diagnosed with hysteria. In fact, in the official history, it was stated that: "Any soldier above the rank of corporal seemed possessed of too much dignity to become hysterical".[96] This was compatible with the pre-war situation where neurasthenia was more likely to be thought of as the disease of the overworked middle classes and just as likely to affect men as women. Peter Leese, in his research of clinical case notes from the First World War has shown that not only the treatment and the conditions of hospitalisation were very different for officers, illness attribution was also completely different.[97] Hence, in the case notes of officers, doctors highlighted the psychological cost of leadership and prolonged active duty, but did not mention family traits or attribute the illness to poor heredity, as did doctors treating men from the ranks.[98] Furthermore, the symptoms exhibited by officers were described in a vague manner with the aid of euphemistic blanket phrases and were rarely described as 'functional'.[99]

Leese argues that it is likely that men and officers genuinely developed different symptoms, while Young has argued that in several cases officers did develop hysteria-like symptoms that were treated in the same way as hysterical symptoms in other ranks, but were nonetheless not called hysterical.[100] Young argues that in officers, hysterical symptoms were not regarded as representative of their condition, hence it was possible for an officer to suffer from neurasthenia yet also exhibit a hysterical symptom; while a patient from the ranks with the same symptoms would be diagnosed with hysteria. Young argues further that the reason for this distinction was that the diagnosis of hysteria implied a necessary link with

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[96] W. Johnson & G. Rows, (1923), p.18.
[97] P. Leese, (2002) pp. 103-116.
[98] Leese states that in his sample of 111 cases of officers only in 1 case is the possibility of a pre-war origin of the illness discussed, while such explanations are routine in the other rank case material, p. 110.
[99] P. Leese, (2002) p.111.

an inherent hereditary weakness, while the diagnosis of neurasthenia left open the possibility at least that the disorder had been caused by external stress alone. Thus, the psychiatrist Millais Culpin described an officer patient whom he had treated for functional paralysis as follows:

> ... in spite of an energetic and self-driving temperament that was the opposite to all common conceptions of the hysteric, his symptom was hysterical and the result of suggestion. Such a diagnosis would have been undoubtedly true but the truth in it was negligible.[101]

The treatments however which have dominated the bibliography of the First World War are those by WHR Rivers, and Lewis Yealland. The two have been contrasted since Eric Leed in 1979 represented each as emblematic of two forms of psychiatric treatment: the analytic and the disciplinary.[102] Since then, a number of authors have used this model although more recently the bibliography has been rather critical, arguing that neither Yealland nor Rivers were representative of psychiatric treatment during the war.[103] These treatments are too well known to need a lengthy analysis here. Briefly, Lewis Yealland worked in Queen Square hospital on mostly intractable cases of other rank hysterics.[104] Yealland essentially used suggestion to cure patients; he persuaded the patients that their symptoms were cured through the application of a strong electric current to the area of the body which was not functioning. This process had a very high success rate according to Yealland's account, but also aroused

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[100] A. Young, (1995) p.62.
[101] M. Culpin, (1940) 'Mode of onset of the Neuroses in War' *The War Neuroses of War* (ed) E. Miller, London: Macmillan, p. 37, cited in A. Young, (1995) p. 63.
[102] E. Leed, (1979) *No man's land: Combat and Identity in World War I,* Cambridge: Cambridge University Press.
[103] For example, E. Showalter, (1985); P. Barker, (1991) *Regeneration,* London: Penguin Books. Criticisms of the model have come from A. Young, (1995), B. Shephard, (2000) and P. Leese, (2002).
[104] There is evidence that Yealland treated at least one officer patient, see E. Southard, (1973) *Shell-shock and other neuropsychiatric problems, New York: Arno Press,* p.782 case 563. However, the electric current used to treat this patient is described as 'exceedingly mild'.

controversy as the process resembled torture; patients were locked in a room with Dr Yealland who applied very strong current to their bodies until they were cured of their symptoms.

Historians have argued that this line of treatment although popular in the other belligerent nations was infrequently used in Britain. In France and Austria, the ethics of using this kind of treatment was played out in the courts. In France, the soldier Baptiste Deschamps hit his doctor Clovis Vincent rather than allow the doctor to electrify him. Deschamps was brought to trial in August 1916 on the charge of resisting orders and assaulting a superior officer. Although most of the medical community rallied round Vincent, the trial generated a lot of bad press; Deschamps was pardoned and Vincent's reputation effectively destroyed.[105] In Austria, the issue came to trial after the war, when an enquiry was held into the psychiatric treatment of soldiers. Among those accused was the Professor of Psychiatry Julius Wagner-Jauregg who was later credited with the malaria treatment for general paralysis of the insane (the tertiary stage of syphilis) and won the Nobel Prize. Among those speaking at his trial, was Sigmund Frued who issued a cautious defence of the doctor. The enquiry exonerated Wagner-Jauregg, who argued that he used only mild electric current and only to the peripheral part of the body while his assistant, Dr Kozlowski was rebuked for excessive zeal.[106]

By contrast, it has been argued that in Britain such treatments were used only rarely. Peter Leese has pointed out that Yealland and his colleague Adrian claim to have treated only 250 cases and that the surviving case notes of the other doctors at Queen Square, show doctors who were caring towards their patients. Faradisation when used was mild and applied for a short time only (compared to the 4 hour marathon treatments described by Yealland himself, who describes the current which

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[105] M. Roudebush, (2001), pp. 272-273.

he uses as varying from 'weak to 'very strong').[107] However, there is some evidence that the use of pain to procure treatment not only for the patient being treated but also for other patients who are observing the treatment was more widespread, even in Britain. For example, Yealland described how various other treatments had been previously used to cure his patient of mutism *prior* to his arrival at Queens' Square hospital, but had all failed:

> Many attempts had been made to cure him. He had been strapped down in a chair for twenty minutes at a time, when strong electricity was applied to his neck and throat; lighted cigarette ends had been applied to the tip of his tongue and "hot plates" had been placed at the back of his mouth.[108]

It is not clear where these treatments had been attempted, but they indicate that this kind of treatment was not an isolated example. In addition, the neurologist Major W.J. Adie, gave this description of his own use of such methods:

> Large numbers of men suffered from hysteria during convalescence from the various diseases for which they had been admitted to hospital. They all received the same sort of treatment by rapid –what I might call Queen Square methods. The most frequent symptom was aphonia. During one period I used to collect these cases once or twice a week and parade them in a surgical theatre in a tented portion of the hospital. I have had as many as a dozen men on one day. My method was to place the first patient on an operating table, and after explaining that his voice would certainly come back I gave him a whiff or two of ether. (I had no suitable electrical apparatus or I should have used it.) After a few whiffs the man would attempt to remove the mask I then said to him 'I shall remove the mask when you say "take it away"' At the same time I pricked the skin over the larynx rather vigorously with a pin. Very soon the patient said in a tone of disgust: "Oh! take it away." I then asked him for his name, number, regiment, etc., and after a short conversation sent him off.

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[106] B. Shephard, (2000), pp. 134-138. According to Shephard, Kozlowski applied electric current to the patients' testicles and encouraged other patients to watch.
[107] L. Yealland, (1918) *Hysterical Disorders of Warfare,* London: Macmillan & Co, p. 14.
[108] Ibid, pp. 7-8.

> This was repeated on the second patient and perhaps on the third. By this time the rest of the men, who had heard everything, although they could not see what was going on, were easily caused to speak without the use of ether.[109]

In contrast to these disciplinary methods, analytic treatments as exemplified by WHR Rivers treatment of officer patients in Craiglockhart, involved the patients in a consensual treatment. Rivers had adopted some Freudian ideas with regard to trauma and centred treatment on reversing the pathogenic effects of repression. Furthermore, Rivers had formulated a theory of the aetiology of war neurosis, part of which was applicable to his treatment of officers, but which also explained the tendency of officers to develop neurasthenia and men from the ranks to develop hysteria.[110]

Rivers had developed an evolutionary theory of hysteria which proposed that the mechanism underlying hysteria, *suggestibility*, had developed in human beings in situations of danger because it was evolutionary advantageous. Its advantage lay in that it permitted gregarious animals to behave in an identical fashion. According to Rivers when a herd of animals are in a situation of danger the most advantageous response is immobility but this response is only viable if followed by every member of the herd. This is possible because gregarious animals are highly suggestible and respond intuitively to one another. Furthermore, the paralyses, mutism and the other hysterical symptoms developed by soldiers were precisely the ones that would be of greater use to a herd of animals trying not to attract attention to itself.[111]

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[109] Major W.J. Adie, MRCP RAMC (Special Reserve); Physician Great Northern Central Hospital; Neurologist Min. of Pensions, *The War Office Enquiry into Shell-shock,* (1922), HMSO.

[110] Although in his explanation Rivers focuses on the different education, culture and military training between officers and men from the ranks, he acknowledges the possibility of a difference in heredity which he argues should not be neglected, but does not discuss. W.H.R. Rivers, (1920) 'Appendix IV: War Neurosis and Military Training', *Instinct and the Unconscious: A contribution to a biological theory of the psycho-neuroses,* Cambridge: Cambridge University Press, p. 210, fn 1.

[111] W.H.R. Rivers, (1920), chapter XVI, 'Hysteria or Substitution-Neurosis'.

Rivers thought that ordinary soldiers were more likely than officers to suffer from hysteria adding that "pure cases of this kind are rare among officers, who, as a rule, only suffer from this sort of disorder as complications of states of anxiety, or when there is some definite, physical injury to act as a continuous source of suggestion."[112] Rivers argued that all forms of war neuroses were caused by an underlying conflict between the instinct of preservation and social standards of thought and conduct in which fear is morally reprehensible. Private soldiers, according to Rivers, solved the conflict by developing some form of disability that incapacitated them. Officers however, whose mental life was more "complex and varied"[113] were unhappy with this crude solution provided by hysteria. Even if they developed hysterical symptoms, these quickly disappeared and were replaced by anxiety. The other factor that encouraged soldiers from the ranks to develop hysteria was their training, which by forcing them to suppress their individuality and behave as aggregate parts of the group increased their natural suggestibility. Soldiers in warfare, Rivers argued, were in an almost hypnotic state in which they were highly suggestible. Repetitious drilling was therefore an important causal factor in the high incidence of hysteria among men from the ranks.[114]

The causation of anxiety neurosis (as Rivers called neurasthenia) was quite different. The principal mechanism involved was repression. Sufferers of anxiety neurosis had not solved the conflict between self-preservation and social expectation; the conflict was active causing them incapacitating anxiety. In contrast, private soldiers protected themselves from anxiety not only by developing hysteria but also by *not* repressing their fear: Rivers argued that the public school education received by most officers rendered them incapable of expressing their emotions while the private soldiers from the working class backgrounds had no such scruples.

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[112] Ibid, p. 207.
[113] Ibid, p. 209.

This tendency was again further encouraged by officer training where officers were encouraged to repress their emotions so as not to let the soldiers in their command know that they were afraid. Therapy therefore, consisted of encouraging officers to give up this repression. Patients were encouraged to tell their stories and to spend sometime thinking of their experiences in the front-line. Rivers aided this process by focusing the patient's mind on a positive aspect of his experience: for example, in the case of a patient tormented by the experience of discovering a friend whose body had been blown to pieces thus separating his head and limbs from the body, Rivers pointed out that the state of his friend's body was certain proof that he had died instantly and had been spared the long suffering so common in war casualties. According to Rivers, once the patient was able to stop banishing from his mind all thoughts relating to his friend, the nightmares in which his friend appeared to him eased off; even when his friend did appear in his dreams, the patient was no longer terrified.[115]

Probably the biggest controversy regarding shell-shock (beginning during the war but continuing until today) is whether among the 346 men executed for desertion and cowardice there were men suffering from shell-shock. Military policy with regard to convictions for desertion and cowardice appears to have been that where there was a possibility that those accused may have been mentally confused at the time of their offence or for some reason not responsible for their actions, sentences should not be confirmed and carried out until the accused were examined by a medical specialist. This was the view expressed for example, by the under-secretary of war in response to a question in parliament[116] and by witnesses at the enquiry into shell-shock after the war.[117] However, historians who have looked at the notes of the trials have shown that this is not borne out in

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[114] W.H.R. Rivers, (1920) 'Appendix IV: War Neurosis and Military Training'.
[115] W.H.R. Rivers, (1920) 'Appendix III: Repression of War Experience'.
[116] P. Leese, (2002) p. 42.
[117] A. Babington, (1997) p. 132.

most cases. There were multiple examples of soldiers who claimed to have suffered from memory loss and confusion at the time of their actions, or others who had only just been returned from Britain where they had received treatment for shell-shock and who were nonetheless convicted and executed without having been examined by a medical officer.[118] However, the picture is complicated by the fact that the only notes available to historians are those of soldiers who were executed.[119] While 346 men were executed during the war, the total number of death sentences passed was 3,080 –which means only 11% of all sentences were carried out. Furthermore, according to the official statistics, the total number of desertions in the First World War was 137,773.[120] Therefore, although the Army appears to have behaved brutally to a few individual soldiers the overall picture appears to be one of leniency especially in the face of what was obviously a very serious problem. Nonetheless, in 1918, the under-secretary for war admitted that on one occasion an officer had been wrongly shot –there had been concerns that the officer in question had been suffering from shell-shock.[121] Apparently, like other issues relating to shell-shock or even warfare in general, the fate of soldiers seems to have been decided partly by rank, as officers were considerably less likely to be shot than men from the ranks.[122] Overall, however, in this like in other instances, luck was probably the most significant factor in determining whether a shell-shocked soldier would be treated punitively or therapeutically.

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[118] For example P. Leese, (2002); A. Babington, (1997).
[119] A. Babington, (1997), p.92.
[120] These figures measure the incidence of desertion rather the number of people deserting; hence, soldiers who deserted more than once would be counted each time. R. H. Ahrenfeldt, (1948) *Psychiatry in the British Army in the Second World War,* London: Kegan & Routledge Paul, Appendix B.
[121] P. Leese, (2002) p. 63.
[122] Ibid.

Intelligence Testing

When in 1917, the United States joined the First World War, American psychologists began a campaign to introduce intelligence testing in the Army. They argued that feebleminded soldiers were a major source of inefficiency that could be eliminated. A committee comprising prestigious psychologists including Henry Goddard, Lewis Terman and Robert Yerkes devised two tests: the Army Alpha to test literates and the Army Beta to test illiterates. Backed financially by the National Committee for Mental Hygiene, psychologists began the testing of 4000 soldiers. The testing program soon won official approval from the Army and by December 1918, a testing program for all recruits had been established. Eventually 1,726,966 men were tested. The stated aim of the testing was: "a) To aid in segregating and eliminating the mentally incompetent, b) To classify men according to their mental ability, c) To *assist* in selecting competent men for responsible positions."[123]

The extent to which the American Army actually made use of the intelligence scores is open to debate, however the tests had an indubitable impact on the discipline of psychology, which had shown itself to be of national importance.[124]

Equally important were the findings of the intelligence testers: Firstly, levels of illiteracy were surprisingly high; 31% of the soldiers were not able to read and write well enough to be tested on Army Alpha, and over half of these men were native-born.[125] Secondly, all the scores were surprisingly low; the average mental age of the white draft was 13.08 years old, a score barely over the 12 year old standard that psychologists had been using to define feeblemindedness. Had this standard been applied to the Army it would have meant discharging 47% of white soldiers and 89%

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[123] F. Samelson, (1977) 'World War I intelligence testing and the development of psychology', *Journal of the History of the Behavioral Sciences,* 13, p. 276.
[124] Ibid.

of black soldiers.[126] Also significant was that the tests correlated strongly with years of schooling.

The conclusion drawn by psychologists was that the results proved that feeblemindedness was far more widespread than had been previously known. The Army results seemed to support those who had argued that a racial disaster was imminent if mentally deficient people continued to be allowed to breed normally, and encouraged oppressive legislation against the mentally deficient all over the world.

The inter-war years 1918-1939

The First World War produced a number of volumes that discussed the aetiology and treatment of war neurosis.[127] These discussed a number of possible causes of shell-shock ranging from heredity to military training and the emphasis varied according to the ideological convictions of the authors. These viewpoints were well summarised in a volume published in 1940 by what was to become known as the 'Tavi' set of psychiatrists from the Tavistock clinic, who proved extremely influential in the Second World War:

> Three schools of thought can be discerned among the numerous aetiological views advanced in the literature of the last war. They attributed war neuroses to: (i) anatomical lesions of the nervous system, (ii) inborn biological and psychological inferiority, the psychopathic constitution, and (iii) psychological reactions to war experience in individuals previously sensitised to emotional

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[125] R. Yerkes, (1921) *Psychological examining in the United States Army,* Washington, D.C.: GPO, cited in L. Zenderland, (1998) p. 288.
[126] Ibid.
[127] For example, G. Elliott Smith & T.H. Pear, (1917) *Shell shock and its lessons*, Manchester: Manchester University Press; L. Yealland (1918); A. Léri, (1919) *Shell shock: commotional and emotional aspects*, London: University of London; F. W. Mott, (1919) *War neuroses and shell shock,* London: Henry Frowde and Hodder & Stoughton; E.E. Southard, (1919) *Shell-shock and other neuropsychiatric problems presented in five hundred and eighty-nine case histories from the War literature, 1914-1918,* Boston: W.M. Leonard; W.H.R. Rivers, (1920); C. S. Myers, (1940) Shell shock in France, 1914-18, Cambridge: The University Press.

> disturbances subjectively similar although objectively different in their nature.[128]

Of these interpretations, the first had become outdated; neurasthenia and hysteria were firmly thought of as psychological rather than neurological disorders and organic explanations of shell-shock including carbon monoxide poisoning or a disruption of the nervous system by tiny lesions caused by explosives or concussion had failed to get any support. The second and third explanation had a wide following and although both located the ultimate cause of war neurosis within the individual soldier rather than within warfare, the latter explanation as interpreted by some psychiatrists at least allowed for the possibility that war neurosis could affect almost anyone. Some authors of the psychoanalytic school such as Karl Abraham described those falling victim to war neurosis as narcissistic personalities, overwhelmingly concerned with their own safety, lacking concern for others, dependent on their wives, weakly potent and suffering from latent homosexual tendencies.[129] Other authors however adopted a more benevolent attitude as to what may cause such vulnerability, like a tendency to repress emotion, to be over-conscientious etc. And while it was generally agreed that those who suffered from neurotic symptoms in peacetime would find it impossible to adapt to the conditions of warfare, Witkkower and Spillane argued that 'some obsessionals, certain types of psychopathic personality, and mental defectives often did well as

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[128] E. Witkkower & JP Spillane, (1940) 'Psychopathology', *The Neuroses in War,* E. Miller (ed) London: Macmillan, p. 11. The third explanation is an essentially Freudian interpretation which says that individuals who have experienced situations in their formative years which are symbolically similar to the experiences of warfare will be particularly vulnerable to war neurosis. Hence, particular individuals may be susceptible to the feelings of guilt, sadism or fear experienced in warfare because these reawaken previous traumas experienced in childhood. E. Miller elucidated this point when he wrote: 'No soldier came into the war with his mind a clean slate; it had already been written over with the story of his past experiences and conflicts. ... In brief, the relatively mild analogues of war conflicts had already existed' (1940, p. 115).

[129] K. Abraham, (1921) cited in E. Miller, (1940).

soldiers'[130] although they frequently broke down at the end of the war. There was even evidence that 'homosexuals proved efficient and enduring soldiers.'[131] Finally, Wittkower and Spillane argued that while small studies had tended to 'confirm the common belief in family and personal predisposition' one large study had shown 'that the preponderance of heredity for the mass of neuroses and psychoses is but a trifle more than for healthy individuals'.[132] In addition, Ronald Hargreaves contradicted psychoanalytic dogma by arguing that few war neurotics showed evidence of past abnormality and therefore 'In war psychoneurosis ... we may have to lay most stress on the significance of the situation present when the breakdown occurred, rather on the history of the past'.[133]

In some quarters at least therefore, an optimistic viewpoint with regard to the nature of those suffering from war neurosis seemed to emerge. For example, the psychiatrists Elliot Smith & Tom Pear from Maghull concluded:

> The war has shown us one indisputable fact, that a psychoneurosis may be produced in almost anyone if only his environment be made difficult enough for him. It has warned us that the pessimistic, helpless appeal to heredity, so common in cases of insanity [is no longer adequate]. In the causation of the psychoneuroses, heredity undoubtedly counts, but social and material environment count infinitely more.[134]

Furthermore, the official history of the war focused on the conditions of warfare for its aetiological explanation:

> These observations serve to emphasize the facts that, although much has been written tending to multiply the causes of the nervous disorders of war, there were only two factors of overwhelming importance, namely, prolonged fighting and heavy bombardments, and that these rendered all other aetiological

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[130] E. Witkkower & J.P. Spillane, (1940) p. 11.
[131] Burchard, (1915) cited in E. Miller, (1940), p.7.
[132] E. Witkkower & J.P. Spillane, (1940) p. 11.
[133] R. Hargreaves (1940).
[134] G. Elliot Smith & T.H. Pea (1917) pp. 87-88.

> factors almost negligible. Wherever these acted together the incidence of the psycho-neuroses approached its maximum.[135]

The above, however, was later modified by stating that: 'besides the influence of the circumstances of war, the temperament of the individual soldier doubtless played a large part.'[136]

General Psychiatry 1918-1939

The historian Martin Stone has maintained that shell-shock helped establish a kinder, sympathetic Freudian outlook in psychiatry.[137] Thomson however, has argued that the shell-shock incidence did not influence institutional psychiatry.[138] In fact, the immediate effect of the shell-shock incident was a wholly negative one, as mental hospitals became requisitioned by the army, and staff from the hospitals volunteered for military service, causing an increase in overcrowding and deaths from tuberculosis.[139]

Probably the most significant consequence of shell-shock was the creation of the Tavistock Clinic. Its founder, Hugh Crichton-Miller, had felt that the treatment of shell-shocked soldiers with a Freudian inspired psychotherapy had been very successful and according to the history of the Tavistock Clinic, he founded the clinic, in order to continue what had been achieved in the Army with cases of shell-shock -the treatment of people with modest income who would normally be unable to afford to have private psychotherapy.[140]

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[135] W. Johnson & G. Rows (1923) p. 16.
[136] *Ibid*, p. 17.
[137] M. Stone (1985) 'Shell-shock and the psychologists,' *The Anatomy of Madness, II* (eds) W.F. Bynum, R. Porter & M. Shepherd, London: Tavistock Publications.
[138] M. Thomson (1998); M. Thomson (1999) 'Status, manpower and mental fitness: mental deficiency in the First World War' *War, Medicine and Modernity*, (eds) R. Cooter, M. Harrison & S. Sturdy, Thrupp: Sutton Publishing.
[139] K. Jones (1993) pp. 124-5.
[140] H. V. Dicks (1970) *Fifty Years of the Tavistock Clinic*, London: Routledge, p.12. Also the obituary of Hugh Crighton-Miller *Lancet*, (1959), i, p. 104.

The Tavistock Clinic was an outpatient clinic designed not for the psychotic but for ordinary people who needed help with ordinary problems. It followed an eclectic psychoanalytic approach using the ideas of Freud, Jung and Adler. It accepted patients independently of their ability to pay and was the first British institution to provide psychotherapeutic treatment for children.

Also promoting voluntary treatment for those with insufficient means was the new Maudsley hospital. The Maudsley was also a teaching hospital and it promoted early treatment and the ideal that psychiatry would be brought closer to mainstream medicine. Unlike the Tavistock, the Maudsley promoted physical treatments and most of its staff were strict opponents of the psychoanalytic movement.

Rather than the shell-shock episode, probably the most encouraging development of the 1920s was the discovery in Vienna of the malaria treatment for general paralysis of the insane (GPI). GPI had been proven decades earlier, to be caused by syphilis, but none of the treatments for syphilis had been effective in its treatment. In 1917, the Austrian psychiatrist Wagner-Jauregg who had been experimenting from the late 19th century with fever therapies (the rationale being that a high fever is the body's way of curing disease) injected nine patients with the blood of a soldier infected with malaria. Wagner-Jauregg claimed that he saw a great improvement in his patients, which was effective for many years, and he continued to use the same strain of malaria to inoculate patients. As Wagner-Jauregg reported more brilliant results, the treatment became internationally renowned finally earning Wagner-Jauregg the Nobel Prize in 1927. As a result, the GPI story became the paradigm in psychiatry; a mental illness which had been proven to have both an infectious origin and a physical treatment. In addition, it encouraged a more positive outlook in psychiatry as it encouraged hospitals to offer treatment to their patients and gave psychiatrists reason to hope that one day the other hitherto incurable

mental illness would be treated effectively with medical treatment thus bringing psychiatry closer to general medicine.

Simultaneously with these changes, the 1920s saw a hardening of attitudes towards the mentally deficient both in Britain and in America. In the US, while some professional opinion was becoming more moderate, legislation was becoming more hardline. The Army tests results published in 1921 fuelled various alarmist and anti-immigration publications although they also provoked some criticism.[141] Nonetheless, 27 states passed laws permitting involuntary sterilisation for the mentally deficient, most famously resulting in the Buck vs Bell case which reached the US Supreme Court where the prosecution used Goddard's work as evidence as to why Carrie Buck should be sterilised. The Supreme Court ruled that the sterilisation laws ought to be extended, arguing that:

> We have seen that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices in order to prevent our being swamped with incompetents.[142]

In Britain, the joint committee by the Board of Control and the Board of Education reported in 1929 that the number of mental defectives was *double* in absolute terms what it was thought to be in 1908.[143] Although the report made it clear that most of the increase could be accounted for by better methods of surveying, an increased survival of mentally deficient babies and the longevity of institutional inmates, the findings nonetheless fuelled nationalistic fears. Crucially the report also identified a much larger

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[141] C. Gould (1922) *America: A Family Matter,* New York: Scribner; L. Stoddard (1922) *The revolt against civilization,* New York: Scribner.

[142] Justice Oliver Wendel Holmes, (1927) *Buck v. Bell,* 274 U.S.200, p. 207. Cited in Medico-Legal Notes, *Journal of Mental Science* (1928), vol.74, p. 499.

[143] *Report of the Mental Deficiency Committee being a Joint Committee of the Board of Education and the Board of Control* (1929) HMSO, part IV p.83. The survey on the prevalence of mental deficiency was conducted to explain the vast differences in the reporting of mental deficiency between different local authorities.

group than the mentally deficient who by virtue of poor inheritance formed the 'social problem group' a phrase that captured popular imagination:

> Let us assume that we could segregate as a separate community all the families in the country containing mental defectives .... We should find that we had collected among them a most interesting social group. It would include as everyone who has extensive practical experience of social service would readily admit, a much larger proportion of insane persons, epileptics, paupers, criminals (especially recidivists), unemployables, habitual slum dwellers, prostitutes, inebriates and other social inefficients than would a group of families not containing mental defectives. The overwhelming majority of the families thus collected will belong to that section of the community, which we propose to term the "social problem" or "subnormal group". This group comprises approximately the lowest 10 per cent. in the social scale of most communities. Though the large majority of its members are not so low grade mentally that they can be actually certified as mentally defective, it is possible that a not inconsiderable number of them might prove, if examined by expert and experienced medical practitioners, to be certifiable and subject to be placed under care and control.[144]

The significance of the 'social problem group' is that by harping back to a perception of mental deficiency reminiscent of *The Kallikak Family,*[145] which by this time had been discredited, it identified as a problem not just the mentally deficient but also the merely 'dull' whose 'social and economic failure is primarily due to their poor mental endowment' pronouncing that

> If we are to prevent the racial disaster of mental deficiency we must deal not merely with mentally defective persons, but with the whole subnormal group from which the majority of them come.[146]

The 1930s saw the biggest change in institutional psychiatry. Firstly, the Mental Treatment Act 1930 allowed for the first time, patients to

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[144] Ibid, p. 80.
[145] G. Goddard (1912) *The Kallikak Family: A study in the Heredity of Feeble-Mindedness,* New York: Macmillan.
[146] *Report of the Mental Deficiency Committee* ...p.81.

receive free treatment in a mental hospital on a voluntary basis without the safeguards of certification. Henceforth legislation was directed towards making psychiatric treatment easily available without stigmatisation; rather than towards protecting the liberty of the public by ensuring that only those who really needed to be, were shut up in asylums.[147] Furthermore, the Act made it clear that boundaries between mental and physical illness were meaningless: physical illness had mental aspects and mental illness had physical aspects.[148] The aim of the Act was to improve the rate of successful treatment, and it was hoped that early treatment would be the key to achieving this.

Secondly, the 1930s saw a huge expansion in the field of physical treatment. Although these treatments would not become commonplace until the 1940s and 1950s, their discovery gave a boost to psychiatrists who now increasingly began to see mental illness in biological terms, but also as potentially curable. In 1933, Austrian psychiatrist Manfred Sakel reported his new therapy for schizophrenia, insulin coma therapy. This treatment consisted of injecting the patient with insulin every day, gradually increasing the dose until it was sufficient to send the patient into a coma, after which, the patient was given a sugar solution through a nasogastric tube. This procedure was extremely labour-intensive, and required the close attention of nurses and doctors to guard against a patient going into an irreversible coma. However, this was the first ever treatment for schizophrenia and was widely regarded as a miracle cure that had transformed mental hospitals from custodial asylums to genuine hospitals using active treatment.

The second radical physical treatment was cardiasol convulsions, invented in 1934 by a Hungarian doctor called Ladislas von Meduna. He

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[147] This tend was reversed by the Mental Health Act 1983. See C. Unsworth (1987) *The Politics of Mental Health Legislation,* Oxford: Clarendon Press.
[148] *Report of the Royal Commission on Lunacy and Mental Disorder* (1926) Cmd. 2700, para. 38; cited in C. Unsworth (1987) p. 113.

had noticed that some of his schizophrenic patients who were also epileptic, apparently improved after having a seizure. He concluded that epilepsy and schizophrenia were antagonistic towards each other, so he injected the drug Cardiasol in patients, in order to induce epileptic fits. This new treatment gained wide and rapid acceptance, rivalling that of insulin. Compared with insulin, an individual cardiasol treatment was easier to administer, required less observation and took up much less time. However, in the time period between the injection and the onset of the convulsions (when the patient lost consciousness) patients experienced intense fear and dread.[149] Secondly, doctors found it almost impossible to control the intensity of the convulsions and patients therefore often broke their limbs as a result.

Aware of the success and the shortcomings of cardiasol treatment two Italian psychiatrists Ugo Cerletti and Lucio Bini developed in 1936 a method to safely induce epileptic fits using electricity. Inspired from watching the practices of the slaughterhouse where pigs were given an electric shock to stun them before they were killed, Cerletti and Bini began to experiment on dogs. However, their original method in which they placed one electrode in the dog's mouth and the other one in its anus was unsuccessful as the current went through the animal's heart and frequently killed it. Cerletti and Bini overcame this problem by placing the electrodes on either side of the dog's head. With this improvement, the treatment became safe so in 1938 they started performing this treatment on humans.[150] Although Electric Convulsion Treatment (ECT) and Cardiasol Therapy both started out as treatment for Schizophrenia and were sometimes combined with Insulin Coma therapy, they soon became established treatments for Depression.

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[149] D. K. Henderson & R. D. Gillespie (1944), *'A Textbook of Psychiatry for students and practitioners'*, Oxford: Oxford University Press, p. 407.
[150] E. Shorter (1997) *A History of Psychiatry,* New York: John Wiley & Sons, pp. 218-214.

Finally, Leucotomy as a treatment for Schizophrenia and Depression was invented by Egas Moniz who received the 1949 Nobel Prize for his discovery. Several different 'cuts' of the frontal lobes were developed which varied in their extensiveness, and although in some cases doctors noticed some undesirable side effects such as apathy and childishness, the overwhelming reduction in symptomatic behaviour made this a very popular treatment.

Significantly, psychiatric practice, like medical practice, ceased to be exclusively concerned with the small group of people who were ill, and turned to the whole population; the potentially ill.[151] Psychiatrists extended their remit beyond the asylum and into the lives of ordinary people.[152] At the same time, out-patient clinics, day hospitals, the 'unlocked door' movement, unrestricted visiting and the early discharge policy encouraged fluidity between the sane and the insane.

The context of a social and preventive medicine, also allowed the Eugenics Education Society to emerge and expand. The Society attracted key figures from the social, political and health landscapes, amongst whom were a number of very influential psychiatrists and psychologists, such as James Crichton-Browne, Hans Eysenck, C. P. Blacker, Eliot Slater, Edward Mapother, Aubrey Lewis, Hugh Crichton Miller and Cyril Burt. The Eugenics Society was a broad church; its members belonged to the political left as well as to the political right and many acknowledged the importance of social and psychological, as well as genetic and hereditary, influences on health and personality.[153]

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[151] D. Armstrong, (1983) *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*, Cambridge: Cambridge University Press.

[152]Adolf Meyer's work was particularly influential in this respect as he advocated the professional unification of neuroscientists psychiatrists/alienists and psychoanalysts under the doctrine of psychobiology. See J. Pressman, (1997) *The Last Resort, Psychosurgery and the Limits of Medicine*, Cambridge: Cambridge University Press, p. 20.

[153]Members of the Society were, for example, the communist biologist J. B. S. Haldane, and the social reformers Richard Titmuss and William Beveridge. See R. A. Soloway,

It has been argued that the 1913 Mental Deficiency Act represents the peak of influence for the Eugenics movement, as the Society's later lobbying for the voluntary sterilisation of the mentally deficient in the early 1930s was unsuccessful.[154] However, the Committee on Sterilisation affirmed that sterilisation should be available on an optional basis to anyone who had cause to think that he or she may be a 'carrier' of hereditary disease, and declared itself

> impressed by the dead weight of social inefficiency and individual misery which is entailed by the existence in our midst of over a quarter of a million mental defectives and of a far larger number of persons who without being certifiable defective are mentally subnormal. This mass of defectives and subnormals is being steadily recruited and is probably growing.[155]

In many ways, the Society's influence was extended during the inter-war years when many of its central claims became accepted as 'common sense'. This was the result of, and the cause of, a larger and more professional membership, which included well-respected physicians, researchers, academics, social reformers, philanthropists and politicians. Furthermore, the appointment in 1931, of the Maudsley psychiatrist and birth control reformer C. P. Blacker as secretary of the Society was particularly significant in changing the society's outlook, raising its status as a professional organisation, popularising its views and shedding at least partially its image as right-wing and anti-working class.[156]

(1995) *Demography and Degeneration, Eugenics and the Declining Birthrate in Twentieth Century Britain,* Chapel Hill: North Carolina Press; A. Oakley (1997) 'Making Medicine Social: The Case of the Two Dog with Bent legs.' *Social Medicine and Medical Sociology in the Twentieth Century,* Amsterdam: Clio Medica; *Eugenics Education Society Papers*, The Wellcome Trust, Contemporary Medical Archives Centre (CMAC).

[154] For example, R. Porter, (1996) p. 394.

[155] *Report of the Departmental Committee on Sterilisation* (1934), HMSO, p.55. The Committee's recommendations were rejected in parliament, as there was huge opposition to the Bill by the Labour Party and by the Catholic Church.

[156] R. A. Soloway, (1995); M. Thomson, (1998).

A typical example, which demonstrates the popular acceptance of eugenic views in the inter-war period, can be found in the aetiology section of the contemporary psychiatric textbook by Henderson and Gillespie. Neither of these authors were particularly biologically oriented, but in 1936 they saw fit to alter the wording in their textbook regarding the aetiology of mental illness from the original which existed for the first three editions:

> Too much stress has been laid in the role of heredity in mental disorders, although it must be very great. The unvarnished truth is that very little even of what is probable is known of the inheritance of mental instability, and almost nothing is firmly established.[157]

In all editions since 1936 the text appeared as:

> The role of heredity in mental illness is of fundamental importance and demands the closest study and investigation. Few definite formulae can as yet be laid down. But there is evidence that every civilised nation, owing to the economic and social burden of caring for the unfit, is paying more attention to racial qualities.[158]

With the expansion of social medicine, it became acceptable at the onset of the Second World War for psychiatrists to adopt not only a therapeutic role but also a prophylactic one in dealing with war neurosis. The wide acceptance in contemporary psychiatric thinking of the view that heredity determined intelligence and to a large extent mental illness allowed heredity to dominate most discussions of war neurosis aetiology. Furthermore, the overwhelming focus by eugenicists on low intelligence as a sign of constitutional inferiority,[159] combined with a contemporary ideal of an intelligence-based meritocracy, meant that intelligence testing

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[157] D. K. Henderson & R. D. Gillespie, (1932) *'A Textbook of Psychiatry for students and practitioners'*, Oxford: Oxford University Press, p.26.

[158] D. K. Henderson & R. D. Gillespie, (1936) *'A Textbook of Psychiatry for students and practitioners'*, Oxford: Oxford University Press, p. 27

[159] Although a simple Mendelyan formula for mental deficiency was not widely accepted. The work of Lionel Penrose is significant in this respect. See for example D.C. Watt, (1998) 'Lionel Penrose, F.R.S. (1898-1972) and eugenics' *Notes and*

became the main means through which suitability for army trades and rank, as well as the potential to withstand the stresses of war would be measured.

Simultaneously, the medicalisation of psychiatry required the destruction of psychiatry's custodial role. The Mental Treatment Act (1930) and the Mental Health Act (1959) both represent the legitimisation of psychiatry's role within a much wider population suffering from mental health problems together with an attempt to reduce the population of the certified chronic wards. Avant-guard mental hospitals of the 1930s, 40s and 50s sought mainly to increase their turn over rate while reducing their population; to treat more patients than ever before while providing shelter for fewer.

Conclusion

Various disparate diseases which in the 19th century were thought of as functional, organic or mental, some of which were prevalent among women, and others more likely to be found in soldiers became the building blocks for what in the twentieth century would be called shell-shock or war neurosis. By the end of the First World War, this disorder was overwhelmingly described in psychological terms although constitutional factors and heredity factors continued to be thought of as very important, particularly in explaining why some soldiers were more susceptible to mental disease than others. Increasingly, in the early twentieth century, low intelligence also came to be seen as a trait that made people vulnerable to mental illness as well as a variety of socially undesirable behaviours. This attitude led to the mass intelligence testing of soldiers in the Second World War.

Records of the Royal Society of London, 52, ii. Many thanks to Malcolm Pines for this reference.

Chapter 2: The Administration of psychiatric services

Introduction

During the Second World War, psychiatrists played a very significant role in the medical services of the military. While the Army suffered huge psychiatric casualties,[160] psychiatrists were invested with the power to recommend who should be given a commission, whose duties should be downgraded, who should be discharged as mentally unfit and who must not be recruited into the Army at all. The psychiatrists' recommendations were usually followed: for example, of the 3,788,000 men who served in the British Army between September 1939 and August 1945,[161] 109,000 men were discharged from the Army on psychiatric grounds,[162] one quarter of whom had served less than one year.[163] Furthermore, a significant number of men were downgraded to non-combatant duties.[164] In fact, psychiatric

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[160] The psychiatrist T.F. Main reported that 2-30% of all battle casualties were psychiatric, T.F. Main, (1946) 'Discussion: forward psychiatry in the Army', *Proceedings of the Royal Society of Medicine*, 39, pp. 140-142. The figure reported in the official medical history was 2-20%, F.A.E. Crew (ed), (1955) 'The army psychiatric service', *The Army Medical Services, Administration, Vol. II,* London: HMSO, p. 489.

[161] W. F. Mellor, (1972) *Casualties and Medical Statistics,* London: HMSO, p. 829.

[162] In the parliamentary section of the *Lancet* it is stated that "Replying to a question Mr John Freeman stated that approximately 109,000 men were discharged from the Army between September, 1939, and VJ-day on psychiatric grounds; 288,000 on account of other diseases and accidental injuries; 26,000 on account of injuries due to enemy action." Anon, (1947) 'Psychiatric Cases in the Army', *The Lancet,* 250, i, p.728. Reference from H.C.J.C. L'Etang, (1951) 'A criticism of military psychiatry in the Second World War', *Journal of the Royal Army Medical Corps,* 97, p. 192. W.F. Mellor, states that in the years 1943, 1944, and 1945 the rate of discharge for mental diseases was 6.24, 8.55 and 9.42 per 1000 troops respectively, W.F. Mellor, (1972, p.448). This calculates to approximately 68000 men having been discharged in the last 3 years of the war. In the *Report of an Expert Committee on the work of psychologists and psychiatrists in the services,* it is stated that approximately 118,000 men were discharged from all three services between September 1939 and June 1944. (HMSO, 1947, p.15).

[163] *Report of an Expert Committee on the work of psychologists and psychiatrists in the services* (1947, p. 15) cited in H.C.J.C. L'Etang, (1951, p.192).

[164] H.C.J.C. L'Etang has estimated that figure to be over 220,000. From the psychiatrists' reports it would appear that between 60-70% of their patients were retained for non-combat duties, but figures differ significantly from psychiatrist to psychiatrist and from particular theatres of war and from hospitals in Britain. It is also

illness remained throughout the war, the No.1 cause of medical discharge, accounting for between 30 and 41% of all discharges due to disease.[165]

Until very recently, only three historical texts dealt with psychiatry during the Second World War. These were a series of lectures written by the psychiatrist J.R. Rees during the war, the official medical history of the Second World War, which contained several sections on psychiatry written by psychiatrists from the War Office, and an independent monograph composed by the War Office psychiatrist R. Ahrenfeldt.[166] Within these texts psychiatrists promoted the story that psychiatry was a specialty of overwhelming value to the war effort but that the effectiveness of the psychiatrists' efforts had been repeatedly compromised by the prejudice of military and medical administrators who refused to give psychiatrists the authority and resources they needed.[167] For example, Ahrenfeldt described the position of psychiatrists at the onset of the war as follows:

> Unwelcomed and regarded with suspicion, if not despised, psychiatrists –the Cinderellas of Medicine— entered the Army, where they had gradually to overcome prejudices, administrative resistance and executive inertia ... Thus they had to fight a battle on two fronts –against mental disease, and against opposition not only from certain military and civil authorities and a section of the public, but also not a few members of the medical profession.[168]

In particular, these histories focused their accusations of prejudice on civilian, military and medical leaders stationed away from the front line – whereas combatant officers and regimental medical officers were usually

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very difficult to estimate how many soldiers were treated/assessed by psychiatrists during the war.

[165] W. F. Mellor, (1972) p. 439

[166] Rees, J.R., (1944) *The Shaping of Psychiatry by War*, London: Chapman & Hall; F.A.E. Crew (ed), (1955), pp. 467-497; F.A.E. Crew (ed), (1957), 'The Army Psychiatric Service. The Middle East Force 1940-1943', *The Army Medical Services, Campaigns,* Vol. II, London: HMSO, pp. 440-513; R. Ahrenfeldt, (1958) *Psychiatry in the British Army in the Second World War*, London: Routledge & Kegan Paul.

[167] The official medical history is considerably more moderate in this respect than the monographs by Ahrenfeldt and Rees.

[168] R. Ahrenfeldt, (1958) p. 251.

portrayed as supportive of psychiatrists.[169] So Rees, for example, wrote that:

> ...we were often told that psychiatrists were the fifth-columnists of the Army, and this because they were advising the discharge of men who were obviously too dull or too unstable to soldier. The administrator who has to produce the 'bodies' and is quite out of contact with real live men is critical, and much opprobrium has come to Army psychiatrists because there has necessarily been a high discharge rate from psychiatric causes. The fighting soldier is in no doubt at all as to the kind of man he wishes to have with him. The further you get away from the front line the tougher become the comments ... It is very striking how few of the really intelligent and valuable leaders fail to appreciate the contribution of psychiatry..."[170]

This picture of the underdog yet heroic psychiatrists has mostly gone unchallenged in the more recent accounts of Second World War psychiatry.[171] In this chapter it will be argued that the power that psychiatrists yielded during the Second World War was extremely significant, and that it was only the overwhelming ambitions of the authors and their desire to tell a traditional story in which the heroes overcame adversity that lead them to describe military psychiatry in this period as the "Cinderella of medicine".[172] While the Army is frequently presumed to be the kind of reactionary, and conservative institution that would naturally object to all things psychological, the evidence from the Second World War is that psychiatry was a well respected and valued specialty. However,

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[169] For example, Ahrefeldt argues that COs and RMOs were supportive of personnel selection, (1958, p.36).

[170] J. R. Rees, (1945) pp. 27-28.

[171] For example, E. Trist & H. Murray, (eds) (1990), *The social engagement of social science: a Tavistock anthology*, London: Free Association; J. Crang, (2000) *The British army and the People's War*, Manchester: Manchester University Press; T. Harrison, (2000), *Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front*, London: Jessica Kingsley. Ben Shephard's *War of Nerves* (2000) is more critical.

[172] Overwhelming ambitions about the role psychiatrists should have in a post-war society are elaborately expressed in Rees's monograph, (Rees, 1945, pp. 117-139) while

this is not simply because psychiatry was overwhelmingly effective, or because the Army became a more liberal and progressive institution –but because the Army favoured scientific solutions to problems and psychiatrists and psychologists were the acknowledged experts in human behaviour. In addition, psychiatrists, medical officers and combatant officers shared the same values about the qualities needed in a fighting Army. Central to these values was keeping up unit cohesion and morale – and the desirability of discharging those who could not or would not fit in and thus destroyed cohesion and morale.

In particular, it will be argued that psychiatrists succeeded in increasing their own power, status, and manpower by taking advantage of two contemporary medical movements: specialisation and preventive medicine. Specifically, the re-invention of psychiatry as mental hygiene allowed psychiatrists in many instances to be involved in matters of policy rather than just therapy and thus extended their remit into many other fields, most notably personnel selection, but also discipline, training, morale and prevention of infectious diseases.[173]

Prevention and Specialisation in the Army Medical Services

By the time of the Second World War, two principles guided the development and growth of the army medical services. These were firstly a move away from general medicine towards specialised fields and secondly a move away from clinical medicine towards the prevention of disease.[174] Psychiatry benefited from the enthusiasm towards both of these principles.

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regret that Army Psychiatry lost its status after the war can be found in R. Ahrenfeldt, (1958, pp. 251-252).

[173] For example: T.F. Main, (1943) 'Psychological Problems of troops overseas. Reports to the War Office' CMAC, GC135 B1 (file 1 of 4); S.A. MacKeith, (1944) 'Psychiatric comments on some issues affecting morale' CMAC, GC135 B1 (1 of 4); E.D. Wittkower & J. Cowan, 'Some psychological aspects of sexual promiscuity. Summary of an Investigation.' CMAC GC135 B2 (4 of 4). For more detail See Ahrenfeldt, (1958) pp. 196-225.

With regard to specialisation, psychiatrists just like the other specialties benefited very clearly by an increase in their numbers; in 1923, the Army employed only 8 specialists, but by 1933 it employed 115[175] by 1941, 1056 specialists and by 1945 the Army employed approximately 3,000, over a quarter of the total medical officers.[176] The psychiatrists' numbers increased disproportionately, from 0 to 2 in 1939 to over 300 in 1945[177] and may have increased more if it had not been for a perceived shortage of qualified psychiatrists.

Psychiatrists also benefited from the move towards specialisation by getting increased administrative control; from 1918 to 1942, four specialties, hygiene, pathology, dentistry and psychiatry, were organised in specialist directorates under their own directors. This move became possible precisely because there was recognition that firstly, increased specialisation was desirable, and secondly that with increased administrative control, certain specialties could contribute towards the prevention of disease. For psychiatrists, having their specialty selected by the Director-General Army Medical Services Sir Alexander Hood, for a specialist directory was a real victory.

Contrary to the climate which favoured specialisation during the war, psychiatrists developed therapeutic regimes which could be put into practice by unspecialised personnel. This was due firstly to the absence of resources and personnel required for more specialised techniques and secondly due to the belief that most casualties were not actually sick –at least not in the same way mental patients in asylums were sick. This practice made psychiatric treatment much more transparent and much less controversial than it might have been and protected it from accusations of

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[174] F.A.E. Crew, (1953) *The Army Medical Service, Administration*, vol. I, HMSO p. 42 & 82-85.
[175] A.D. Young, (1968) 'Introduction', *Commissioned Officers in the Medical Services of the British Army 1660-1960,* (ed. Robert Drew), London: The Wellcome Historical Medical Library, p.xiv.
[176] F.A.E. Crew, (1953) p. 149 & p. 152.

charlatanism. It may have reduced the perceived need for more psychiatrists, however it paid off in allowing relations between psychiatrists and other medical and combatant personnel to run smoothly.

With regard to the principle of prevention psychiatrists were successful in instituting a number of controversial reforms although not as many as they would have liked. It will be shown that the psychiatrists' successes and failures in increasing their power within the military machine depended largely on the extent to which they succeeded in persuading others that psychiatry could be used preventively. The crux point of this campaign was persuading the army that psychiatrists could foretell who was going to become a psychiatric casualty and who would remain sane –a central argument in persuading the Army to use psychological methods in selection.

Morale

The large-scale employment of psychiatrists during the Second World War was partly due to the commanders' experience of shellshock in the First World War. In particular, concern over the troops' morale was a building block for the employment of psychiatrists. Concern for the troops' morale was associated with casualty consciousness, as a major cause for low morale amongst troops was the belief that senior officers needlessly sacrificed their lives. Casualty consciousness was deeply embedded in the thinking of senior British officers during the inter-war period. In 1927, the Chief of the Imperial General Staff G.F. Milne wrote in one instance that 'in the war of the future we cannot depend on the man-power that we had in the last great war, nor will any nation stand the losses we went through

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[177] J.R. Rees, (1958) 'Foreword' in R.A. Ahrenfeldt, (1958).

again for another 100 years.'[178] Furthermore, the Field Service Regulations (1929) explained that:

> Troops engaged in close fighting under conditions of modern war are soon affected by physical and moral exhaustion; recovery from the former is endured by a few hours sleep and suitable food; but recovery from the latter is a longer process. ... it is important that their moral qualities should not be reduced to a point at which comparatively speedy recovery is impossible. The individual soldier should, therefore, not be engaged to the point of exhaustion.[179]

This advice is very similar to that which psychiatrists gave towards the end of the First World War and during the Second World War. The restorative treatments employed by psychiatrists near the field aimed to catch soldiers at the very onset of a breakdown before their symptoms became established and harder to shift. The employment of psychiatrists was therefore a preventive measure against soldiers being exhausted beyond the point of recovery.

The military solution to maintaining the men's morale was similar to that for the other problems that the army faced; scientific experts with new technologies were brought in. As the doctrine of the British Army developed in support of having a small but well equipped force, low on personnel and high in technology, this included psychiatric techniques. However, in the same way that, doctrine aside, the British Army faced the onset of war technologically unprepared,[180] the employment of psychiatrists was also slow, not reaching full strength until 1943.

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[178] *Report of the Staff Conference held at the Staff College Camberley,* 17-20 Jan.1927, TNA, WO 279/57. Cited in D. French (2000) *Raising Churchill's Army; the British army and the War against Germany 1919-1945,* Oxford: OUP p. 14.
[179] General Staff, (1929) *Field Service Regulations, ii. Operations,* London, p. 101. Cited in D. French, (2000) p. 24.
[180] D. French, (2000).

The Army Medical Department

In charge of the medical services was the Director-General, Army Medical Services, (DGAMS). Under him, several Directors ran individual services. Above him was the Adjutant-General, the top administrative post in the Army in whose department fell all issues regarding army personnel. This included, apart from the medical services, education of the troops, recruitment and selection.[181] The Adjutant-General was the second most senior military member of the Army Council, the top military body. The other members of the Council were: the Chief of the Imperial General Staff, the Quarter-Master General to the Forces, the Vice Chief of the Imperial General Staff, the Secretary of State for War, two Parliamentary Under-Secretaries of State for War, the Financial Secretary of the War Office, the Director-General of Army Requirements and the Permanent Under-Secretary of State for War. Many decisions were made by the Executive Committee of the Army Council (ECAC), which consisted of the Permanent Under-Secretary of State, the Adjutant-General, the Quarter-Master General, the Vice-Chief of the Imperial General Staff and the Director-General of Army Requirements.

During the 1914-18 War, there were four Directors operating directorates under DGAMS, but none of them was responsible for a specific medical specialty. In the aftermath of the war, the Director-General created two new (sub) directorates, one for pathology and one for hygiene. According to the official history of the medical services, there were two related lines of reasoning behind these changes: the first was the growth of specialisation; the second was a new emphasis on the prevention of disease. Pathology and hygiene were seen to be the branches of medicine most likely to prevent wastage from disease thereby justifying the use of greater administrative powers than other branches of medicine.

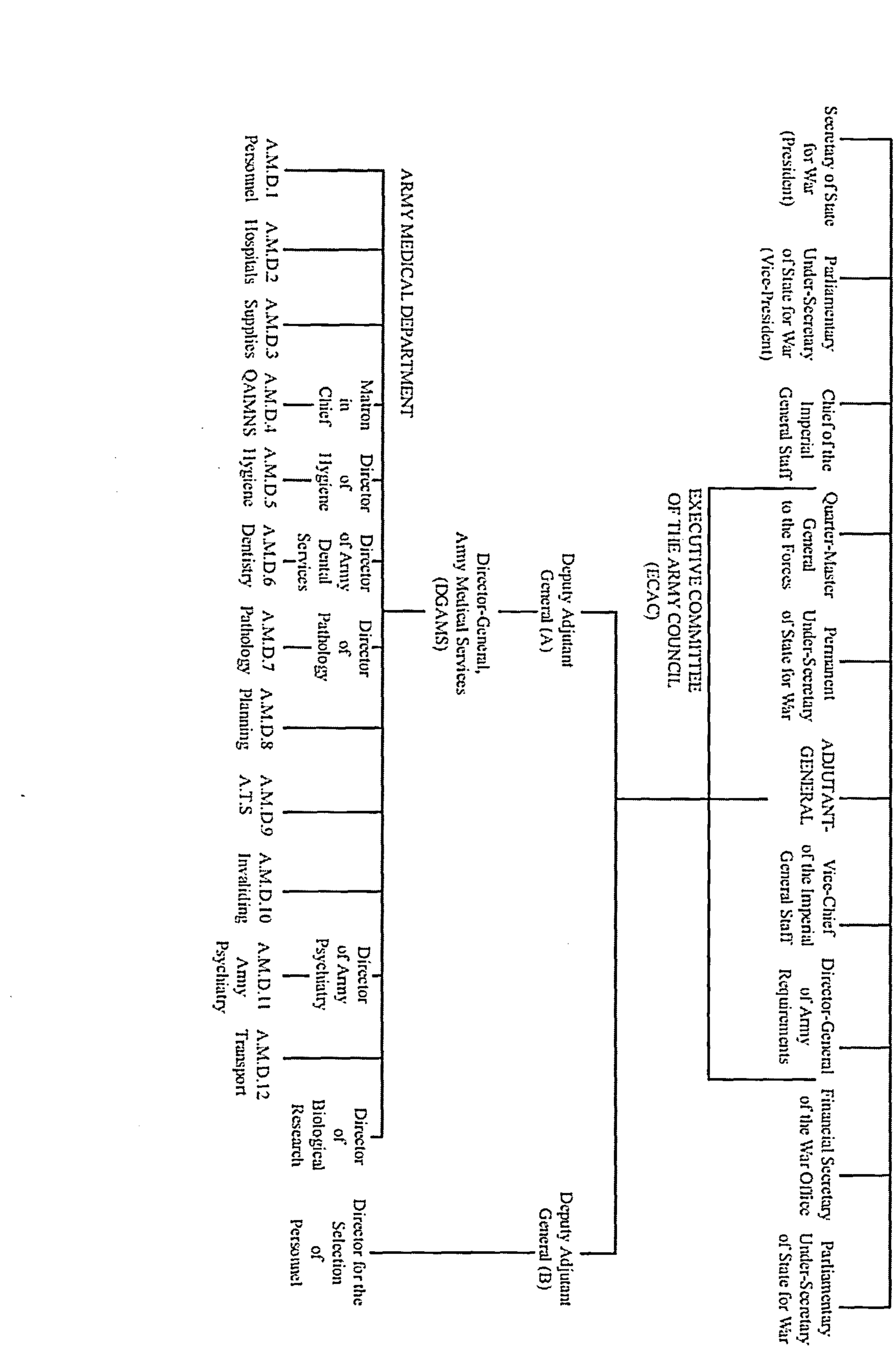

Diagram 1: The Adjutant-General's Department. Partially adopted from F.A.E. Crew (1953) 'Fig.2. Organisation of A.M.D. December 1942', p. 42.

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[181]In the editorial of *The Army Quarterly* it is stated that "The provision, administration and care of the human element are the pivotal activities of the Adjutant-General's staff" Vol XLVI. No. 2 August, 1943 p. 217.

The creation of these two specialist directorates paved the way for other such medical directorates. Although in 1932, the Directorate of Pathology was abolished, in the period from 1936 to 1942 seven new directorates were formed, including a new Directorate of Pathology (A.M.D.7) bringing the total to twelve. Only five of these directorates, hygiene, pathology, dentistry, psychiatry, biological research had their own director and of these only the first four could be described as specialist medical subjects.[182] This shows that at the highest level within the medical services, it was recognised that psychiatrists had a role to play in the Army that involved both the prevention of and the specialised treatment of psychiatric casualties.

The Directorate was responsible for the development, control and co-ordination of the psychiatric services of the Army at home and overseas, and acted in an advisory capacity within the War Office. It had three branches with the following functions:

"A.M.D. 11 (A) Psychiatric aspects of morale, discipline, training and equipment.

A.M.D. 11 (B) Selection, training and allocation of Army psychiatrists. Psychiatric aspects of recruiting, selection, grading, allocation and transfer of officers and other ranks. Psychiatric liaison with the Ministry of Labour and National Service.

A.M.D. 11(C) Clinical policy and research. Psychiatric clinics and hospitals. Psychiatric liaison with the Ministry of Pensions, Ministry of Health and Board of Control. Psychiatric aspects of discharge and medical boards."[183]

The responsibilities of the Directorate and of its psychiatrists included much more therefore than just the clinical responsibilities, which

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[182] The directorate for the nursing services was directed by the Matron-in-Chief, a position similar to a Director.

[183] From 'The Army Psychiatric Service', *The Army Medical Services, Administration, vol. II,* (1955) (ed) F. A. E Crew, HMSO p. 469. The substance of this account was provided to Crew by the Directorate of Army Psychiatry.

were covered by AMD 11(C). AMD 11(B) outlines the Directorate's role in personnel in which it cooperated strongly with the Directorate for the Selection of Personnel. AMD 11(A) however makes it explicit that the psychiatrists' remit was more extensive; consequently, psychiatrists produced multiple reports on morale, discipline, training and equipment.[184] It is unclear whether the psychiatrists' recommendations were ever implemented; it is entirely conceivable that once submitted to AMD11 many of these reports were filled without ever having been read by anyone outside the Directorate. One exception is training, where psychiatrists had a significant input in what should be taught in battle schools and also produced various leaflets for the training medical officers to handle psychiatric disorders.[185] Yet, merely the fact that psychiatrists were commissioned to explore such fields is significant because it demonstrates that they were perceived by DGAMS and by some of the War Office to be more than just clinicians; psychiatrists were experts on all aspects of human behaviour.

In many respects, however, the status of the Directorate of Army Psychiatry was not equivalent to the Directorates of Hygiene, Pathology and Dentistry. In the War Office the differences were not so stark: the most significant point was that the Director of Army Psychiatry appointed by DGAMS was *not* a psychiatrist but a regular RAMC officer with a diploma specialising in Hygiene. The D. of A.P. as he was known, H.A. Sandiford, had an interest in psychiatry and had delivered educational lectures on the subject to RAMC officers, but had no formal qualifications on the

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[184] For example, T.F. Main, (1943); S.A. MacKeith, (1944); Anon, (1944) 'Eighth Army Morale Report' GC135 B1 (4 of 4); E.D. Wittkower & J. Cowan, (1945). See also R. Ahrenfeldt (1958) pp. 196-225.

[185] R. Ahrenfeldt, (1958), pp. 196-225; Anon, (1944), 'Psychiatric Technical Memorandum No. 1. "Field Psychiatry for Medical Officers" 21 Army Group.' CMAC, GC 135 B2 (1 of 4).

subject.[186] The other three directorates were of course directed by men who were specialists in the respective areas. However, as will be shown later this was a situation which did not necessarily harm the interests of psychiatrists, and may in fact have aided them by recognising an essential link between psychiatry and hygiene in the form of 'mental hygiene'.

Furthermore, although the Directorate of Army Psychiatry had a smaller staff in the War Office than the Directorate of Hygiene it was similar to and in some ways larger than the other two specialist Directorates. Besides the Director, there were two Assistant Directors of Army Psychiatry (ADAPs) and two Deputy Assistant Directors of Army Psychiatry (DADAPs). In conjunction with this staff, also worked the Consulting Psychiatrist to the British Army, J.R. Rees, and by 1944 also a Consulting Psychologist and a Consulting Psychiatrist to the Army at home who although working in the war office were officially attached to the Royal Army College. However, the position of the consultants was different to that of the director and his assistants. While the director and the assistants were staff officers with administrative duties, the consultants were mere advisors; they enjoyed military rank equivalent to the Director (Brigadier) but had no administrative duties. For the most part the duties of the consultants appear to be inspecting military psychiatric establishments in Britain and overseas, reporting on their situation and *recommending* to the Director of Army Psychiatry and the Director-General of Army Medical Services possible improvements.

However, the more significant differences between the Directorate of Army Psychiatry and the other specialist Directorates were in the medical administrations in the various commands at home and abroad. The differences in personnel numbers are very complicated. It is very difficult to find exact figures, but we know that by the end of the war, over 300

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[186] H.A. Sandiford, (1938) 'War Neuroses', *Journal of the Royal Army Medical Corps,* 71, pp. 222-235. This lecture was delivered to officers of the RAMC, Aldershot

Army psychiatrists,[187] in contrast to 2,100 dentists, were employed.[188] However, the differences between the numbers of psychiatrists and specialists in hygiene and pathology were definitely not as stark as even by the end of the war there were only approximately 3000 specialists employed by the Army.[189] In addition, psychiatric service patients, in the early years of the war, were mainly treated by *civilian* psychiatrists working for emergency medical hospitals in the U.K. who were not included in these figures. In comparison to other specialities, psychiatrists certainly did very well, for example in 1941 there were only 73 ophthalmology specialists in the Army.[190]

Secondly, in the various commands, specialists in hygiene, pathology and dentistry were led by specialists who were assistant directors and deputy assistant directors i.e. *staff officers* who were part of the managerial structure of the command and not mere 'experts' to be called upon when their advice was needed. In contrast, psychiatric services in commands were headed by *consultants* with limited decision-making powers. In this situation, army psychiatrists were on a par with consultants from other specialties such as ophthalmology, who had not formed their own directorate. The situation had arisen originally because consultants had been appointed prior to the formation of the directorate of Army Psychiatry. Once the Directorate was formed, the consultants, the director of army psychiatry, DGAMS and the Adjutant-General all pressed for consultant psychiatrists to become staff officers, but the proposals were repeatedly turned down by the Executive Committee of the Army Council,

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Command.

[187] J. R. Rees, (1958) 'Foreward' in R. H. Ahrenfeldt, *Psychiatry in the British Army in the Second World War.*

[188] Anon, (1948) 'Appreciation for Alexander Hood', *Journal of the Royal Army Medical Corps,* 90, p. 223.

[189] F.A.E. Crew, (1953) p. 152.

[190] F. A. E Crew, (1955) p. 516. This figure may have increased by the end of the war but there is no such record.

and the Secretary of State on the basis that psychiatry formed part of *curative* rather than *preventive* medicine.[191]

In the various commands, consultants in psychiatry were based in command headquarters and had a role similar to that of the consultant to the Army, but on a smaller scale. They visited general hospitals, supervised the work of the medical officers with regard to psychiatric cases, lectured and conducted some out-patient work. Consultants then reported back to the staff officer in charge of the medical services at headquarters (the Deputy Director DDMS or the Assistant Director of the Medical Services ADMS) with any recommendations that would reduce psychiatric casualties and improve the 'return to unit' figures.

Gradually more psychiatric hospitals were put in place, and the psychiatric staff increased to include area psychiatrists, corps psychiatrists, and even divisional psychiatrists.[192] In most commands, consultants organised a three-tier system for the treatment of psychiatric casualties. The corps or divisional psychiatrist operated an 'exhaustion centre' near the front line where patients could be treated with restorative measures. Those who were thought not likely to be ready to return within a few days were sent further back to another psychiatric centre where more elaborate treatment could be administered. Those still unable to return to duties were sent to the base hospital, and finally, those deemed incurable and impossible to use in non-combative tasks were evacuated (either to the UK, South Africa or India, depending on the command) for discharge.

The corps (or divisional) psychiatrist's duties as laid down by the War Office in February 1944 can be classified into four categories: treatment, selection, discipline and the promotion of mental health. With regard to treatment, corps psychiatrists were expected to treat early cases and supervise the treatment of psychiatric cases during action. With regard

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[191] 'Psychiatric Services in Operational Theatres', TNA, WO32/11550 .

to selection, they had to pick out soldiers who were unfit for duty and attend medical boards where they advised on the medical reclassification and posting of these men. In addition, corps psychiatrist had to write reports on disciplinary cases, advise "on all matters pertaining to mental health", on "the psychiatric aspects of discipline, morale and training", and "assist in the promotion of mental health and in preventive psychiatry"... "by lectures and informal discussions with officers (staff, regimental and medical)".[193]

The tasks of the area psychiatrists were similar to that described above: they provided an out-patient service for every area where there were troops or military hospitals; they visited units to discuss with R.M.Os., the military value of men who had been referred to them, advised medical and administrative officers on a variety of problems arising in units and assisted in the selection procedure.[194]

Consultants in psychiatry had, by the end of the war, a staff of 15-25 psychiatrists under them.[195] However, because psychiatrists remained mere advisers to the DDMS or ADMS, the extent of the psychiatrists' powers depended largely on the relationship they forged. In some commands, relations between Staff officers and consultants were good and psychiatrists felt able to accomplish all they wanted. In other commands, a more attritional relationship existed and the psychiatrists' efforts were thwarted, particularly when they diverted from clinical practice on to issues regarding morale and man management. The psychiatrist P.J.R. Davis made this point when he wrote that:

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[192] A corps psychiatrist was included in the war establishment of the headquarters of a corps in 1943. Divisional psychiatrists were only used in Burma.
[193] From F. A. E Crew, (ed) 'The Army Psychiatric Service', *The Army Medical Services, Administration, vol. II,* (1955) HMSO p. 490.
[194] Ibid, p. 468.
[195] Except from Gibraltar, Palestine and West Africa which had a total of 4 psychiatrists. Commands in Britain also had fewer staff, averaging at about 10 psychiatrists per command.

[The] very high degree of assistance and encouragement which I received ... from the Divisional Commanders and ADMS under whom I served. ... enabled me to function efficiently and to improvise ... In circumstances where this full co-operation is not forthcoming, the position of the Divisional Psychiatrist could be extremely difficult, and it is for this reason that I consider that there is a strong argument that he should be posted to a Division with the status of a Staff Officer, recognised on the establishment of a Divisional Headquarters, and officially provided with the medical equipment, transport, and staff which he requires if he is to do full justice to his job.[196]

The Directorate for the Selection of Personnel

Although, as it has been shown, psychiatrists had in many ways fewer powers than the specialists of other directorates, the situation was different in the field of personnel selection. Under the Director for the Selection of Personnel Brigadier K.G. MacLean (a professional soldier, also in the Adjutant-General's department, independent from the medical services), psychologists and psychiatrists worked with the Directorate of Army Psychiatry and influenced recruitment. Although psychiatrists did not examine every recruit, they produced in conjunction with psychologists, intelligence and aptitude tests that from 1942 were given to all recruits. Psychiatrists personally interviewed recruits who did badly in these tests, approximately 10% of the intake. Furthermore, psychiatrists and psychologists became members of the War Office Selection Boards, which tested the candidates' suitability for commissions along the line psychiatrists and psychologists had suggested. This last privilege however

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[196] P.J.R. Davis, (1946) 'Divisional Psychiatry. Report to the War Office', *Journal of the Royal Army Medical Corps,* p. 274. For an example of an attritional relationship between psychiatrists and medical officers see the relationship between the psychiatrists Wishart and Kenton and the DDMS in Algiers. CMAC GC135 B1 (4 of 4). General Cantlie however eventually began to approve of psychiatrists, to the extent that he spoke in the conference they held in Calcutta 1944 TNA,WO32/11550. Another famously conflicting situation arose between the psychiatrists W. Bion and J. Rickman and the inspecting officers in Northfield Hospital, which cost Bion and Rickman their jobs. Ultimately however, the Northfield experiments were continued new personnel. This will be discussed further in chapter six.

was revoked before the end of the war. The details of the psychiatrists' role in selection and recruitment will be discussed in Chapter Three.

However, when it came to discharging a particular soldier due to a medical problem, psychiatrists like other specialties were only able to make a recommendation. It was the Officer Commanding a hospital or a medical unit who could call a medical board, and only if the medical board agreed, could a soldier be discharged.[197]

Psychiatrists and the Tavistock Clinic

A number of influential psychiatrists employed by the Army had worked previously in the Tavistock Clinic, while many others started working there after the war. Some of the more influential were JR. Rees, Consultant Psychiatrist to the Army, Ronald Hargreaves, psychiatrist to the Northern Command, Assistant Director of Army Psychiatry (ADAP) and primary instigator of psychiatric selection, Eric Wittkower, involved in the design of the procedures for officer selection, T.F. Rodger also ADAP and psychiatrist to Scottish Command. Indeed five out of six of the command specialists in the UK, were Tavistock psychiatrists.[198] By contrast, the psychiatrists of the very prestigious Maudsley Hospital did not enlist, but treated military casualties as they arrived in Britain within the emergency medical services framework.

According to the obituary notice of Hugh Crichton-Miller, founder of the Tavistock Clinic, it was he who encouraged his staff to enlist at the onset of the war. In the case of the position of Consultant to the Army at home (this soon became Consultant to the Army as a whole),[199] the Director of the Tavistock, J.R. Rees was nominated for the position by the Royal College of Physicians. Considering that the Tavistock Clinic's

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[197] Prior to January 1941 an officer commanding a medical unit would have to go through the ADMS twice, both before and after conducting a medical board, in order to get a man discharged. FAE Crew (1953) pp. 439-440.
[198] Anon, (1959) 'Obituary', *The Lancet*, i, p. 104.

psychotherapeutic approach was quasi-Freudian, controversial, and at odds with both the asylum psychiatrists and the Maudsley Hospital, J. R. Rees might be seen as an unusual candidate for what was in 1939 the most prestigious psychiatric job in the Army. What was probably of significance for this appointment however was firstly that J. R. Rees had spent some years working for the Ministry of Pensions as the Neurological Specialist and secondly that the Tavistock Clinic had a military tradition of sorts, based on the fact that a number of Tavistock psychiatrists had experience of treating shell-shock patients during the Great War. For example, Hugh Crichton-Miller founded the clinic partly because he had felt that the treatment of shell-shocked soldiers with a Freudian inspired psychotherapy had been very successful.[200] The initial staff of the Tavistock also included J. A. Hadfield, also a shell-shock psychiatrist, while other psychiatrists who made their name through their treatment of shell-shock such as Millais Culpin, Bernard Hart and William McDougal were at various times members of the Medical Advisory Board and regularly lectured in the Clinic[201]. The link between the Tavistock and the Armed Forces is also demonstrated by the appointments of Field Marshal Haig and Admiral Beaty as honorary presidents of the Tavistock Clinic when it opened in 1920.[202] In 1939, the Tavistock organised a series of lectures published as *The Neuroses in War*[203] in which various psychiatrists with war-related experience contributed, although Rees's appointment probably preceded this.

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[199] R. Ahrenfeldt, (1958) p. 16.
[200] H.V. Dicks, (1970) *Fifty Years of the Tavistock Clinic,* London: Routledge & Keegan Paul, pp. 12-13.
[201] Ibid, p. 23.
[202] M, Stone, (1985) 'Shellshock and the psychologists', *The Anatomy of Madness,* II (eds) W.F. Bynum, R. Porter & M. Shepherd, London: Tavistock Publications.

Psychiatry and Preventive Medicine

During the Second World War, the relationship between the medical services and the military was centred on medicine's ability to conserve manpower.[204] Instead of focusing exclusively on treating the wounded, the medical services tried to prevent casualties from disease through improvements in sanitation, vaccinations and other preventive measures.[205] In many contemporary texts, it is explicitly stated that prevention of disease is a greater priority than the care for the wounded. For example, the 1941 War Office Manual for medical officers focused on the importance of 'preserving health,' arguing that a medical officer's 'main duty' was 'to conserve man-power, to maintain the unit at its highest state of physical and mental efficiency' adding that 'your professional duties though important are only subsidiary to the major responsibility of preserving the health of the soldier.'[206] In a similar tone, the editorial of the *Journal for the Royal Army Medical Corps* stated that civilian doctors joining the RAMC had to adjust their outlook and learn that the prevention of disease was a greater priority than the cure of disease:

> Paragraph 7 of Regulations for the Medical Services of the Army lays down in order of priority first, the prevention of disease and, secondly, the care and treatment of the sick and wounded. This is a completely new aspect of medical practice to most medical men.

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[203] E. Miller, (1939) *The Neuroses of War,* London: Tavistock Press.

[204] See M. Harrison, (1996) 'Medicine and the management of modern warfare', *History of Science,* 34, pp. 379-410; M. Harrison, (2004) *Medicine and Victory, British Military Medicine in the Second World War*, Oxford: Oxford University Press; D. French, (2000).

[205] Claire Herrick has also described how the medical profession placed the blame for the vast casualties from what were seen as preventable diseases during the Boer war, with the military administration that refused to place sufficient significance on medical advice and reform. During the Russo-Japanese war, the medical profession sought to gain support for its reforms by rhetorically equating the Japanese military success with a victory against disease and the Russian defeat with the absence of medical reform C. Herrick, (1999) 'The Conquest of the Silent Foe: British and American Military Medical Reform rhetoric and the Russo-Japanese War', *Medicine and Modern Warfare,* 55, (eds. R. Cooter, M. Harrison & S. Sturdy), Amsterdam: Clio Medica, pp. 99-130.

[206] The War Office, (1941) 'Self –Training for Medical Officers', CMAC, RAMC 762/4.

> Rightly or wrongly most emphasis is laid, both in hospital training and in practice, on the treatment of sick people. ... But here is the primary duty that is laid upon us –the prevention of disease– which is only another way of saying economy in man-power in all its aspects.[207]

Similar priorities were also set out in an address delivered to the Royal Medical Society by Major-General Philip H. Mitchiner, who argued:

> The aim of the existence of the medical profession is primarily to benefit the human race and in this respect preventive medicine is far more valuable to our patients than the attempts to patch up and alleviate their established diseases, though such is the established civil practice; in the Services, on the other hand, prophylaxis has long held pride of place wherein Service medicine has been greatly in advance of civilian. In preventive medicine the war had undoubtedly provided an enormous advance.[208]

One of the largest and more powerful medical directorates was that of Hygiene. Pervasive of all attempts by psychiatrists and their supporters to win greater powers therefore was the comparison between the field of psychiatry and that of hygiene. Aided by the fact that the Director of Psychiatry himself, was a specialist in hygiene, psychiatrists used the preventive/hygiene aspects of psychiatry rhetorically to argue either that they must be given similar powers as hygiene specialists or that psychiatry needed to be taken a lot more seriously.

For example, the consultant psychiatrist G.W.B. James compared the resistance shown in previous years by army officers to hygienic measures, to the resistance he thought they showed currently to psychiatric measures:

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[207] Anon, (1944) *Journal of the Royal Army Medical Corps,* 82, pp. 130-131. However, the *Regulations* do not actually state that that the ordering of the duties of the medical services is "in order of priority first". Nonetheless, this passage is indicative of the perception in the RAMC that prevention of disease is 'the primary duty.' Anon (1938), *Regulations for the Medical Services of the Army,* London: HMSO, p.2, para. 7.

[208] P.H. Mitchiner, (1946) 'The Aftermath of war in medicine,' *Journal of the Royal Army Medical Corps,* 87, p.241. In the same article Mitchiner stated that: *'Psychiatry* has become firmly established and is undoubtedly of very great use' p. 243.

> ... effort will be required to establish mental hygiene as an important feature of the medical officer's training as had to be made to demonstrate the value of hygiene. "What does the soldier want with soap?" asked a senior officer not so many years ago. One can perhaps be permitted to hear his counterpart asking the question "What does the soldier want with this 'trick-cycling'?"[209]

The psychiatrist H.B. Craigie even went as far at to state that 'mental hygiene ... proved during the war in many respects more important than physical hygiene.' [210]

Broadly speaking there were three ways in which psychiatry could be used preventively: by teaching junior officers 'man-management', by picking out men who were on the brink of breakdown and treating them with restorative measures and by preventing unsuitable men from performing key jobs. With regard to man-management, a memorandum on Army Psychiatry stated that it is the duty of Army Psychiatrists to prevent psychiatric disabilities by training medical officers on how to maintain morale and discipline, discussing with regimental and staff officers the psychiatric aspects of morale and its implications for the control and administration of units; and by making suggestion to training officers on the various aspects of the "mental training of the soldier".[211] Psychiatrists therefore were asked to advise other officers, sometimes their superiors, on how best to conduct this work.

The psychiatrists' work in selection and treatment will be discussed at length in chapters 3-6. Suffice to say, this work took up most of the psychiatrists' time, and involved a high degree of cooperation with army and medical officers.

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[209] 'Trick-cycling' was the semi-affectionate, semi-derogatory popular name for psychiatry. G.W.B. James, (1945) 'The Future of Psychiatry in the Army Medical Service' *Journal of the Royal Army Medical Corps*, 84, p.53.
[210] H. B. Craigie, (1945) 'Forward Psychiatry in the Army', *Proceedings of the Royal Society of Medicine*, p.140.
[211] TNA, WO32/11972

The identification of psychiatry with hygiene was also a successful strategy for diffusing psychiatric methods to non-psychiatrists. For example, many non-psychiatrists were convinced that 'man-management,' was an inherent part of hygiene. Lieutenant-Colonel R.A. Mansell of the RAMC argued in a lecture that there was no distinction:

> Some people will tell you that this is not hygiene, which I am supposed to be teaching you, but some other and quite different thing, not my job at all. I would then remind them that "Hygiene is the study of man rather than matters. The study of the development of the soldier is more important than the study of the disposal of his faeces." [212]

Mansell later added:

> Can't you take our hygiene of the field and the barrack room, which we have been trying to teach you, or even into the higher spheres of civil life, and realise that our "chain of infection" –"source-route-destination"– can be applied equally to the social, mental and, if you like the word, psychological difficulties of our fellowmen?[213]

In addition, the editorial of the *Journal of the RAMC* argued after the war:

> One great advance that had been made is in the application of psychiatry to military problems. It has long been felt that there should be a very close connexion between hygiene and psychiatry and this happy state of affairs seems likely to be realized. While the psychiatrist must never forget that he is a physician who treats the mentally ill he has also a very valuable, indeed essential role as a mental hygienist.[214]

However, in the instances where those in authority sought to limit the psychiatrists' power and involvement with non-clinical issues, the

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[212] R.A. Mansell, (1942) 'Man-management' *Journal of the Royal Army Medical Corps,* 79, p. 75. Mansell reported that he was quoting J.A. Anderson, (1924) but gives no other reference.
[213] Ibid, p. 76.
[214] Anon, (1948) 'Editorial Forward', *Journal of the Royal Army Medical Corps,* 90, p. 228.

argument was used that psychiatry was part of curative rather than preventive medicine and psychiatrists could not predict future conduct. Therefore, while Adam told the ECAC that psychiatrists should become staff officers arguing that:

> There is, ... a limit to what can be achieved by improved facilities for treatment. Preventive measures are essential, and these must proceed through administrative channels, with close collaboration between general, administrative and medical staff officers. The same considerations led to the appointment of hygiene specialists as staff officers and to the establishment of a Directorate of Hygiene. The status of the officers concerned has a practical bearing on the results achieved and it is significant that the high standards of physical health maintained during this war has followed upon the establishment of hygiene staff officers and the establishment of a directorate of Hygiene. Higher standards of mental health may be expected to result from a reorganisation of psychiatric staffs on similar lines. In operational theatres, psychiatrists should be staff officers instead of professional advisers. The senior psychiatrists should be deputy and assistant directors.[215]

The ECAC's reaction was unfavourable:

> In discussion, it was questioned whether the position of the psychiatrist in Army Medicine was a true parallel with that of hygiene and whether it was not, perhaps, a retrograde step to separate the organisation of psychiatric treatment from the general medical organisation ... From this standpoint, it was suggested that hygiene was an aspect of preventive medicine, while psychiatry was more a part of curative medicine [216]
> ... as concerned further wars, it was hoped that the selective machinery of the Ministry of Labour would prevent personnel prone to psychiatric breakdown being allocated to the Army.

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[215] Psychiatric Treatment In Operational Theatres: Status Of Psychiatrists (Memorandum By A.G. For Consideration By The Executive Committee Of The Army Council At Their 220th Meeting To Be Held On Friday, 29th June, 1945.) TNA, WO32/11550.

[216] Underlined in crayon and in margin the word 'both!' is noted.

> AG said that in view of the importance of the issue at stake, he must adhere to the proposals .... and the COMMITTEE invited the Chairman ... to submit for the Secretary of State's decision ...[217]

The Secretary of State agreed with the ECAC and the AG's suggestion was rejected.

Opposition and Patronage

From the above discussion, it should be clear that psychiatry was a valued specialty in the Army. Psychiatrists may never have attained status similar to that of the hygienists, but in comparison to other specialties such as ophthalmology or dermatology, which also had wide application in the Armed Forces, psychiatry did well. Psychiatrists convinced the Army to employ them in considerable numbers, to give them administrative control over their staff and patients, and to follow their recommendations regarding treatment and personnel selection. On the whole, psychiatrists carried out all their own inspections of treatment facilities –and even though their reports were addressed to the local Directors of Medical Services, psychiatrists essentially monitored themselves. Furthermore, the Directorate of Army Psychiatry and the Directorate for the Selection of Personnel were developed (albeit under non-psychiatric Directors) and established the significance of psychiatry in treatment, selection, morale, discipline and the preservation of mental health. The psychiatrists' recommendations regarding the discharge of personnel were usually followed as can be seen from the fact that psychiatric disability was the most significant cause of medical discharge. Finally, psychiatrists succeeded in making psychological testing compulsory for all recruits, designed the procedures of the War Office Selection Boards (WOSBs) that selected candidates for commission and became permanent members of the Boards.

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[217]32A 'Extract from the minutes of the 220th meeting of the Executive Committee of

Psychiatrists also failed in some of their goals. For example, psychiatrists would have preferred to have psychiatrists directing the two Directorates and they would have liked to have obtained Staff status in greater numbers. They also wanted the Army to hire many more psychiatrists, at least one for every division, corps, and command, as well as one for every WOSB. Finally, towards the end of the war, psychiatrists were stopped from interviewing all candidates at WOSBs and after the war, they were removed from the Boards as permanent members.

The successes psychiatrists had must be seen within the context of an army that on the whole embraced modernity and saw science and technology as the means through which future victories could be ensured. The Army respected and admired specialists, promoted bureaucracy, and most significantly, was willing to divert fairly central power to experts. Although the efforts of the British Army were hampered in the first years of the war through relatively deficient weapons etc, this was due to inadequate funding and the expectation in the inter-war period that Britain would not have to fight a first class enemy[218]. At the level of doctrine however, the army favoured a small but highly equipped force. David French has recently argued that:

> Far from seeing the army as some king of refuge from the modern world, the General Staff regarded war against a first-class power as an industrial undertaking. They … therefore … tried to guide the development of the army along the same path towards a more capital-intensive future as did the managers of British industry. In the same way that managers of industry believed that capital-intensive technologies would increase the productivity of each worker, so senior officers believed that technology would increase the productivity of each soldier by enabling fewer soldiers to kill more of the enemy and at less cost to their own side.[219]

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the Army Council held on Friday, 29th June, 1945.' TNA WO32/11550.

[218] D. French, (2000).

[219] Ibid, p. 276.

Relations between psychiatrists and the armed forces can be viewed in the same context. For example, psychiatrists attempted to infiltrate and evaluate procedures in recruitment and promotion that had up until then been outside the scope of doctors and scientists. Although in their own histories psychiatrists maintained that they were opposed by the military, the fact remains that they were largely successful in their overhaul. The psychiatrists' success was dependent on convincing a number of people in authority that their approach was the rational, scientific and democratic one, and that the opposition was backward-looking traditional and blimpish. The opponents of psychiatry (many of whom were doctors) dismissed psychiatrists as charlatans and as *unscientific.*

For all its success, psychiatry did face some vociferous opponents among politicians, medical officers and combatant officers. In the book *In My Fashion,* written immediately before his death, the eminent physician to Winston Churchill, H.M. Moran, included a contemptuous account of the psychiatric contribution to the Armed Forces. Within this account, Moran argued that psychiatric interference had resulted in manpower wastage, but that the medical service had been unable to control them:

> The heads of our medical service, while often resenting the waste of men at a time when our manpower had become a burning question, were not prepared to stand up against the solid phalanx of psychiatrists, who were known to be backed by a very powerful non-medical authority.[220]

This very powerful authority was none other than the Adjutant-General, Ronald Adam. He was not alone, however, in protecting the psychiatrists. J.R. Rees, Consultant Psychiatrist to the British Army, thanked two more non-psychiatrists in his book: Lieutenant-General Sir Alexander Hood (DGAMS), and Brigadier Hugh Sandiford, Director of

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[220] H.M. Moran, (1946) *In My Fashion,* London: Peter Davies, p. 142.

Army Psychiatry.[221] To this list, Brigadier FH Vinden, Assistant Adjutant-General to the War Office should be added. The most important and powerful of these men, the Adjutant-General, Ronald Adam (in conjunction with his staff) instigated psychiatric involvement in recruitment, attempted to establish a pro-psychiatric 'independent' committee to assess the work of the psychiatrists when such a committee was demanded and tried to give psychiatric consultants and advisers the role of staff officers. Alexander Hood established the Directorate of Army Psychiatry. Hugh Sandiford defended his Directorate against all charges of manpower wastage and charlatanism and also attempted to secure staff status for the leading psychiatrists.

Ronald Adam was undoubtedly a moderniser. He supported greater education of the troops and introduced compulsory group discussions of current affairs. In his memoirs, he wrote condemning the state of education and argued for its improvement. He supported the social sciences writing that:

> If we devoted even a quarter of the resources that are devoted to research into the natural sciences in carrying out research into the social sciences, we could make Great Britain into a much happier place for our young people and save much delinquency.

With regard to Army education, Adam recommended the education of officers in civilian universities in order to broaden their horizons:

> I would, ... have liked to see all officers trained at the universities taking appropriate degree courses. It is most important that the future leaders of the Army should complete their education with civil servants, scientists, etc. with whom they will work in time of war and that they should broaden their minds which are bound to be narrowed in a military institution.[222]

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[221] J.R. Rees, (1944), *The Shaping of Psychiatry by War,* p.11.
[222] R. Adam, (1960) 'Various Administrative Aspects of the Second World War', Liddell Hart Centre Adam papers, 3/13, p.3.

Finally, Adam and his staff defended psychiatrists, particularly the 'introduction of scientific methods of selection' and stereotyped their opponents as ignorant:[223]

> It was difficult to persuade the Army that psychiatry and psychology were not new inventions made by some medical officers and being tried out on the unfortunate Army thus enabling a number of men to escape their duties in the fighting line.
> There was also considerable criticism of the use of these specialists not only from Army officers, but from some politicians and even from a few eminent medical men.
> This was due to ignorance, fear of new ideas and ... superstition that mental sickness was the work of the devil and should be ignored.[224]

Until 1943, psychiatrists were increasingly gaining more powers. Although they continued to increase in numbers until the end of the war, other powers were curbed. The move partly originated with Winston Churchill who in this often quoted passage wrote to the Lord Privy Seal in December 1942:

> ... it would be sensible to restrict as much as possible the work of these gentlemen, who are capable of doing an immense amount of harm with what may very easily degenerate into charlatanry. The tightest hand should be kept over them and they should not be allowed to quarter themselves upon the Fighting services at the public expense. There are, no doubt, easily recognizable cases which may benefit from treatment of this kind, but it is very wrong to disturb large numbers of healthy, normal men and women by asking the kind of odd questions in which the psychiatrists specialise. There are quite enough hangers-on and camp followers already.[225]

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[223] F.H. Vinden, (1977) *War & Society,* Vol. II, (eds)B. Bond & I. Roy London: Croom Helm, p.122
[224] R. Adam, '(1960) p.5
[225] W. Churchill, (1951) *History of the Second World War, vol. 4* quoted in B. Shephard (2000) p. 195. These comments should be seen in the context of Churchill's impatience towards all non-combative troops in an army whose proportion of combatants was constantly diminishing. When the war started 50% of the Army were in infantry units, and this proportion rose to about 60% after Dunkirk. By the middle of the war however, infantry units formed only 20% of the Army while 25% of the Army soldiers worked as

Similar sentiments were also expressed a few months earlier in the War Cabinet. With Adam's interference however, psychiatrists remained sheltered. On the 16th of June 1942 it is minuted that:

> reference was made to the fairly extensive use now being made of psychologists and psychiatrists in the Services. The main purpose for which they were employed was in order to discover the aptitude of recruits in particular occupations. It was represented, however, that there might be a tendency to use the psycho-analytical technique too extensively; and, moreover, that, *if unwisely handled it might encourage the very tendencies it was hoped to combat*.[226]

In that meeting it was decided that the Lord Privy Seal, Sir Stafford Cripps would investigate the matter. Cripps asked for information and Adam provided two memoranda by DGAMS and the Director for the Selection of Personnel. Cripps suggested that it was best to appoint an 'independent medical man who is not connected with any of the services' to investigate the matter.[227] Adam had severe objections. He responded:

> I am frightened by this proposal. There are two types of medical men and neither of them are independent. The older school dislike psychologists and will do anything to stop their use. The younger school on the other hand, are mostly psychologists themselves to some extent....We are all sceptics about psychiatry and have only adopted any particular methods after great trial and experiment. ... [handwritten] If we must have a medical man, ... I trust it will not be the "prosecutor."
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> The 'prosecutor' referred to was Lord Moran who it was assumed was behind Churchill's dislike for psychiatrists. In the event, Cripps investigated and wrote the report himself. He exonerated psychologists and

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skilled tradesmen. According to Adam, Churchill 'was always attacking the Army because of the large tail compared with the fighting arms which he called teeth'. R. Adam (1960), p.7.

[226] My italics. TNA, WO32/11972 'Use of Psychologists and Psychiatrists in the Services - Enquiry by Lord Privy Seal.'

psychiatrists, concluding 'that there was no substance in the criticisms which had been made of the use of psychologists and psychiatrists in the Army',[228] but also recommending that an expert committee was formed to coordinate their work.

With regard to the Expert committee, Adam intervened again repeatedly in order to ensure that its members were people who would be likely to agree with the Army psychiatrists. He tried for example to exclude the psychiatrist Aubrey Lewis from the Maudsley saying that he 'was the great rival to our Consultant in Psychiatry, Colonel Rees'. In this instance, it appears Cripps refused to negotiate changes to the committee.[229] Nonetheless, when the report was published it proved complimentary to the work of psychiatrists attributing any inadequacies to the insufficient numbers of psychiatrists employed rather than to psychiatric methods.[230]

In 1943 however, the Secretary of State for war, Sir James Grigg suggested to the ECAC that the role of the psychiatrists during selection needed to be limited:

> ... The Secretary of State has received representations from C.-in-C., Home Forces, with regard to the very high proportion of rejections of candidates for permanent commissions following their examination by psychiatrists; and from cases ... the Secretary of State considered that the somewhat dominating position which psychiatric selection had attained in the Army selection machinery must be reviewed and limited. While the Secretary of State agreed that psychiatric examinations served a useful purpose in diagnosing abnormal conditions and suggesting the remedy, *he had considerable doubt of its usefulness in the appraisement of an individual's likely course of future conduct*, as a factor in determining, for example, the suitability of a candidate for a permanent commission in the Army.

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[227] TNA, WO32/11972 'Use of Psychologists ... .' 6A 24 June 1942. Letter from Cripps to James Grigg. On the paper it is handwritten 'AG what about it? Signed James Grigg.
[228] TNA, WO32/11972 18A 'Extract from the conclusions of the 103rd (42) Meeting of the War Cabinet held on 4th August,1942.'
[229] TNA ,WO32/11972 (30th August 1942).
[230] B. Shephard, (2000) p. 195.

The Secretary of State therefore desired that DAG (B), acting for AG in his absence, should reconsider the question of the part played by psychiatry in the personnel selection machinery in the Army and should provide for some review in particular for those candidates for Regular Commissions who had been rejected. The Secretary of State also had it in mind to invite Lord Moran to give him the benefit of his advice on this question of psychiatry in the Army.[231]

Again it was the psychiatrists ability to predict future behaviour which was being questioned and which provided the argument for their removal. Soon afterwards, psychiatrists were removed, first from the selection boards for permanent commissions and eventually from the WOSBs.

Besides Ronald Adam, how did other military people view psychiatrists? In *The Army Quarterly* and *The Fighting Services,* psychiatrists were mentioned infrequently, but not usually in negative terms. The Selection of Personnel received pretty good press in the *Quarterly*, which also published material from the Directorate for the Selection of Personnel. In the *Services*, a fictional story regarding psychiatrists was published in 1942 in which two officers discussed how the 'trickcyclist' got rid of 'old Blimp' by asking him tricky questions and catching him out. In the story, it is stated that 'superficial smartness did not delude the psychological sleuth' who is mainly after 'office wallahs' rather than fighting men. The story concluded with the two officers drinking to the psychiatrist's success saying 'A catfish in the tank keeps the rest of us fish on the jump and in good fettle –besides he got rid of old Blimp for us!'[232]

There are other examples of psychiatrists being positively perceived by Army staff. As in the above story whether a psychiatrist was positively

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[231] 54A 'Extract from the minutes of the 108th meeting of the Executive Committee of the Army Council held on Friday, 30th April, 1943.' TNA, WO32/11972.
[232] F. Ambroso, (1942) 'The Trick-cyclist' *The Fighting Services* Vol XIX No. 3 pp.156-158.

or negatively perceived seemed to depend on whether he had similar objectives and shared the same views with regard to the value of the soldiers as the other staff. A case that exemplifies that point is that of Major P.J.R. Davis, a military doctor who had recently qualified as a specialist psychiatrist. He wrote that he received every help and encouragement from the Divisional Commanders and ADMSs.[233] Knowing that the troops would go into action in a couple of months he decided that his first priority was to decide which soldiers were not good enough and discharge them. At that point, 'My ADMS was extremely helpful, encouraged me to go straight ahead and work on my own initiative'.[234] As soon as he started work:

> it at once became evident that the Division, and in particular the Infantry Battalions, contained a very considerable number of men in whom the officers had little or no confidence, and of whom they would be only too glad to dispose ... large numbers of dullards, psychoneurotics, and a few psychopaths and psychotics were unearthed. Combatant officers proved to be extremely enthusiastic at the idea of getting rid of these men –more so, in fact, than the medical officers, who in some cases had a valuable sobering effect on too high a degree of enthusiasm– and were quick to appreciate the fact that such men in a battle would not only be a liability to themselves, but also might be a positive danger to others, and would certainly have an adverse effect on the general morale of the Unit.
> The procedure I adopted was to ask the Company or Platoon Commander to write a relevant report on the man, and to state whether his retention was desired or not. I gave the men the Progressive Matrices to do, followed by an interview, and in the light of all the information available, decided on their disposal.[235]

In this example the psychiatrist worked to the wishes of the Commanding Officers who in return cooperated fully:

> I think it is not out of place to stress once again how very alive to the importance of selection work the Division proved to be. I came

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[233] P.J.R. Davis, (1946) p. 256
[234] Ibid, p.259
[235] Ibid.

across practically no examples of the attitude of "they are trying to get away with it"–an attitude which in my experience, becomes more and more prevalent among officers the farther away from the front line they are, and perhaps reaches its acme amongst some Medical Officers at Base Hospitals. The Combatant Officer, who knows his troops, has learnt from bitter experience that certain types of men are constitutionally unable to make the grade and that there is nothing that can be done about it. Perhaps the more pertinent criticism came good-humouredly from the CO of a Battalion who asked me: "Why should I send these men to you so that they will survive the war and go home and breed like rabbits, whilst all my finest men are going to risk being killed?" To which I could only reply that, be that as it might, he had referred more men from his Unit than I had seen from any other![236]

Such eugenic concerns were in fact a recurring theme with regard to selection. Furthermore, other psychiatrists complained that it was in fact the most bitter opponents of psychiatry that tended to make greatest use of their services, and that psychiatrists had become 'invaliding officers'.[237] After the war, the psychiatrist Lieutenant-Colonel Harry Pozner wrote that:

> It is axiomatic that the degree of suspected mental illness in a soldier is directly related to the amount of administrative inconvenience he is likely to cause his officers. ... officers who unhesitatingly label their regimental misfits as "mental cases" ... are often the most vociferous in private in their criticisms of psychiatry as a suspect form of medicine.[238]

Conclusion

After the First World War, it became established that casualties from disease and particularly mental disorder, were one of the most significant causes of manpower wastage. Furthermore, it was accepted that after the

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[236] Ibid, p. 260. Eric Leed has also argued that the psychiatric diagnosis had a function for military authorities but he argues this was to prevent disgruntled men from mutineering. E. Leed, (1979), *No man's land; Combat and Identity in World War I,* Cambridge: CUP

[237]H. Pozner, (1961) 'Common Sense and military psychiatry', *Journal of the Royal Army Medical Corps,* 107, p. 155.

[238]Ibid, pp. 155-156.

huge fatalities of that war, the soldiers' morale in any future conflict would be vulnerable. In line with these views, the Army during the Second World War invested in psychiatric prophylaxis, which aimed to reduce casualties, maintain morale and remove the mentally unfit and the 'misfits'. In practice, although, psychiatrists could only recommend action, in the majority of cases their proposals were followed. The effectiveness of the psychiatrists was largely dependent upon the relationship each had with his boss, the Assistant or Deputy Director Medical Services, but it appears that in the majority of time there was effective cooperation between medical directors and psychiatrists.

This investment in psychiatric expertise was consistent with the Army's approach of relying on experts and technology. However, as with other scientific innovations, the Army was with regard to psychiatry, relatively unprepared at the onset of the war and its staff did not reach full strength until 1942-1943.

In comparison to the other medical specialties in the Army, psychiatrists were offered significant administrative powers; albeit less than those of the hygienists, who were at the heart of preventive medicine. In fact, the psychiatrists' ability to prevent casualties and predict behaviour appears to have been the crux of their negotiations with the Army. Psychiatrists and their supporters, particularly the Adjutant-General argued that these were the key ways in which psychiatrists would support the Army and that psychiatrists therefore required greater administrative powers such as those of their hygienist colleagues. Their opponents on the other hand argued that psychiatry was part of curative medicine and there was no argument for a special case. This argument was used also to gradually remove psychiatrists from the selection boards for permanent commissions.

Finally, one of the most important ways through which psychiatrists contributed to preventive medicine and to the Army itself during the war,

was through the psychiatric testing of personnel. The following chapter will discuss this.

Chapter 3: Selection of Personnel

Introduction

During the Second World War, all three armed services used some form of intelligence testing to select recruits and officers. Psychologists and psychiatrists, under the remit of the Directorate for the Selection of Personnel, were invited to devise the tests, administer them and train military personnel in their use. The purpose of the tests was ostensibly to increase efficiency and promote equality of opportunity. Psychiatrists also argued that by eliminating the 'dull and backward' the tests would also help improve hygiene, discipline and morale and reduce psychiatric casualties. Furthermore, it was claimed, that by instituting scientific methods for the selection of officers-cadets, not only the quality but also the quantity of officers would improve as more men would be willing to put themselves forward for commission once they realised that the new system was egalitarian and no longer favoured the upper and middle classes.[239] To increase numbers further, the system of recommendation which was based on commanding officers picking out men for commissions from their own units was by-passed, and psychologically trained regimental officers were able to put forward men whom they thought were suitable for commissions at the point of entry into the Armed Forces.

It will be argued here that the introduction of intelligence testing was not inevitable or progressive, but was accepted partly because the use of

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[239] For example, the Adjutant-General stated in his memoirs that the fact that candidates felt that the traditional boards did not give them "a fair chance" had led to "a decline in volunteers for commissions". R. Adam, (1960) 'Various Administrative Aspects of the Second World War', Chapter 2, p.7, Liddell Hart Centre, Adam papers, 3/13. This account was originally written in 1949. Cited in J. Crang, (2000) *The British army and the People's War,* Manchester: Manchester University Press, p. 29. This problem was compounded by the fact that Commanding Officers seemed unable to put forward for commission a sufficient number of candidates because of the perceived low quality of the troops.

such tests had for some years been spreading to British industry and foreign armies[240] and partly because in this period, people with low IQ were being stigmatised as a 'social problem group'.[241] Furthermore, while the scientific selection of officers was probably successful to some extent in convincing the public that commissions were offered fairly, it nonetheless continued overwhelmingly to promote those educated at public and secondary schools. As to whether the men selected by the new methods were actually better officers than those who would have been selected by the previous methods, it is impossible to discover. While there are some statistics that show that the new methods had a better success rate at the level of training, any number of reasons could account for this difference and even if taken at face value, this does not prove that they were better officers in the field too. What seems more probable, is that the officers selected by the new methods were more or less the same people as would have been selected by the old methods –the only difference being that as the new methods were longer and more thorough the same criteria were applied more reliably.

Psychologists and psychiatrists succeeded in gaining this considerable influence in the Armed Forces because they were able to convince military authorities of a link between efficiency, meritocracy, intelligence, and science and ultimately link these with psychology. The argument went as follows: In order to improve efficiency men must be selected to jobs according to merit –the essence of merit is intelligence, and the only people who can assess that scientifically are psychologists and psychiatrists. In the selection of both officers and men from the ranks,

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[240] The American Army had been using intelligence tests since the First World War and the German Army since 1927. Privy Council Office, (1947), *Report of an expert committee on the work of psychologists and psychiatrists in the services*, HMSO. British Library, B.S. 32/10.

[241] There was no organised policy of stigmatisation that would make the situation in Britain remotely comparable with that of Nazi Germany. What is argued for here is that people of low intelligence and to some extent their genetic relatives were perceived in both scientific and popular environments as a problem that required a solution. See M.

intelligence was thus promoted as the one factor of overwhelming significance that could only be assessed by technical personnel. In the selection of officers, the assessment of personality also mattered significantly, nevertheless an intelligence score significantly higher than that perceived to be the average for the men in the ranks became a prerequisite for commission.

Current historiography

Until a few years ago, the only texts that described the work of psychiatrists and psychologists in the selection of 'other ranks' during the war had been written by men who had been personally involved in the process.[242] These accounts invariably tended to be uncritical; within them, the use of intelligence tests in the Army was presumed to be a good thing, an assertion treated as obvious and as easily verifiable by a number of quoted studies correlating low intelligence with a propensity to mental and physical disease and an inclination towards committing military offences.[243] The introduction of officer selection tests were particularly admired. This enthusiasm crossed over to historians thus leading Shelford Bidwell to declare that one of these tests was "probably as important to the country's war effort as the 25-pounder gun and the Bailey Bridge."[244] Recently, other works have been published by both historians and psychiatrists.[245] However, they too have tended to rely on autobiographical

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Thomson, (1998) *The problem of mental deficiency; Eugenics, Democracy, and Social Policy in Britain c.1870-1959*, Oxford: Clarendon Press.

[242] R. Ahrenfeldt, (1958) *Psychiatry in the British Army in the Second World War*, London: Routledge & Kegan Paul; F.A.E. Crew, (1955) 'The Army Psychiatric Service,' *The Army Medical Services,* Vol. II., HMSO; J.R. Rees, (1945) *The Shaping of Psychiatry by War, New York: W.W. Norton & Co;* P.E. Vernon, & J. B. Parry, (1949) *Personnel Selection In The British Forces,* London: University of London Press.

[243] For example, R. Ahrenfeldt, (1958) chap IV.

[244] S. Bidwell, (1973) *Modern Warfare, A study of men, weapons and theories,* Allen Lane, p.118.

[245] For example, J. Crang, (2000); T. Harrison, (2000), *Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front*, London: Jessica Kingsley; B. Shephard, (2000) *A War of Nerves* London: Jonathan Cape; E. Trist & H. Murray, (eds)

accounts and with regard to selection frequently concur with the opinion expressed in the 1940s; that selection was necessary because not 'every soldier carries a field marshal's baton.'[246] Even David French, in his otherwise brilliant account of the war-time British Army, treats the concept of 'intelligence' as an unproblematic entity to be as easily determined as the recruits' weight or height. He is therefore uncritical of the sources that attribute the Army's problems prior to 1942 to the recruits' low intelligence or even to the psychiatrists who link low intelligence and psychiatric breakdown.[247] On the whole, therefore, the historiography has assumed that the introduction of intelligence tests was an inevitable, progressive step, following on the work done in America, and that this move had no ideological content beside a desire to increase efficiency and meritocracy.

Standing out from these accounts is Nikolas Rose's book, *Governing the Soul*.[248] Rose identifies the psychological technologies used in the Second World War, including intelligence testing, as the starting point for the study of subjectivity (what is usually known as the study of individual differences), which he argues had a profound influence in the post-war

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(1990) *The social engagement of social science: a Tavistock anthology*, London: Free Association. This criticism applies to the issue of intelligence testing only and does not detract from the excellent work in these volumes.

[246] The Napoleonic line that 'every soldier carries a field marshal's baton in his knapsack' was rhetorically dismissed by the consulting psychiatrist J.R. Rees, (1945, p.25). For an example of how those writing secondary material sometimes have very similar perspectives with 1940s psychiatrists see T. Harrison, (2000) pp. 87-89. Harrison explains that the opposition to psychological selection was completely unreasonable. Using the above quote, he proclaims: "This romantic fantasy, widely current in the British Army, kept alive the notion that it was possible for every man to achieve the highest rank if they just worked at it ... The resilience of this idea, in the teeth of the evidence, is quite remarkable in retrospect." (p. 88.)

[247] D. French, (2000) *Raising Churchill's Army,* Oxford: Oxford University Press, chapter 2. Although French conceded that to ascribe the wartime army's problem to its failure to attract sufficient men of high intelligence "is misleading and oversimplistic", his account appears to concur with the views from the Directorate for the Selection of Personnel which argue that men recruited into the Army were of low intelligence and were hence more likely to break down. In addition, the fact that nearly 30 per cent of recruits were apparently of below average intelligence is lamented while this is a rather good result and similarly the statistics quoted by French himself show that army recruits were better educated than the rest of the population (pp. 65-66).

[248] N. Rose, (1989) *Governing the Soul,* London: Free Association books.

world by helping construct a new concept of the self, which is 'desiring, relating actualising'.[249] Rose is particularly interested in the other psychological technologies used in wartime particularly in America: the surveys of public opinion, the studies of group dynamics, the construction of attitude scales; aspects more obviously dealing with the personality or the psyche of the subject. Nonetheless, Rose identifies the significance of testing in allowing for the first time a mechanised system of job allocation, the Hollerith machine which matched the soldiers' intelligence and aptitude with military occupations.

More relevant for the account that will be presented here, has been the extensive literature on the history of intelligence testing and the eugenics movement. While between the 1960s and the early 1980s, most of this literature was written with the specific purpose of showing that those who had regarded intelligence as a quantifiable and mainly heritable entity were wrong,[250] the more recent literature has presented more nuanced accounts focusing on the politically complex background to both the eugenics movement and intelligence testing. Much of this literature focuses on America,[251] however works by Mathew Thomson, Adrian Wooldridge and Richard Soloway have focused on Britain.[252] These works have succeeded in weaving together the subtle yet pervasive effect of the

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[249] N. Rose, (1999) *Governing the Soul,* London: Free Association books, pp.xxx, 1-55.
[250] For example, S. J. Gould (1981) *The Mismeasure of Man*, New York: W.W. Norton &Co; L. J. Kamin, (1974) *The Science and Politics of IQ,* Maryland: Lawrence Erlbaum Associates.
[251] For example, J. Carson, (1993) 'Army Alpha, Army Brass, and the Search for Army Intelligence', *ISIS,* 84, pp. 278-309; D. Kevels, (1985) *In the name of Eugenics, Genetics and the Uses of Human Heredity,* New York: Knopf; J. Trent, (1994) *Inventing the Feeble Mind: A history of Mental Retardation in the United States,* Berkley: University of California Press; L. Zenderland,(1998) *Measuring Minds: Henry Herbert Goddard and the origins of American Intelligence Testing,* Cambridge: Cambridge University Press.
[252] M. Thomson, (1998) *The problem of mental deficiency; Eugenics, Democracy, and Social Policy in Britain c.1870-1959,* Oxford: Clarendon Press; R. Soloway, (1990) *Demography and Degeneration, eugenics and the declining birthrate in twentieth-century Britain,* Chapel Hill: The University of North Carolina Press; A. Wooldridge,

eugenics movement on government policy, educational psychology and the treatment of the mentally defective during the first half of the twentieth century. Moreover, they have been instrumental in showing the political complexities of the period, showing for example, how faith in intelligence testing is simultaneously compatible with left wing progressivism, meritocratic ideals and eugenic attitudes. This chapter builds on this work by showing that reforms that took place in the selection of recruits during the Second World War have a complex background; besides being the result of efforts to improve efficiency, reduce medical casualties and military offences and increase the opportunities for those from poorer backgrounds (which are the explanation for the reforms provided by those who took part in their implementation) they are also the result of a culture that had identified the mentally defective as a problem in society at large.

Section 1: Men in the Ranks

The introduction of new selection procedures

At the onset of the Second World War, there was no selection procedure for men who wanted to enter the Army and all men who passed the medical fitness tests were admitted. The Navy and the Air Force, which were seen to be the elite services, received many more applications than they had places and consequently candidates were selected by a short interview, after which many were rejected. By 1941 however, all three services had adopted some kind of intelligence testing. Initially, the Army rejected proposals to carry out selection, but some military psychiatrists carried out their own experiments using intelligence tests. Then the Army Council, in discussions with the Industrial Health Research Council agreed to have an intelligence test given experimentally in military training units,

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(1994) *Measuring the Mind, Education and psychology in England c.1860-c.1990,* Cambridge: Cambridge University Press.

under the direction of a small group of civilian psychologists. At the same time, Professor Bartlett of Cambridge University was asked to provide tests for selecting Anti-Aircraft specialists.

By 1942, the system of recruitment had changed beyond recognition. In the Army, Ronald Adam had become the Adjutant-General, which is the most powerful administrative position in the British Army.[253] Adam believed strongly that the Army needed to become scientific in order to become efficient, and he welcomed technical expertise. Having been impressed by the intelligence tests the psychiatrist Ronald Hargreaves had carried out under his command, Adam helped institute a nation-wide selection mechanism. A new Directorate for the Selection of Personnel was set up in the War Office, which employed 19 psychologists, 31 officers with some psychological training, and approximately 1300 non-technical officers and NCOs. About 20% of the total staff were women, more in the case of the qualified psychologists. The Director, however, was a regular soldier not a psychologist.

Under the new system, men were no longer accepted into the Army until they had received a period of basic training where they were subjected to a series of intelligence tests. The most important of these tests was the progressive matrices designed by J.C. Raven. This was a pattern completion test, which was thought to measure 'native', inborn intelligence rather than the education. A recruit's score on the progressive matrices determined the Selection Group in which he would be placed. These ranged from SG 1, 2, 3+, 3-, 4 and 5, where each group was meant to correspond to 20% of the population, apart from the very top and bottom groups, which corresponded to 10%. The selection group of a recruit would then determine the suitability of the recruit for any military job.

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[253] R. Bowyer, (1999) *Dictionary of Military Terms*, Teddington: Peter Collin Publishing, p. 4.

In many ways, the progressive matrices test exemplified the meritocratic element of selection –that the purpose of selection was to measure innate ability rather than educational differences determined by class. However, by 1943, follow up results on soldiers who had undergone training courses, revealed that the progressive matrices were not able to predict success in training as efficiently as did measures of education or the intelligence tests with a high educational component. From 1943, selection group was determined by a range of five tests, which included as well as the matrices, a verbal intelligence test, a mathematics test, a test measuring the ability to follow written instructions and a mechanical comprehension test.[254]

As well as having their intelligence measured, recruits also filled in a biographical questionnaire outlining their work experience and underwent a short interview by a Personnel Selection Officer (PSO). PSOs were regimental officers who had undergone three weeks psychological training in order to be able to assess the men's suitability for particular jobs, their potential leadership qualities, mental stability, and combat temperament. Recruits marked as unstable, of low combat temperament, as well as those in the lowest intelligence group were re-assessed by a psychiatrist, while those marked as potential officers had their commanding officers informed of the fact. Finally, PSOs made three broad trade recommendations about the type of employment each man was suited for, such as signaller, or driver, each job having a minimum standard of intelligence. The training recommendations and the age, medical category and Selection Group of recruits were sent back to the Directorate for Selection of Personnel where

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[254]B. Ungerson, (1953) *Personnel Selection,* War Office, p.53, TNA, WO277/19. Progressive matrices were found to be particularly unreliable in identifying those with low intelligence, causing concern among testers that the test scores did not match the intelligence of the subjects. The tests were more reliable at the top end of the scale. See J.A. Fraser Roberts "Further observations on the efficiency of the Progressive Matrices Test", TNA, CAB 98/28, P.P.(SC)(43)(24).

a match between the trade recommendations with the Army needs was attempted.

Similar personnel selection systems were formed in the Navy the RAF and in the ATS. In the Navy, interestingly, once the Senior Psychologist's Department was established in the Admiralty, nearly all the staff (both the sergeant testers and the Personnel Selection Officers) were women. Although they were supervised by a male psychologist, it was women who made all the initial decisions that could impact on the men's career: they classified the men's intelligence, they made recommendations with regard to what job each recruit should be given, whether he should be examined by a psychiatrist and whether he had potential officer qualities. In the Air Force as well, women were given a role in personnel selection although it usually involved administering tests rather than interviewing and making decisions. In total, women played a very significant part in selection for the duration of the war, although their jobs were discontinued once the war ended.[255]

Although the selection process took into account other traits besides intelligence such as work record, prior education and mental stability, as defined by the interviewing psychiatrist, intelligence tests were the dominant selection tool. The selection group in which recruits were placed remained on their records for their entire military career and was an important factor in all future postings. Some men with very low intelligence were excluded from the Armed Forces altogether, but the majority of men in the lowest selection group were placed in the labouring corps *The Pioneers*. Low intelligence excluded candidates from various army jobs, and barred them from getting a commission and to some extent even from getting a promotion of any kind.

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[255] For a more elaborate description of selection in the Armed Forces, see R. Ahrenfeldt, (1958); P. E. Vernon, & J. B. Parry (1949).

Nonetheless, as intelligence tests only became established in 1942, many men recruited prior to that had not been tested. For this reason, intelligence testing was introduced at other points in the men's career. Mainly it took place when a soldier applied for a new job or was rejected from his own Arm or had his medical category reduced significantly (this included many men who were recovered psychiatric casualties). These men were sent to Army Selection Centres were they were tested and re-allocated into jobs considered more suitable. In addition, all men whom it was thought would eventually take part in the liberation of Europe were tested from September 1943 onwards. The rationale for this was that as the army was expected to suffer large casualties and there would be no facilities in which to undertake the tests once combat had began, it was essential that the potential of all the soldiers had been assessed so that decisions about how casualties could be replaced could be made quickly and efficiently.[256]

The corollary to the principle of placing men into jobs according to their levels of intelligence was that some jobs required less intelligence than others. Since a particular concern had been that men with low intelligence were incapable of handling complex equipment, many men with low test scores were placed in the infantry while infantry men with higher test scores were removed. This policy was reported to have an adverse effect on the morale of Infantry Commanding Officers, who reportedly complained that "the ever increasing tendency to remove from the infantry all who show any intelligence is felt to have reached the danger point."[257]

The Purpose of Personnel Selection

The aims of personnel selection were multiple. Mainly, the purpose of the tests was to increase efficiency by placing the right man in the right job.

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[256] B. Ungerson, (1953) p. 88.
[257] *Morale Report* (February 1942) TNA, WO63/88, p.2.

The reasoning was that it was right that officers were more intelligent than the men they led and that therefore promotions should be based on objective criteria like intelligence tests. The move was also seen to be meritocratic; it seemed to end the favouritism for those with a public school and university education. Of course, in reality, intelligence tests strongly favoured the better educated and probably served to biologise the perceived superiority of the upper classes. Nonetheless, this process appeared to make better use of personnel; skilled men and easily trainable men became tradesmen, while men with the lowest intelligence became labourers; everyone fitted their place.[258]

However, in the majority of accounts given by psychiatrists and military men, the purpose of intelligence testing was more specifically to identify 'dull and inadequate men' who are a liability in numerous ways.[259] The main reasoning was that warfare had become technologically more advanced, and that men with low intelligence could not acquire the technical skills required even for an infantry private. The use of intelligence tests therefore, confirmed the view that the war was a highly scientific and technological affair in which only those with an at least average level of intelligence could be expected to cope. However, these 'dull' men were also perceived as overwhelmingly likely to contract disease, suffer a nervous breakdown and commit military offences. In the official medical history of the Army Psychiatric Service these points were reiterated:

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[258] It is very difficult to know whether the selection methods improved the quality of either the officers or the tradesmen as there is no possibility of a scientific comparison. However, judging from the discussions regarding selection in *The Army Quarterly* it is true that the majority of the soldiers and the general public seemed to have believed that selection worked. Furthermore, the results of the testing were not always adhered to; according to David French, by the second half of 1943, the infantry was so short of men that Ronald Gladman, who was conscripted in June 1943, remembered that when he was undergoing his intelligence tests 'It had been made clear, ... that at this stage of the war everyone would be posted to the infantry no matter what trade had been followed in civilian life. (D. French, 2000 p. 70.)

[259] R. Ahrenfeldt, (1958) chap. IV.

There had been in the past a popular tradition that the dull man made a good soldier. The stresses and increased tempo of modern warfare, and the duties of the modern infantryman, which demanded a technical knowledge of a number of specialised weapons, required, however, an average degree of intelligence, and presented a difficult task to the dullard. Whereas he might have been capable of carrying out some simple job in a restricted, protected environment in civil life, the dullard, placed among men of relatively higher intelligence in the Army, often became maladjusted and developed feelings of inferiority and anxiety. Mental defect was a frequent cause of military delinquency, particularly of absenteism, and the dullard often became a disciplinary problem in his unit through failure to understand the nature of regulations and the reason for them. Investigations also seemed to show that there was a positive correlation between mental dullness and proneness to venereal disease, and to scabies and pediculosis. It was clear, therefore, that the misplaced dullard in modern war was a general liability to the Army.[260]

On a similar note, the Adjutant-General wrote in his memoirs this account of intelligence testing in the ATS, which focused on the link between nits and intelligence:

> Conscription started and numbers of young women from the poorer quarters of our industrial cities came into the reception camps. The officers and NCOs were horrified to find that they had to spend the first days scrubbing or supervising the scrubbing of heads to get rid of nits....
> I knew something of intelligence gradings at this time and I went to see Mr Bevin to ask if he would agree to raise the minimum intelligence grade of acceptance by one grade. After considerable argument he agreed. He liked the Army, but I felt he thought we could take any man or woman and turn them into good soldiers and auxiliaries.
> The result of raising intelligence standards was that the need for head washing was immediately reduced ...[261]

What is evident from this statement is that while Adam was dubbed

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[260] F.A.E. Crew, (1955) p. 475.

"the Army's No.1 Democrat"[262] and was responsible for a number of liberal reforms particularly in the field of Army education he had little time for the notion that poverty itself caused disease and low scores on intelligence tests. Similarly to the majority of reformers in this period, Adam's concern was mainly with providing opportunities for inherently bright young men and women born into the working classes. Adam's comment on Ernest Bevin, the trade unionist Minister of Labour and National Service, also highlights an important ideological conflict. The crux of this conflict rested on the idea that human beings have an abundance of potential which they may fulfil given the right circumstances. This was a notion that contemporary psychologists and psychiatrists routinely dismissed as a romantic myth.[263]

Alternative accounts by other Army psychiatrists suggest that intelligence was perceived to have multiple effects and manifestations. Some psychiatrists claimed that an average intelligence was necessary in British soldiers because it enabled them to comprehend the values for which the war was being fought. They argued further that intelligence testing did not have to be used in the examination of Indian soldiers because Indians were a military race at ease with the state of war and hence did not need to understand such values. During a Conference on Psychiatry in Forward Areas held in Calcutta in August 1944, it was remarked that due to the lack of appropriate intelligence tests it was difficult to assess the intelligence of I.O.Rs. [Indian Other Ranks] but that this was not so important:

> To determine the intellectual level of the I.O.R is less important

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[261] R. Adam, (1960) 'Various Administrative Aspects of the Second World War', Liddell Hart Centre for Military Archives, Kings College London, Adam papers, 3/13 'Introduction' p.3. This account was originally written in 1949.

[262] *Leicester Evening Mail,* 27th April 1946, Adam Papers, 2/6/1, Liddell Hart Centre, p.3. Cited in M. Harrison, (2004) *Medicine and Victory,* Oxford: Oxford University Press, p.182.

[263] For example, J.R. Rees, (1945) p. 25

than the B.O.R. [British Other Rank] In the B.O.R. the dull and backward break down in action. In the hardships and dangers of active service he has nothing to support him except a vague desire to do his bit. Sentiments such as patriotism, appreciation of the alternative to winning the war, tradition, and other complex ideas which keep up the morale of the average man, are beyond his grasp. In addition, he has been brought up with one set of ideas which can be summarised as the Christian attitude, and he lacks the capacity to adjust to what is in many respects, the antithesis of this attitude. The I.O.R. however, is accustomed to a lower standard of living and he finds the hardships less onerous ... And most important of all, the I.O.R. infantry soldier comes from a martial race and being at war requires no reorientation of attitude.[264]

So for this psychiatrist, an average intelligence is necessary only in British men and then it was for the maintenance of morale, rather than for learning how to use weapons or for keeping free of disease. Although psychiatrists did agree therefore that a reasonably high intelligence was an important quality in British soldiers, there was not always unanimity about what precisely this quality allowed them to achieve. Nonetheless, this tentative consensus ensured that intelligence testing would dominate personnel selection.

The Report of the British War Office Committee of Enquiry into Shell Shock (1922)

During the First World War, the issue of mentally deficient soldiers was not considered a problem by the Armed Forces. Prior to 1918, there was virtually no attempt to detect mental deficiency among British recruits, although the examinations did become more thorough towards the end of the war. Mathew Thomson argues that while at the end of the war the rejection rate on the grounds of mental deficiency was around 0.3%, it was

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[264] *Report of a Conference on Psychiatry in Forward Areas, held at Calcutta in Aug. 8-10. 1944,* TNA, WO 32/11550.

almost certainly much lower during the early stages of the war.[265] Thomson argues further that there is plenty of evidence that many mentally deficient men did enlist, although much of his evidence comes from psychiatrists who reported after the war that a high proportion of their shell-shocked cases were mentally deficient.[266] According to Thomson, it was only after the war that mental deficiency among soldiers began retrospectively to be considered a problem and began to be linked with the incidence of shellshock.

Touching on this new link between mental deficiency and psychiatric instability, psychiatrists writing on the subject of selection during or after the Second World War, frequently mentioned as their starting point, the 1922 *Report of the British War Office Committee of Enquiry into Shell Shock.*[267] This report, commissioned to investigate the high incidence of shellshock, had highlighted it was argued, the need for better selection to ensure that the army did not recruit men who were not of 'normal mental stability'[268] further adding that 'all cases of mental dullness or deficiency should be sent home for invaliding.'[269] However, a closer reading of the report shows that any link between low intelligence and vulnerability to psychiatric breakdown, was far from an accepted fact according to the testimonies found in the report. Within the report a number of causes of shell-shock were cited by witnesses: low morale, poor discipline, lack of 'man management' skills in officers, personal or family history of mental or other diseases, physical exhaustion, financial worries etc. Only three witnesses expressed the opinion that men with low intelligence were particularly vulnerable to shellshock. They were all doctors and

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[265] M. Thomson, (1999) 'Status, manpower and mental fitness: mental deficiency in the First World War' *War, Medicine and Modernity*, (eds) R. Cooter, M. Harrison & S. Sturdy, Thrupp: Sutton Publishing, p.152.
[266] M. Thomson, (1999) pp.152-155.
[267] R. Ahrenfeldt, (1958); J. Rees, (1944).
[268] *Report of the British War Office Committee of Enquiry into Shell Shock*, (1922) HMSO.p.169 cited in J. Rees, (1945) p. 55.
[269] *Report*, (1922) p.135 cited in J. Rees (1945) p. 56.

psychiatrists: the psychiatrist Edward Mapother, Medical Superintendent of the Maudsley Hospital, Professor G. Roussy, late Consultant in Neurology to the French Army and Dr J. Dunn, Regimental Medical Officer. In contrast, the Lieutenant-Colonel E. Hewlett, and Dr W. Johnson argued that in some cases low intelligence protected soldiers against shellshock. Furthermore, Major-General Sir Alfred Bayly, Dr A.F. Hurst, and Major Pritchard Taylor said that shellshock was unrelated to intelligence while Sir James Galloway stated that he had read 'of the exceedingly elaborate methods put into operation by our colleagues in the United States' but 'from experience of what did happen to the American troops, I do not think it did much good. I do not think their casualties so far as "Shell-shock" was concerned were much minimised by this elaborate examination.'[270] Typical of the witnesses with regard to selection as a means of preventing future casualties was the testimony of Lieutenant-General Sir John Goodwin, Director-General of the Army Medical Services during the First World War. He argued that 'actual war' was, 'the real, final and crucial test of nervous instability in a soldier', and he said he considered it very difficult to say at a recruit's examination whether he would eventually become a good soldier or not.

This sentiment was repeated time and time again by various doctors and military officers who warned that it was impossible to foretell who would break down in battle. They suggested that the best ways to prevent shell-shock were to not give the disorder a name, not let the soldiers think that it provided an honourable means of leaving the Army and to look after the men well so they are physically comfortable and know that their officers care for them, thus keeping their morale high. In terms of the administration of the Armed Forces, it was said firstly that the period of training was too short for men to establish *esprit de corps* and secondly that

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[270] *Report*, (1922) p.182.

soldiers were kept for too long in situations where they had to fight extremely hard.

The conclusions of the Committee were somewhat contradictory. On the one hand they stated that: "Any type of individual may suffer from one or other form of neurosis ... it is extremely difficult to say beforehand what type of man is most likely to break down, the only certain test being exposure to battle conditions ..." while at the same time summarising the witnesses evidence as "... it was admitted that there are certain individuals who are unlikely ever to become efficient fighting soldiers. No general characteristics were given." Although 'no general characteristics were given', the Committee stated that: "All cases of mental Dullness or Deficiency should be sent home for invaliding". Nonetheless, the report clearly stated:

> We do not regard the specific efficiency tests (such as Binet) as suitable for the purpose of general recruiting, nor do we think that consultant advice need be provided except in cases in which it is specifically asked for, and the circumstances are such that it is practicable to provide it [271]

In fact what the Committee suggested was that medical officers should examine recruits more carefully than in the past and that they should discharge anyone who has at anytime been insane or has a *serious* mental defect. The mental defect would have to be severe enough to be apparent to any doctor performing a 15 minute examination and would only occasionally require a second opinion and then not necessarily from an expert. Put another way, it was not the 'dull' men falling in the bottom 10 per cent of the intelligence spectrum that were the cause for concern but the 'idiot', 'imbecile' and 'feebleminded' men in the bottom 0.1-1.0% of men who were supposed to belong to specialized institutions.

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[271] *Report*, (1922) p.170. The 'efficiency tests' referred to here are intelligence tests e.g. *Binet-Simon Measuring Scale of Intelligence* (1908).

Psychiatrists however seized upon the report as a recommendation for their own involvement in a selection procedure that excluded those with limited intelligence. Selection became the central method of preventing psychiatric casualties, a decision that contrary to the evidence provided by many medical and military witnesses who had argued that no one could predict who was going to break down. While in the First World War men of low intelligence had been welcomed into an Army which accepted all but the most extreme cases as fit,[272] by the Second World war the same men had been identified as a source of inefficiency. "The dullard" argued the consulting psychiatrist to the army, JR Rees, "becomes … in modern war a consumer of manpower rather than a contributor".[273]

Factors that facilitated the adoption of intelligence tests

Without a doubt, psychiatrists and psychologists promoted the use of intelligence tests partly because they wanted to promote themselves; any elaborate selection technique meant more jobs and prestige. As some made clear, psychological selection in the Armed Forces was going to be only the first step; soon such techniques would be used in recruitment everywhere.[274] Intelligence tests, in particular, had added advantages in comparison to other psychological techniques, in that they were easy to use, transparent in how they worked and fitted with the new technocratic, efficient and intelligent image the Armed Forces were trying to create. However, these considerations alone would not have been sufficient to make the tests acceptable, either politically or militarily as their introduction did result in some net loss of manpower and in some loss of organizational control by the Armed Forces. The tests became accepted because at least some members in high administrative positions in the Armed Forces became convinced that they would indeed help reduce

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[272] M. Thomson, (1999).
[273] J. Rees, (1945) p. 43.

inefficiency. This psychological coup succeeded because of a number of events that occurred in the previous 30 years.

One of the most significant of these events was the use of intelligence tests by the American Army during the First World War and by the German Army since 1927.[275] Also of the essence was the use of intelligence tests in education and in industry. The British state had accepted the value of intelligence testing since 1913 when Cyril Burt, became the first educational psychologist to be appointed by a government body as the official psychologist of the London County Council.[276] In addition, the prestigious National Institute of Industrial Psychology, which was run by the shellshock psychiatrist and psychologist C.S. Myers, had been using such tests as part of its work of improving the efficiency of industry through psychology in the 1920s and 1930s.[277] Cyril Burt and C.S. Myers were both members of the advisory committee who in 1941 persuaded the Adjutant-General, Ronald Adam, that he must employ intelligence tests in the Army. Adam became convinced that intelligence testing was modern, efficient, and consistent with the ideals of scientific management. He persuaded his superiors that the Army should use psychometric technology by advocating that the British Army, as Britain's largest employer, ought to use the tests which have modernised industry, and by arguing that the British Army should not lag behind other modern armies.[278]

Part of what made intelligence testing acceptable to the Armed Forces was that it ratified a link between a variety of problems (psychiatric breakdown, disease, lack of discipline, low morale) and an abnormality residing within the soldier rather than inherent in warfare. With regard to

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[274] J. Rees, (1945).
[275] *Report of an Expert Committee...* , (1947), p.11.
[276] For the best analysis of Cyril Burt's work, see A. Wooldridge, (1994).
[277] Welch, H.J. & C.S. Myers, (1932) *Ten Years of Industrial Psychology: An Account of the First Decade of the National Institute of Industrial Psychology,* London: Sir Isaac Pitman & Sons, LTD.

psychiatric breakdown in particular, although in the Second World War it had become accepted that any man may break down given sufficient stress, treating all psychiatric casualties as war casualties, it was feared, would lead to huge difficulties. Financially, the problem was that all war casualties were eligible for life long incapacity pensions, but even worse, in terms of discipline, such a policy would have stopped men feeling ashamed to go sick with a mental disorder, thus creating an epidemic.[279] Psychiatrists therefore tended to think of psychiatric breakdown in terms of predisposition and constitution in all cases except those of men with a proven track record of bravery and battle experience. "Dullness" readily fit the model as one predisposing cause that rendered men vulnerable to breakdown.[280]

On a very different note, what politically encouraged the use of intelligence tests in the Armed Forces, was the perception of low intelligence as a national problem. The significance given to low intelligence during this period mirrors to some extent the process taking place in the conceptualisation of mental illness. As interest towards the major psychoses gave way in the 1920s and 1930s to an interest in neurosis

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[278] R. Ahrenfeldt, (1958); Adam, (1960), cited in J. Crang, (2000), pp. 8-10.

[279] That sympathy from relatives and the prospect of a pension encouraged men to fall sick with a psychological disorder was discussed in the *War Office enquiry into shell-shock* (1922) and later at a psychiatric conference held prior to the war. TNA, PIN 15/2401. See B. Shephard, (1999) '"Pitiless Psychology": The role of prevention in British military psychiatry in the Second World War', *History of Psychiatry,* 10, pp. 491-524.

[280] There were of course many other perceived predisposing causes to breakdown that centred on the personality of the soldier. While some psychiatrists perceived personality as almost entirely genetically determined, others thought early life experiences played a more significant role. In both instances however, the cause of the breakdown was found to lie within the soldier rather than with warfare. Evidence of an inadequate personality was usually gauged from an examination of childhood problems and the adult employment records. For a discussion of predisposing causes to breakdown see chapters 4 & 5; F. Crew, (1957) 'The Army Psychiatric Service. The Middle East Force 1940-1943', *The Army Medical Services, Campaigns, vol. II.* HMSO., p.506; H.D. Hunter, (1944) Eighth Army Memorandum No.1, (Ref. Hdh/110/8/44), Psychiatric Casualties in Battle, CMAC. GC135, B1 (4 of 4).

and in the mental health problems of ordinary, sane, people[281] so concern with mental defect shifted from the 'imbeciles' and 'idiots' to the 'high-grade feebleminded' and the 'dull and backward'.[282]

During this period, journals such as the *Lancet*, the *BMJ* and the *Journal of Mental Science* published relatively few articles on the subject of mental deficiency –it was not a fashionable subject[283]. However, as mentioned in chapter 1, a national debate on the problem of mental deficiency was going on: two statutory committees reported on the incidence of mental deficiency and on the benefits of voluntary sterilisation of the mentally deficient while the Eugenics Society organised a wide-ranging campaign for sterilisation. The joint committee of the Board of Control and the Board of Education reported that the absolute number of mental defectives was double what it was thought to be in 1908,[284] but crucially it also identified a much larger group than the mentally deficient who by virtue of poor inheritance formed a 'social problem group'. This group was composed of the families of the mentally defective and comprised 10% of the population and included a large proportion of the insane, epileptics, criminals, prostitutes and alcoholics.[285] The significance of this 'social problem group' is that it identified as a problem not just the

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[281] R. Porter, (1996) 'Two cheers for psychiatry', in H. Freeman & G. Berrios (eds), *150 Years of British Psychiatry, Volume II: The Aftermath*, pp. 383-406. London: Athlone.

[282]This is exemplified in the work of the most famous British psychologist, Cyril Burt who estimated that approximately 10% of city children and 20% of rural children within the normal school system (i.e. excluding the mentally defective) were backward. He found backward children more interesting than mentally defective children because: 'Backward children are seven times as numerous as the mentally defective ... as their subsequent life-histories show, it is from their ranks, rather than from those of the mentally defective, that the bulk of our criminals, paupers, and ne'er-do-wells are eventually drawn.' C. Burt, (1937) *The Backward Child,* London: University of London Press, p. 88.

[283] For a more elaborate discussion of the low status of mental deficiency work, see M. Thomson, (1998) pp. 125-127.

[284] This survey on the prevalence of mental deficiency was conducted to explain the vast differences in the reporting of mental deficiency between different local authorities, (*Report, of the Mental Deficiency Committee being a Joint Committee of the Board of Education and the Board of Control,* (1929) HMSO, part IV, 1929, p.83).

[285]Ibid, p. 80.

mentally deficient but also the merely 'dull' whose 'social and economic failure was primarily due to their poor mental endowment' and pronounced that in order "to prevent the racial disaster of mental deficiency" this entire subgroup must somehow be dealt with.[286] Professional concern during the interwar period about the problems caused by a significant 'dull' minority anticipated, therefore, the importance that would be placed on intelligence during wartime. This conceptualisation of the 'dull and backward' as a national problem paved the way for the attribution of the various problems of military inefficiency to those with a lower IQ.

The final and determining event for the introduction of intelligence tests was the report in August 1941 of the Select Committee on National Expenditure.[287] This committee, proposed radical changes including not only the introduction of intelligence testing to all potential recruits prior to enlistment but also the posting of recruits according to their scores to A depots for the more intelligent and B depots for the less intelligent. The reasons offered as to why such testing was necessary included the high standard of intelligence required for mechanised forces "since valuable weapons and equipment are wasted if put into the hands of unintelligent and therefore unskilled users" and that men of "poor mentality" break down under the stress of military discipline.[288] The Committee also suggested that officers should be selected exclusively from a pool of men whose intelligence scores were above a particular level and that all men who fell into that category should be considered. Thus while admitting that high intelligence was not the most important quality in an officer it was agreed that it was an essential requirement.

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[286]Ibid, p.81.
[287] *Twenty-Second Report for the Select Committee on National Expenditure* (1940-1941) Parliamentary Papers, vol.3 p.3.
[288] *Twenty-Second Report* (1940-1941) p.3.

Section 2: The Officers

Selection

Personnel selection focused not only on the testing of recruits but also on the selection of officers. The shortage of officers had been a problem in the British Army long before the Second World War, and in the late 1930s, Leslie Hore-Belisha, then Secretary of State for war, had introduced various reforms intended to increase recruitment and open commissions to pupils from secondary schools by improving pay thus making it a sustainable profession for those without a private income. Such reforms were not universally liked –one senior officer in discussing the proposed reforms stated that "Whilst ... it may be ... necessary for political reasons to open entry into the Army to Secondary School boys, it would prove very unfortunate for the Army in general if such an entry were at all large." Among the reasons for this were that such men would not be respected by the rank and file and that their recruitment would have the effect of reducing recruitment from the upper classes presumably because the overall image of the Army would be tainted.[289]

During the war, the pressure to increase the numbers of officers became acute. While repeated instructions were given to Commanding Officers to suggest candidates for commission, the number of candidates remained low and the failure rate at the Officer Cadets Training Units (OCTU) was high. Among the suggestions to remedy the situation was one that originated with the Tavistock psychiatrist, Wilfred Bion. He recommended that soldiers should be asked to nominate members of their company whom they regarded as good potential officers in a secret ballot. Commanding Officers would not be bound by the results of the ballot for their recommendations, but would examine the results to see which soldiers had good all round support –not just from the rank and file but also from

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[289] TNA, WO32/4461, DGTA '1D The Willingdon Committee Report', dated 19/01/38.

the non-commissioned and commissioned officers. The Adjutant-General liked the scheme and implemented it experimentally in the Scottish Command where it did help in increasing the supply of officers, but when he suggested the scheme to the Army Council, it was rejected.[290] The scheme had some support, and it was noted in the minutes that the Civil Member said "he saw nothing dangerous in the scheme as presented, which had the hall-mark of success."[291] However, the majority of the Army Council opposed it. It was suggested that the scheme would lead men to believe that they had the right to select their own officers, and in turn, this would mean that commanding officers would be pressured into recommending the candidates most popular to the men. Furthermore, the system could become corrupt with men being bribed into voting for particular candidates, and the whole scheme would be impossible to repeal once introduced. It was suggested that instead a system of quotas should be imposed in units to encourage Commanding Officers to put forth more candidates.[292]

At the same time, changes were taking place in the methods of selecting candidates for commission from the batches of soldiers recommended by Unit Selection Boards. According to Edward Grigg, the Parliamentary Under-Secretary of State for War, who described the new procedures in parliament, candidates were watched over for a couple of days by the President of the Board and given intelligence tests. The rest of the tests are described below:

> The second test is for alertness and quick reaction to events. The third test is of personality, the power to inspire confidence. The

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[290] Adam later said that the experiment had also showed that the men in the sub unit were the best selectors and the senior NCOs were the worst, R. Adam, (1960) chapter II, p. 11.

[291] Army Council Minutes AC/M(42)5, 29 October, 1942, 'Regimental Nominations of Candidates to Commanding Officers, p.7, TNA WO 163/51. See also J. Crang, (2000) pp.26-27.

[292] TNA, WO 163/51.

> fourth test, the hardest of all, is a test of toughness of fibre, moral and physical, and it is being carried out by trained psychologists.[293]

This description, although flattering to psychologists was misleading as the actual tests included only what contemporaries acknowledged to be the most tentative tests for personality and no test of alertness or toughness. A more informed account was later offered by the Assistant Adjutant-General, F.H. Vinden, responsible for the provision of officers.[294] According to Vinden, he was inspired to experiment with the methods of interviewing candidates after talking to the psychiatrist and German immigrant, Eric Wittkower, who at the time was translating a German document obtained by the Americans, which outlined German methods of officer selection. Vinden commissioned experiments that used the German methods of selections. In later accounts, many of the tests were ridiculed as inappropriate for British soldiers –the tests famously included spying on soldiers to see what their political preferences were and watching their facial expressions as they pulled on a spring coil from which an electric current electrocuted the candidates.[295] Nevertheless, the essential points of the German methods were retained. These included increasing the assessment to a 48-hour period, and introducing intelligence tests and a psychiatric interview.[296] (In the German scheme, psychologists rather than psychiatrists interviewed the candidates, but unsurprisingly considering that it was mainly psychiatrists that put together the British scheme, this role was given to psychiatrists). Initially, the British scheme, like the German, also involved a medical examination –later this was dropped as

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[293] Commons Debate, 5th Series, 377, 19th Feb 1942, pp. 1989-1990.

[294] F.H. Vinden, (1977) 'The Introduction of War Office Selection Boards in the British Army: A Personal Recollection', *War and Society, a yearbook of military history,* B. Bond & I. Roy, (eds.), London: Croom Helm.

[295] F.H. Vinden, (1977). Edward Grigg's justification in parliament as to why the British had been so slow in implementing the tests that were already been used in the German and American Armies was that "we are not Germans or Americans, and we were not sure that tests of other nations might prove applicable to our own people." Commons Debate, 5th Series, 377, 19th Feb 1942, p.1990.

unnecessary, which meant that the psychiatrist became the only doctor involved in the process. The British scheme also introduced a variety of military tasks and psychological tests, essentially, however, the scheme relied on intelligence tests to measure intelligence, and on the psychiatric interview to assess personality.

The final make up of these new War Office Selection Boards (WOSBs) came to include a President who was a senior officer, a psychiatrist, a psychologist and a number of other military officers who were in charge of the military testing. All officers reported to the President who also interviewed the candidates, saw their performance on the tests and made the ultimate decision. Gradually the job of the psychologist developed so that in addition to intelligence tests he administered a number of projection tests which it was thought would provide an indication as to the personality of the candidate and thus allow some candidates to be interviewed more briefly by the psychiatrist, as he would have some idea what he was looking for. A number of projection tests were used including the Word Association test, originally devised by Carl Jung, in which soldiers were shown in rapid succession, a series of cards, each with a word printed on it, and asked to write their immediate reaction. The responses were then scrutinised by the psychologist. Simon Gillman, Senior Psychiatrist in the Middle East Selection Board, wrote:

> ... from the answers to certain key words such as Mother, Afraid, Home, Worry, he can distinguish the anxious, spoiled, homesick youth from the stable well-balanced man. Again, a number of words can be interpreted either in a war or non-war sense-Butt, Barrel, Desert, Arm, Front. The man who is war-minded tends to seize on the military meaning and reject the other. All these points are valuable clues to personality.[297]

After the war, it was acknowledged by psychologists that the

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[296] P.E. Vernon & J.B. Parry, (1949) pp. 21-23.
[297] S. Gillman, (1947) 'Methods of Officer Selection in the Army', *The Journal of Mental Science,* p. 104.

'ambiguous words' had not been at all effective in picking out military minded men.[298]

The other test was the Thematic Apperception Test where each candidate was shown a picture depicting an ambiguous social situation, which he was told to use as an illustration in a story. He was then given three and a half minutes to write a relevant story. The candidate, it was assumed, projected himself on the principal character. The argument went like this:

> If all the stories end happily, with the hero overcoming his difficulties, it is likely that the writer is well balanced and energetic. On the other hand, where the hero is helpless, victim of his circumstances, and passive, there is a strong suspicion that the writer himself is an ineffectual person with little drive.[299]

By assessing the tests psychologists were supposed to come up with 'personality pointers' that the psychiatrist would use for his interview.

Projection tests soon became the most controversial part of the procedure. This was partly because it became apparent that there were not enough psychologists in the Armed Forces to service all the War Office Selection Boards. This task therefore became allocated to Personnel Selection Officers who had had only a few weeks training in interpreting the tests. Furthermore, psychologists had difficulty in proving that the tests had any validity or even that the scoring of different testers was completely reliable.[300]

The military tests were originally devised as tests for military competence and according to psychologists were introduced as a cover plan –they would impress the Army while allowing psychiatrists and psychologists to get on with selection.[301] Soon however, psychiatrists became involved in these tests too. In 1943, Wilfred Bion developed the

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[298] P.E. Vernon & J.B. Parry, (1949) p.57.
[299] S. Gillman, (1947) p. 105
[300] P.E. Vernon & J.B. Parry, (1949) pp. 57-58.

tests into what were later called the 'leaderless group tests'. The idea was that a group of candidates would be given a task to do that involved cooperating with each other as a group. Testing officers then picked out the men who naturally took the lead in a situation where no leader had been appointed and also the men who were capable of sublimating their own desire to show themselves to do well for the sake of doing what is best for the group. The tests were observed by the military testing officers, the psychiatrist and the President. These tests had face-validity and became the most successful element of selection as far as the military was concerned although psychologists placed much more emphasis on the written tests, because the assessment of the leaderless groups was subjective and unreliable.[302]

Meanwhile for all the assertion that the WOSBs contributed to a large increase in the numbers of soldiers willing to put themselves forward for commission[303] in October 1942, there was still a perceived shortage as shown by the discussion on nominations discussed earlier. In 1943, the solution reached was that all those earmarked for commission by PSOs upon entering the Army would be automatically sent to a WOSB irrespective of the opinion of their commanding officers.

By the end of the war, some 140,000 candidates had been through the new procedure, of whom about 60,000 passed.

Validation

There were several attempts to validate the WOSBs and more specifically the psychiatric input to the WOSBs. The WOSBs' overall procedure was validated through a comparison between candidates produced by the old boards and the new as judged by training officers at OCTU. This research showed that candidates from the new boards were

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[301] Ibid, p. 60.
[302] P.E. Vernon & J.B. Parry, (1949), p. 63.

rated higher.[304] Other research showed however that correlation between WOSBs was not particularly high.[305] More interestingly, the psychiatric interviews were validated by comparing the assessment of candidates by psychiatrists (who had had access to intelligence testing results and interviewed the officer-candidates for an hour) to those made by training officers who had trained the candidates for a period of five weeks and also had information of their track records from their previous regiments. In both of these experiments, the degree of agreement was between 80 and 90%.[306] While the way in which this high degree of consistency was achieved was somewhat biased –the psychiatrist and the officer decided together to what extent their opinion converged and the psychiatrist at least had a vested interest in this convergence being high –this also demonstrates that the values that psychiatrists brought to the Army were not different from those of the Army officers.

In the few cases where there were differences of opinion between psychiatrists and officers, these were mainly due to differences in the perception of the candidates' intelligence (in most cases officers rated the candidates' intelligence as higher than that measured by the tests). In a few other cases, there were differences in the assessment of the candidates' personalities –sometimes because the psychiatrist had judged that there was some psychiatric disability. Some of these differences were reconciled after further discussion, particularly when the officer accepted the psychiatrist's judgment on the candidate's intelligence. In a few cases however, the officer stated either the tests were wrong and did not reflect the candidate's true intelligence or that the lack of intelligence was not as important as the

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[303] J. Crang, (2000) p.34.
[304] P. Vernon, (1942) p.124.
[305] This meant that of candidates passed any one board, 21.5% were deferred or rejected by another. P. Vernon, (1942) p.125.
[306] The first experiment was conducted by Lt.-Col. T.F. Roger and Major E. Wittkower, in 1941 and the second by the Directorate of Army Psychiatry. TNA, CAB98/28 P.P. (S.C.) (43)35. 13th August 1943; 'The Reliability And Consistency Of Psychiatric Opinions On Officer Quality', CMAC, GC/135 B1 (1 of 4).

psychiatrist thought because the candidate's other qualities that made up for it.[307]

Overall, however, these experiments with validation show that a primary reason for the psychiatrists' success in their involvement with military selection was that they did not bring into the procedures principles that clashed with the establishment. While the psychiatrists' and psychologists' obsession with the primacy of intelligence above all other traits contrasted to some extent with military views, overall most values about what constituted a good officer were shared.

Meritocracy?

The introduction of the WOSBs had as its primary aim to increase the quantity and quality of officers. A corollary of this aim was that the new boards would be meritocratic and would therefore draw talent from all social classes. This was an important political point and several questions had been asked in parliament regarding the social background of officers. In December 1939, prior to the new selection methods, the Liberal MP Geoffrey Mander asked the Secretary of State for War for the number of officers who had been educated at elementary schools, adding that this information would be "extremely interesting as showing the democratic character of officers in the Army". He received the answer that such information would require great labour to obtain and was therefore not available but that "Everybody knows that the system for provision of officers for the Army could hardly be more democratic than it is."[308] In 1942, Edward Grigg gave an update to the House of the new selection methods making the point that "the Army is not in the least concerned with the origins of the candidates who come up for commissions" that "everyone, whatever his background, starts at once with an equal

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[307] TNA, CAB98/28 P.P. (S.C.) (43) 35 p.11.
[308] Commons Debates, 5th series, 355, 12, December 1939, pp. 1005-1006.

opportunity for promotion". In particular, he stated that the intelligence tests which were used were tests of general intelligence and not educational achievement in order to counter the point made previously by the Labour MP Jack Lawson that "candidates were being selected because they had been to secondary schools or universities."[309]

Under the WOSB system, the majority of officers were drawn from those who had been to a secondary rather than a public school. Most figures show that approximately 25% of successful candidates at OCTU were from public schools whereas around 60% were from secondary schools and 15% from elementary schools.[310] This in itself indicates that whereas the social background of officers was far more mixed than it had been during the inter-war period, it was still far from representative. In a regular Army intake, only 25% were educated in secondary schools,[311] while in the country at large, only 7% of children attended public schools in 1937-38.[312] More significantly, the WOSBs were *less* inclined to accept elementary school boys for commissions, than were Commanding Officers and the Unit Selection Boards. Figures published by the office of the Adjutant-General show that for a period of six weeks late in 1942, out of the candidates at WOSB (who therefore had had the recommendation of their CO and had passed the Unit Selection Board) 15% were from public schools, 61% from secondary schools and 24% from elementary schools.

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[309] Commons Debates, 5th series, 377, 19 February 1942, pp. 1987-1990. The industrialist MP Austin Hopkinson (Independent) responded to Grigg's distinction between educational achievement and intelligence by asking: "Surely if a high level of education does not accompany a correspondingly high level of intelligence, it is time to scrap our educational system?". Grigg responded: "That is not a question for the War Office".

[310] In this period, elementary schools educated pupils until the age of 14. A system of exemptions meant that that those educated prior to 1921 would have been able to leave school as young as 12 or 13. R. McKibbin, (1998) *Classes and Cultures, England 1918-1951,* Oxford: Oxford university Press, p. 207.

[311] Also, in a regular Army intake 5.8% of recruits had a school certificate. B. Ungerson (1953) p. 47 & 95.

[312] In the 1910s and 1920s when most of the men who fought in the Second World War were educated, this figure was probably even smaller. B. Simon (1991) *Education and the social order 1940-1990,* London: Lawrence & Wishart, p. 25.

However, the success rate at WOSB was 70% for public school boys, 59% for Secondary School boys and only 40% for elementary school boys. This, in turn changed the final results so that from the successful candidates 19% were from public schools, 63% from secondary schools and 18% from elementary schools.[313] Nonetheless, these figures were particularly 'good' as far as the proportion of elementary school boys was concerned. Adam in his memoirs mentioned that these figures changed throughout the war and frequently the proportion of elementary school boys went down and the proportion of public school boys went up.[314] So while the WOSBs had been formed partly to counter the problem of Commanding Officers being unable to judge men who were of a different social class to themselves[315] and according to one psychiatrist "completely restored soldiers' faith in selection" and "enabled the Army finally to shake off the charge of being Blimpish and class-ridden"[316] in reality they probably promoted fewer working class men that would have been promoted by the previous techniques.

In all likelihood, the main reason why boys with only elementary education were so much less likely to pass the WOSBs was the introduction of intelligence tests, as these strongly favoured the better educated. This is supported by the fact that once the system changed so that all those marked as potential officers by Personnel Selection Officers during initial recruitment were sent to WOSBs independently of their Commanding Officer, the supply of candidates (and so presumably the supply of officers) became even more socially stratified. According to the Chief Psychologist, 96% of those recommended by PSOs were 'above normal elementary school standard' (i.e. secondary and public school boys)

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[313] Liddell Hart Centre, Adam 3/4/2, Office of the Adjutant-General (1943) 'Selection of Personnel' p.14.
[314] Liddell Hart Centre, Adam 3/13 'Selection of Men and Leaders' p. 11.
[315] This claim was originally made in J. Rees (1945) p. 64 and has been subsequently repeated in all the relevant literature, e.g. J. Crang (2000) p. 28.
[316] Interview with John Bowlby cited in B. Shephard (2000) p. 192.

and 60% had obtained a school certificate.[317] This means that 60% of candidates were selected from 5.8% of the population, 36% from 19.2% of the population and 4% from the remainder.[318] The PSOs had considerable less information on candidates than the WOSBs and the most significant information they had was the intelligence test results. So ironically the reform which was supposed to be most meritocratic in that it recognised ability in any walk of life was precisely what stopped working class men getting commissions.

Adam argued in his memoirs that this injustice was the fault of society which did not provide a good education for all and the Army had no choice but to pick its officers among the better educated for "an officer in modern war must have a certain standard of education if he is to train and lead men."[319] However, this view was not shared by everyone. For example, Lieutenant-Colonel Hutchison argued that whereas public school boys had the advantage of a better diet and physical education, boys educated in elementary schools were better trained in the psychological and sociological spheres as they had a better understanding of how the world worked, had had the opportunity to work and specialise from a young age and did not suffer the disadvantages of an education based on cramming and social isolation.[320] Even more persuasively, F. Warhurst who trained officer cadets in an OCTU during the war, had statistical results about the quality of the cadets in which he showed that boys from elementary schools did better than boys from public and secondary schools.[321] Of course Warhurst acknowledged that doing well in an OCTU was very different from doing well in the field, and he conceded that the younger public

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[317] B. Ungerson, (1953) p. 47.
[318] In a regular Army intake only 5.8% of recruits had a school certificate and 25% were educated in secondary and public schools. B. Ungerson, (1953) pp. 47 & 95.
[319] Adam 3/13, p. 11, Liddell Hart Centre.
[320] G.S. Hutchison, (1941) 'Selection and education of an officer', *The Army Quarterly,* Vol XLII, No.2, pp. 66-74.
[321] F. Warhurst, (1946) 'Training Army Officers, An analysis of some results obtained in war', *The Army Quarterly,* Vol. LII, No.2, pp. 252-261.

schoolboys might do better than their colleagues, once they acquired experience and maturity. Nonetheless, he concluded that 'an elementary school education was an adequate background provided that the required inherent characteristics were present'.[322]

Others disagreed. The argument was put forward that only upper class men had the right skills to lead men. Famously, Colonel Bingham who also worked in an OCTU, was sacked for breaking the rules for publishing without permission a letter to *The Times* arguing that officers who were not upper class could not lead men because they had not grown up with servants and therefore did not know what it was like to be responsible for the lives of others. Instead, the argument went, these new officers had 'been reared in an atmosphere where the State spoon feeds everyone from cradle to grave, and no one feels any responsibility for his fellow men.'[323] Nonetheless, according to Warhurst, the men with best man-management skills were not public school boys raised with servants, but men with experience of being employers.

A number of sources which criticised Army Officers reserved their greatest contempt not for working class officers but those from the middle class who were presented as pale imitations of the real upper class. So in the satirical publication 'Bless 'em All', the upper class author sang the praises of the traditional public school officer even while claiming that such men were not very intelligent.[324] He argued that such officers should be supplemented not by middle class men who imitated them but by men selected for "their brains, their scientific ability, their business experience or their bad moral characters."[325] The socialist William Shebbeare who argued that many upper class officers were ineffective because they had no

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[322] F. Warhurst, (1946) p. 258.

[323] Col. Bingham, *The Times,* 15th January 1941, p.5.

[324]The author describes the qualities of the upper class officer as follows: "Patriotism, yes: Breeding, yes: Courage, yes: Noblese oblige, yes: *Esprit de Corps*, yes, yes, yes: Intelligence, No." Boomerang (1942) *Bless 'Em All: An Analysis of the Morale, Efficiency, and Leadership of the British Army,* London: Secker & Warburg, p.49.

understanding of the lives of their men, also condemned middle class 'imitations' –instead, he argued, men with experience of leadership from the trade unions should have been selected.[326] Nevertheless, it was middle class men educated in secondary schools that emulated the public schools, who formed the majority of the officer ranks of the Army of the Second World War.

Psychological Defeat?

From as early as 1943, some of the powers vested in psychiatrists and psychologists began to be removed. As seen in chapter two, psychiatrists were removed from Boards selecting candidates for permanent commissions and an expert commission was set up to judge their work. In practice, the expert committee which consisted of doctors, psychiatrists and psychologists, including the Director-Generals of the medical services of each Service proved no threat to the psychiatrists and psychologists. Service psychiatrists and psychologists attended most meeting and their overall conclusions were extremely positive. The only potential threat –Lord Moran, physician to Churchill, and primary advocate against psychiatry did not attend. In 1946, however, Adam was replaced by a new Adjutant-General, and two more committees were set up –and this time the members were not doctors but senior officers. Like the expert committee before them part of their remit was explicitly to judge whether too much use was being made of psychiatrists and psychologists. The Ritchie Committee which dealt with permanent commissions recommended the removal of psychologists as well as psychiatrists and the removal of the intelligence tests.[327] The report argued that psychiatric assessment was not necessary as the candidates for permanent commissions had already passed

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[325] Boomerang, (1942) p.53.
[326] Captain X, (1944) *A soldier looks ahead,* London: The Labour Book Service, pp. 55-57.
[327] TNA, WO32/12133

through WOSBs and had proved themselves in the field. The Crocker report was more moderate and argued that as there was a severe shortage of service psychiatrists and psychologists since demobilisation had began, and most WOSBs operated without their help anyway and so it would be more profitable if the few remaining staff were detached from particular WOSBs and were used instead in a research capacity where they could improve and validate the tests.[328] Furthermore, it suggested that the projection tests should be removed as without a psychiatrist to interpret these properly their results would be misleading. Finally, it argued that PSOs should no longer have the authority to send new recruits to WOSBs but merely to suggest to the candidate and his commanding officer, that the man had the potential to become an officer. Nevertheless, the Crocker report acknowledged that "the general opinion held by DSP, Presidents and members of WOSBs is that they [psychiatrists] are of great value as members of Boards."[329]

The Director of Army Psychiatry and the Director of Army Medical Services both put forward a robust defence of the psychiatric methods. However, all the recommendations were accepted with the exception of the suggestion to remove intelligence tests from the permanent commission boards, which was opposed by Presidents of Boards and rejected by the Director of Selection of Personnel. In December 1946, a parliamentary question was asked about why psychiatrists and psychologists had been removed from selection boards "in view of the fact that these experts devised the successful techniques now in use". The response merely cited the shortage of technical personnel and the recommendations of the Crocker and Ritchie reports rather than offering any objection to the continued presence of psychiatrists and psychologists.[330]

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[328] TNA, WO32/12134
[329] TNA, WO32/12134 *Report of the Crocker Committee p.*14.
[330] Tuesday 10th December 1946, TNA, WO32/12134

psychiatric input did result in a particular emphasis on the importance of high intelligence as an essential officer quality, but this was one of the least controversial aspects of the new selection methods and was as such maintained after the war.

In addition, this chapter has also shown that psychiatric input into the methods of officer selection was immense and demonstrates not only that psychiatrists enjoyed great patronage under Ronald Adam and his staff, but also that psychiatrists and Army officers in general, had essentially similar values and this permitted them to cooperate successfully. After the war, once the post of Adjutant-General was refilled, psychiatrists and psychologists did lose many of their powers –however this was to a large extent inevitable as conscription ended and the Army had once again the option of selecting their officers almost exclusively from the public schools. The fact that the intelligence tests, the leaderless group tests and the 2-day selection procedure were maintained as well as that some psychiatrists and psychologists were retained in a research capacity is a sign that psychiatrists did have a large impact on selection procedures. To retain psychiatrists and psychologists in peacetime in their prominent wartime positions would have been unrealistic, as the Army no longer needed to pick its officers from unwilling civilians with no military experience nor was the danger of psychiatric casualties as imminent. In total, peacetime offered far fewer opportunities for preventive psychiatry so the value and status of military psychiatry was inevitably reduced.

Chapter 4: Sutton Emergency Hospital 1940-1942

Introduction

Prior to the Second World War, the authorities had expected that any conflict that involved the aerial bombardment of British cities would lead to massive casualties. While the estimates of the civilian dead run as high as 35,000 a day, estimates of the psychiatric casualties run even higher – psychiatrists had warned that for every physical casualty up to three psychiatric casualties could be expected.[332] In order to deal with the expected casualties, civilian hospitals in Britain became organised under the authority of the Emergency Medical Services (EMS). In EMS hospitals, the medical staff were not conscripted but each unit had a military registrar and some military staff.[333]

In the first few months of the war, it became apparent that civilian casualties from aerial bombardment would be much lower than expected. EMS hospitals were under-used and so when the Dunkirk evacuation took place many casualties were treated in EMS rather than military hospitals. In particular, military psychiatric facilities in the UK were scarce and catered mainly for psychotic patients. In June 1940, there were three units for psychotic patients but only one for neurotic patients.[334] This was partly because it had been hoped that the majority of patients would be treated near the front line and not evacuated to the UK.[335]

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[332] B. Shephard, (2000) *A War of Nerves,* London: Jonathan Cape, pp. 174-175; T. Harrison (1976) *Living through the Blitz*, London: Collins; R.M. Titmuss, (1950) *Problems of Social Policy*, London, HMSO.

[333] W. Sargant, (1967) *The Unquiet Mind, The Autobiography of a Physician in Psychological Medicine*, London: Pan Books, p. 114. *The Unquiet Mind* and Sargant's earlier best-selling book *Battle for the Mind* were written in collaboration with Robert Graves who edited the scripts and earned a third of the royalties. See CMAC PP/WWS, Box 3 A.21 & A.22.

[334] F.A.E. Crew (ed), (1955), 'The army psychiatric service', *The Army Medical Services, Administration, Vol. II,* London: HMSO, pp. 470-474.

[335] Questions were asked in parliament by Dr Howitt and Mr Freemantle in February 1940 about why psychoneurotic patients were being evacuated to England and treated in general hospitals contrary to the 1922 committee recommendations. The Secretary of

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Soldiers evacuated to EMS hospitals were, on the whole, treated as if they were civilian patients. This chapter will explore the psychiatric treatment of military patients in one such unit where the medical records of the patients are available. It will show how in the pressurised conditions that arose, the doctors' priorities were mostly to discharge patients rather than return them to their units. This attitude was facilitated by the belief that most of the patients were constitutionally inadequate and hence incurable and unlikely to be of much further use to the military. In addition, the shortage of available treatment facilities meant that treatment was rationed and only those most likely to benefit were treated. The decision on who to treat was reached after examining the patients' personal histories when an assessment was made of the extent to which each patient had adapted to the responsibilities and lifestyle appropriate for a contemporary young man. However, at the same time, elaborate and experimental treatments were being used on civilian patients where they were thought likely to benefit from them.

In London, the Maudsley psychiatric hospital became part of the EMS and was evacuated to two different locations, one in Mill Hill, North London and the other in Sutton, South London. This chapter will be concerned with Sutton, the unit that was developed by psychiatrists interested in physical therapies. The clinical director of Sutton was Eliot Slater, a committed advocate of genetic explanations for mental illness, intellectual differences and personality and a keen member (later a Fellow) of the Eugenics Society. The Deputy Director was William Sargant who was also a proponent of constitutional explanations for mental illness but who nonetheless viewed mental illness as identical to physical illness and therefore capable of striking anyone at anytime. In later years, Sargant

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state for war responded that a psychiatric centre and convalescent depots had been set up in France for this purpose but that inevitably some patients had to be evacuated. Later, the Dunkirk evacuation made treatment in the UK inevitable. Commons Debate, 5th Series, 357, 20th Feb 1940, p.1137-1138; 27th Feb 1940, p.1918.

became renowned for his hostility to psychoanalysis and for the experimental and dangerous treatments that he practised.

Sutton 1940-1942

In the summer of 1940, Sutton was flooded with service patients from Dunkirk. Sargant described the situation in his autobiography:

> I shall never forget the arrival of these Dunkirk soldiers in their 'tin hats' and filthy uniforms, some of them wounded, many in states of total and abject neurotic collapse, slouching along, mixed up with Belgian and French civilians who had scrambled aboard the boats at the last minute. What the papers termed a great British achievement seemed to us at the time nothing better than a defeated and defeatist rout. Men swarmed into the hospital, some raging mutinously against their officers for having deserted them in a panic and others swearing that they would never fight again.[336]

During the Blitz, the hospital was subject to repeat bombings that caused multiple casualties. In the following passage, Sargant described how life proceeded at the hospital:

> In September, … the main hospital building caught a direct hit ... We dug patients out unconscious but still alive after perhaps trampling on their faces in our rescue efforts. We found many others blown into pieces. Sixteen patients were found killed, and many of the survivors were badly injured. Heroic feats were performed that night by patients who had hitherto seemed hopelessly incapacitated neurotics, and most of whom relapsed as soon as the crisis ended. …
>
> During the long Blitz, several very normal members of the hospital staff showed signs of breaking down … When a bomb dropped near the hospital, a frightened patient might lose the use of his limbs before the ward doctor's very eyes …
>
> As soon as the sirens sounded, soldiers and civil defence patients would rush madly out to some supposedly safer sheltering place. Those whose nerves had originally broken down while they were sheltered by a house, would make for the open and often stay out all night, returning almost frozen in the morning. Those, on the other hand, who had been bombed and broken down in the open,

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[336] W. Sargant, (1967) p. 114.

would take cover in buildings. Some men even made a habit of going two or three miles every night to find a safe shelter. [337]

In July 1940, Sargant and Slater published their first article on their experience of soldiers suffering from acute war neurosis.[338] In this article they put across the somewhat counterintuitive theory that the less severe the strain that caused a man to break down the less likely it was that he would recover. They argued that: "... prognosis will to some extent depend on the severity of the strain; if it was not very severe it is probable that the patient is constitutionally not entirely stable, and therefore unfitted for the most arduous military duty." In Sargant and Slater's practice, prognosis (and the decision whether a patient should be discharged from the Army or be returned to his unit) was linked to constitutional fitness and this was determined by a number of factors of which the severity of the stressor was one but which also included the patient's personal history, IQ score etc. The men evacuated from Dunkirk were generally judged to be considerably less constitutionally damaged than either peace-time civilian patients or the men who had broken down "under the comparatively trivial stresses of life abroad under army conditions, without any of the severe strains entailed in actual fighting". Nevertheless even in the Dunkirk cases, constitutional factors were thought to be important as "compared to an average population, they would almost certainly show an excessive proportion of men who had suffered from nervous troubles in earlier life, and an excessive frequency of psychiatric disorder in the nearer blood relatives".

Overall, the prognoses of these men was not optimistic. Sargant and Slater believed that "A history of previous neurotic illnesses or symptoms in civil life" must exclude patients "from duties that will be the equivalent of front-line service".[339] In addition, many of the patients "expressed a conviction that they could never go through such an experience again

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[337] W. Sargant, (1967) pp. 129-133.
[338] W. Sargant & E. Slater, (1940) 'Acute War Neuroses', *The Lancet,* ii, pp.1-2.

without breaking down at once." No statistics about the proportion of men who returned to their units was provided at this stage but it seems unlikely that it was high.

Two years later Eliot Slater reported that from the 2,000 military patients sent to Sutton, (including the evacuees from Dunkirk) only 26% had returned to duty[340] and it is very unlikely that any of these men would be involved in front-line duty. Sargant explained the rationale:

> Our experiences after Dunkirk taught us the folly of trying to patch up soldiers and expect them to face again the stresses that had caused their breakdown ... we found that if these soldiers were sent back to full duty, fresh battle stresses would at once reproduce the former symptoms. So we decided to avoid the terrible chronic neuroses from World War I by arranging for nervously unstable patients to be discharged from the Army, hoping they would make some sort of success in civil life. In less severe cases, we recommended that they should be kept on base-line Army duties; and many of these rehabilitated themselves without further breakdown.[341]

Slater also provided statistics on treatment in Sutton –actual psychiatric treatment was relatively infrequent and reserved for the patients who were deemed more likely to benefit from it:

> Nearly 60 per cent. of the patients received no specific treatment other than that provided by the usual hospital routine, physical training, occupational therapy, etc., and perhaps a few short therapeutic interviews. ... The possibilities of treatment were limited on the one hand by the frequency of a rather low intelligence and firmly anchored constitutional instability, and on the other hand by working conditions. There was a great pressure on beds and a rapid turn over ...[342]

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[339] Ibid, p.2.
[340] E. Slater, (1943) 'The Neurotic constitution, A statistical study of Two Thousand Soldiers', *The Journal of Neurology and Psychiatry,* p.12
[341] W. Sargant, (1967) p. 117.
[342] E. Slater, (1943) 'The Neurotic constitution, A statistical study of Two Thousand Soldiers', *The Journal of Neurology and Psychiatry,* 6, Nos 1 & 2, p. 9.

Treatment in Sutton was guided partly by the patients' symptoms. In particular, loss of weight was treated by modified insulin therapy where patients were injected with insulin at sub-coma levels and fed large amounts of boiled potatoes.[343] Hysterical loss of function (amnesia, paralysis, mutism etc) was treated with chemical abreaction. The psychiatrist injected the patient with sodium amytal, which induced a hypnotic-like state. Then the psychiatrist encouraged the patient to relive traumatic events he had recently experienced. William Sargant understood this treatment in a behavioural way and so felt that its curative aspect lay exclusively in the discharge of emotion rather than in the content of the forgotten event. Following Pavlov, Sargant believed that soldiers were conditioned through the war, into a constant state of anxiety, and that a new stressor would break the conditioning. Sargant tried to artificially create such a stressor for his patients by making them relive horrifying situations, and if a patient had not experienced a suitably terrifying event Sargant invented one.[344] In his book "Battle for the Mind" Sargant recalls:

> Much better results could often ... be obtained by stirring up emotions about ... imaginary happenings. For example it might be suggested, under drugs, to a patient who had broken down as a result of a tank battle, that he was trapped in a burning tank and must fight his way out. ... a falsely implanted memory might create a larger emotional discharge than the real and induce the physiological effects needed for psychological relief. A technique of deliberately stimulating anger or fear under drugs, until the patient collapses in temporary emotional exhaustion was finally perfected with the help of Pavlov's findings ...[345]

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[343] This treatment was developed by William Sargant as an adaptation to the standard insulin coma therapy for Schizophrenia invented by Manfred Sakel in which patients entered a coma and were revived by intravenous sugar solution. Sargant's method was safer because it did not induce a coma and more convenient in war-time when sugar was rationed. W. Sargant (1967) pp. 119-120.

[344] For a good discussion of Sargant's abreactive methods, see R. Leys, (2000), *Trauma, A Genealogy*, Chicago: The University of Chicago Press.

[345] W. Sargant, (1957) *Battle of the Mind*, London: Heinmann, p. xxi

Sargant recorded that in one case: "treatment done in open ward behind screens and therefore difficult to press for details owing to his shouted reply heard by other patients".[346]

However, although these treatments were ostensibly therapies for specific symptoms, in practice the decision on whether or not to treat a patient depended on a lot more than just his symptoms. For example, in a sample of 334 cases treated by Sargant, in which 105 patients were classified as having lost weight, only 60 patients were treated with insulin while 6 others were treated with other treatments. Also treated with insulin were 32 other patients who had not lost weight (including one patient who had *gained* weight during service). So while patients who had lost weight were considerably more likely to be treated than those who had not, (the average was around 38%) therapy was not very specifically targeted.

What seems probable is that Sargant was more likely to treat patients who had lost weight, not because he needed to remedy the symptom, but because he believed that patients who broke down after enduring some kind of physical deterioration were more likely to be constitutionally sound than the men who broke down for purely emotional reasons.[347] Some men who had lost weight were not judged to be constitutionally sound, so they were not treated. The judgment on whether a patient was constitutionally adequate or not depended on a number of factors. One such factor, as mentioned earlier was military stress and Eliot Slater's statistical information shows that patients who had endured severe stress before breaking down were far more likely be treated, particularly by the more respected physical treatments. Although in Slater's categorisation, the majority of patients are classified as having received "non-specific treatment", in practice, as mentioned earlier, this meant that they received

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[346]CMAC, PP/WWS, Box 10, E.3/1.

[347] W. Sargant & E. Slater, (1944) *Physical Methods of Treatment in Psychiatry*, Edinburgh: E. & S. Livingstone.

no actual treatment beside the benefits of a hospital environment and an assessment by a psychiatrist.

Treatment	Military Stress undergone		
	Severe %	Moderate %	Trifling %
Non-Specific	30.2	52.1	64.8
Physical Measures	43.9	30.1	16.3
Psychotherapy	25.9	17.8	18.9

Table 1: The relationship between receiving treatment and having undergone military stress. Extracted from E. Slater, (1943) p. 13, table 11.

Another criterion that determined whether a patient would receive treatment in Sutton was his family history. Only 59 patients were recorded as having a negative family history, which meant that all their relatives were mentally healthy. However, 32 of them were treated which is considerably higher than the average. Intelligence also mattered: out of the 85 patients who were described as having a low intelligence (either impressionistically or based on an IQ test) only 19 were treated.

What also determined whether a soldier was constitutionally vulnerable was his pre-morbid personality. Sargant's patients were far less likely to receive treatment if Sargant felt that they had always been inadequate, neurotic people whose symptoms were merely aggravated by the war. Out of the 101 patients of whom it can be said that they were seen to have a poor pre-morbid personality, only 18 were treated.

One way of conceptualising which patients became classified as having a poor personality is in terms of the male gender role. Hospitalised soldiers had already failed at the occupation that was the pinnacle of male virility and Sargant searched in the men's past for compounding evidence of emasculation. When he found it, patients were often classified as constitutionally inadequate. For example, one area in which Sargant was particularly interested in was the patients' work record. Most of Sargant's patients had good work records but for those who did not, their chances of

receiving treatment were bleak: out of the 41 patients who had very poor work records only 8 were treated and from the 83 patients who had fairly poor work records only 22 were treated –considerably less than the average.

Other manifestations of manliness Sargant and the other Sutton psychiatrists were interested in were sexual functioning and athletic appearance. For example, Eliot Slater made the following observation about service patients:

> The number of men in whom sexual relations began at a late age, occurred with unusual rarity and were associated with little interest or satisfaction was so high as to attract attention… an inhibited sex life is especially frequent among mental defectives and psychopaths … It is clearly a quality of deep biological significance, and it may be that it is genetically associated with the factors that make for inferiority of intelligence and temperament.[348]

Slater inferred that "inferiority of intelligence and temperament" were genetically linked to a low sex drive; nature's way of assuring inferior men would be unlikely to reproduce.[349] Slater also found a correlation between low sex drive, non-athletic physique, and poor clinical outcome. Predictably, he thought this correlation suggested an overall genetic inferiority. When Eliot Slater conducted a factor analysis on the negative traits exhibited by soldiers, he found that poor intelligence was mostly associated with poor work record, and that poor work record correlated strongly with all negative traits. Since patients' intelligence was assessed by the overall impression a patient made, (actual intelligence tests were conducted on only a small proportion of patients); it is possible to infer that a poor earning capacity led psychiatrists to infer that a patient was

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[348] E. Slater, (1943) p.4,

[349] In this respect, Slater's views are markedly different from those of other members of the Eugenics Society who were particularly concerned with the supposed superfecundity of dull men and women.

unintelligent, had a constitutional vulnerability to mental illness and was unlikely to get better.

As none of the military patients who were treated in Sutton were officers, it is difficult to infer his attitude to rank or class. However, the medical notes give the impression that middle class soldiers would have only been more likely to be treated if they were hard working and ambitious not if they were intellectuals or men of leisure. For example, 'Bill',[350] who broke down after a bombardment where he was buried under debris for several hours was described by Sargant as "an artistic, intellectual type" with "many feminine characteristics". According to Sargant, Bill had "been spoilt all his life", was "highly strung", and tended "to whine". Bill's mother came from "a musical family" and was "excitable, artistic [and] erratic". Sargant concluded: "[Bill] still claims that symptoms are entirely due to bombing. In my view, present condition is the effect of bombing on a constitutionally anxious and hysterical person with poor heredity ... Not a good case for a pension". According to his medical notes, Bill received no treatment even though he stayed in the hospital for over 6 weeks. He was finally boarded out of the Army.

Another patient, 23-year-old 'Charles'[351] was admitted to hospital after having been mute for five months. Sargant treated him with abreaction, which was the standard cure for all hysterical symptoms. Nonetheless, Sargant regarded Charles as a poor personality. As Charles could not speak, the information was elicited in writing:

> Personal History
> ...Since leaving school has been a shop assistant, in the same job—never earned more than 25/— a week. Gives poor reasons for not leaving to get higher wages. No affairs with girls. Occupies spare time with music and piano playing.
>
> Present State

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[350] CMAC, PP/WWS, Box 10, E.3/1. All names are fictional.
[351] Ibid.

> ... Past history shows that he is a poor personality with a bad family history.
>
> 18.8.41 (after treatment)
> Talks in a high squeaky voice. Is actually singing in ward concert as a woman.

These patients' perceived femininity, interest in the Arts and absence of a successful career or sufficient interest in the opposite sex lead to their classification as poor personalities with poor heredity.[352]

When treatment results were poor, patients' constitutions were often blamed and their personalities retrospectively reclassified as inadequate. Eliot's[353] medical notes show how a good patient could become a bad patient through the course of their stay in hospital, if treatment failed. Eliot suffered from anxiety, lack of energy, and being upset by the sounds of guns. He was originally described on the 11th November 1940 as follows:

> Apparently a very hard worker. Doing up to 14 hours a day in his own business...
> Gives excellent impression –seems a good personality and I do not lay much store by his history of previous worrying. He seems to have been very conscientious and hard working ...Quite frank about his troubles which are alien to his nature. Only too anxious to get wel [sic] and return to his [unit] which may be going abroad again ... [there is] no real psychological cause for his illness. It seems that reason may well be found in physical state.

On the 14th of November, Eliot was physically examined and no physical condition was found. From this point, Sargant's view of the patient changed. On the 12th of December, Sargant wrote:

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[352] Only one of Sargant's patients was overtly described as a homosexual. This man was thought by Sargant to have a high IQ, to have "really done his best against heredity odds" and to be "genuinely upset by his conflicts and would give anything to be normal". However, he also had a history of nervous instability, which stood in the way of his career as an actor. He was not treated.
[353] CMAC, PP/WWS, Box 10, E.3/1.

> I am increasingly doubtful about this case. The more you see and talk to him the more one thinks that this condition is of long standing. Finally confessed that he had been like this before he came over here... [he] makes little attempt to get well. Always one complaint or another.

Finally, on the 10th of January 1941 Sargant concluded:

> Thyroid does not seem to have altered condition ... Seems a complete "softy" and that is all there seems to be in this case. I am sure that treatment will do no further good.

When Sargant realised that this patient's problems were not due to a physical cause his opinion of the patient changed. Sargant's opinion became gradually more negative as his suspicion that Eric was a chronic neurotic became confirmed.

While the rationing of treatment can partly be explained by the fact that wartime resources were scarce, it is likely that the most significant reason for limiting treatment was that most patients were seen to be unlikely to benefit from it due to their inherent inadequacies. For example, some civilian patients who were thought to have very good previous personalities and therefore very good prognoses were treated with a leucotomy –at the time a highly experimental and resource-consuming procedure. The patients chosen for these procedures during the war suffered from relatively minor symptoms, for example one young female patient 's complaint was recorded to be "looking at men's trousers, can't bear to go out anywhere because of what people will think of such conduct" while another suffered from headaches and disliked waiting[354]. Yet, such operations took precedence over the much simpler treatment of military patients. This may have been partly because the Sutton psychiatrists had a particular interest in developing experimental treatments but it was also because they felt that such 'good' patients were more likely to benefit from treatment.

Conclusion

The decision in the early part of the war to send military psychiatric patients to EMS units such as Sutton rather than to military hospitals near the front line was borne out of necessity. In such units, civilian psychiatrists worked on the presumption that most of their patients were constitutionally inferior and would be unable to return to the military. Consequently, a large majority of such patients were discharged –most of the time without anyone even attempting to treat them. This situation did not necessarily contradict military wishes, as there is some evidence that combatant officers did not like to have men who had broken down in their units. In the later years, most soldiers received treatment abroad where the discharge rates were significantly lower. However, most solders evacuated to the UK continued to be discharged.

[354] CMAC, PP/WWS, Box 15, F.7/1.

Chapter 5: Psychiatry in the Theatres of War

Introduction

This chapter will discuss the different clinical practices adopted by psychiatrists working in theatres of war. Unfortunately, the absence of sources means that few details are known about the psychiatric practices in the Far East or in Normandy beyond a few statistics published by individual psychiatrists,[355] so inevitably this chapter will focus on the Middle East, North Africa and Italy. However, this disadvantage does not overwhelmingly affect this work because the institutional model for psychiatric practice initially established in the Middle East remained much the same in the other theatres of war. Of course, model aside, the practicalities of setting up psychiatric facilities were different and some recent work has discussed how these influenced the return of casualties to the front line.[356]

Furthermore, this chapter will show that actual therapeutic practice was very local and depended on the interaction between the specific circumstances in which each psychiatrist found himself and the ideas and values he brought to that situation. Hence, none of the practices discussed here are specific to a particular theatre. Instead, it will be shown that therapeutic practices were influenced by a number of factors such as the local military requirements for psychiatrists to either retain or remove patients, the psychiatrists' proximity to the front line, their interest in developing experimental new treatments and whether their patients had experience of battle. All these aspects became crystallised in one all-

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[355] Regarding Normandy see T. Main 'Quarterly Report, October 1944', CMAC, GC 135/B.1; J.W. Wishart 'Psychiatric Summary, Week ending Sunday 18 June, 1944', CMAC, RAMC 408/3/2; D.J. Waterson 'Weekly Report by Psychiatrists attached to 2nd Army for week ending 24 June'. For the Far East, see 'The Medical Services with 2nd Division', CMAC, RAMC 814; 'Operation by 33 Indian Corps', CMAC, RAMC 1237/1/1.

important question: What did the psychiatrist think had caused the individual patient's breakdown? Was it his experience of warfare or his deficient intelligence and inadequate personality –lesions formed decades ago by poor genetic inheritance and incompetent upbringing.

This question of aetiology mediated clinical practices. This was not because treatments were specific to what was seen to be the cause of the breakdown but because the possibility of treatment was dependent upon the possibility of a cure, and while some aetiological explanations allowed for the possibility of cure others did not. For example, when the cause of psychiatric breakdown was seen to lie within the patients' constitution, it was presumed that no treatment (besides, according to some psychiatrists, years of psychoanalysis) would work. By contrast, when the cause was thought to be physical exhaustion, the treatment (rest and nourishment) was assumed to be very successful.

Of course, no psychiatrist had identical aetiological narratives to explain the breakdown of all their patients, and differences were frequently just a matter of emphasis. All psychiatrists invariably agreed that the following causes played a significant part in the psychiatric breakdown of soldiers: constitutional inadequacy, inadequate personality, mental deficiency, physical exhaustion, difficult climate, low morale, lack of *esprit de corps*, poor leadership, homesickness, financial anxieties, no/bad news from home, lack of confidence in their own weapons, death of a close friend, or a near miss. Often these causes were subdivided into predisposing and precipitating causes and all were give due notice. Nonetheless, psychiatrists did invest in particular aetiological accounts that determined their clinical practice. Furthermore, some psychiatrists gave aetiology a much more prominent role in their writings.

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[356] M. Harrison (2004) *Medicine and Victory, British Military Medicine in the Second World War*, Oxford: Oxford University Press.

During the Second World War, a significant number of British soldiers (approximately 10% of battle casualties) received psychiatric treatment whilst in a theatre of war, sometimes in close proximity to the front line. A system of treating psychiatric casualties near the front line had been established during the First World War and in the Second World War this system was expanded. The model that emerged was a three-tier system in which soldiers were treated initially very close to the front line in an exhaustion centre run by the local corps or divisional psychiatrist. Treatment in exhaustion centres consisted mainly of restorative measures (plenty of food, rest, tranquillisers to aid sleep, and sometimes chemical abreaction). After two or three days rest, patients who were thought to have recovered were returned to the front line while the others were sent to a hospital further back where they could be treated further. If this treatment was not successful then casualties were evacuated to a base hospital where more elaborate treatments could be tried such as ECT, continuous narcosis and insulin therapy. If this treatment failed to restore patients at least to the extent that they could be usefully employed in a non-combat capacity, they were evacuated back to the UK where they were usually discharged from the Army.

Psychiatrists practicing in theatres of war faced a number of pressures from the military some of which where conflicting. One very significant pressure was the number of patients psychiatrists had to look after. Most hospital units of 100 beds were catered for by a single psychiatrist, yet this fact alone does not demonstrate the real pressure psychiatrists were under in high turn over units. For example, the Tripoli Area psychiatrist, Harold Palmer, treated 1071 in-patients and 343 outpatients in a period of two months in the spring of 1943, in a unit of only 80 beds where the average stay was just five days.[357]

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[357] R.F. Barbour ,(1943) 'An Experimental Forward Psychiatry Unit', CMAC, GC135 B1 (2 of 4).

Secondly there appeared to be no clear military leadership on what precisely psychiatrists should be aiming for –to return as many soldiers as humanly possible to their units or to evacuate all those who were unlikely to ever become good and efficient soldiers. While psychiatrists with high Return to Unit (RTU) results were praised as for example when the Adjutant-General praised the work of Harold Palmer who achieved an evacuation rate of less than 2%,[358] other psychiatrists reported that they worked with Commanding Officers and Directors of Medical Services who were keen to evacuate as many as possible of the soldiers who did not fit in the units.[359] This conflict was referred to by the consulting psychiatrist J.R. Rees when he defended the high discharge rate for psychiatric disorders and argued that while administrators back home were critical of psychiatrists for discharging too many soldiers, fighting, commanding officers were not.[360]

In addition, psychiatrists also had the task (as did all medical personnel who came into the Armed Forces) of realigning their civilian medical ethics to fit the war environment. This meant that their patients' welfare was no longer of primary concern as the interests of the Army as a whole had to have primacy at all times. As the corps psychiatrist Dugmore Hunter said: "Mentally, the psychiatrist, like every other soldier, finds himself in a new world with standards and values of its own."[361] According to Hunter:

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[358] R. F. Adam, (1943) *The Health of the Army,* p.5, CMAC, RAMC 466/38.

[359] For example, one psychiatrist reported that COs in infantry battalions were 'extremely enthusiastic' at the idea of getting rid of many men who they considered a liability rather than an asset. P.J.R. Davis (1946) 'Divisional Psychiatry. Report to the War Office', *Journal of the Royal Army Medical Corps,* 86, p. 259. Another psychiatrist reported very positive comments regarding psychiatry by three ADMS who thought psychiatric work was very helpful in "cleaning up" and "weeding out" their divisions. R.J. Philips, (1944) 'Psychiatry at Corps Level', CMAC, GC135, B1, (4 of 4).

[360] J. R. Rees, (1945) *The Shaping of Psychiatry by War*, London: Chapman & Hall; pp. 27-28.

[361] D. Hunter, (1946) 'The work of a corps psychiatrist in the Italian campaign', *Journal of the Royal Army Medical Corps,* 86, p. 128.

[The Corps psychiatrist's] usefulness varies directly with his own capacity to adapt, his willingness to learn and the extent to which he can identify himself with the basic aims of an Army at war. It also depends on his ability to get on with combatant officers and men and to offer technical advice under the guise of "plain common sense"...

While making full use of his professional training, he must keep both feet firmly planted in the real situation, which is the Army as he finds it. He must indeed feel himself to be genuinely part of that Army and not an outsider, looking on.[362]

One psychiatrist who explored the subject of how the psychiatrists' own feelings affected their clinical practice was T.F. Main, who worked in the Middle East and later with the British Liberation Army in the invasion of Europe and in Northfield Hospital in the UK. He pointed out that front-line psychiatry was not objective and that psychiatrists were influenced by their external situation:

> It would be nice to report that in the forward areas psychiatry is cool and accurate and unimpassioned. But if we take thought for an instance we can see that this can never be so. Psychiatric disease and normality are only relative matters affected by current social standards and culture patterns. An emotional problem which might at home be described legitimately as severe anxiety, might on the field be called bravery or cowardice depending on whether the psychiatrist himself is frightened or not.
>
> A forceful moral diagnosis is therefore sometimes made by the psychiatrist before he applies the new nomenclature of the Royal College of Physicians, and treatment is sometimes affected by the psychiatrist's needs as well as by the patient's.
>
> Other influences also affect objectivity. There is an understandable desire during a war to feel important and useful. The inevitable hardships and sacrifices of war affect everyone to some extent, and lead to various emotional by-products of bitterness and impotence, anger, and –if one's own job is not heroic or important enough—to defensive swashbuckling or a guilt-driven compassion for the others who have to undertake risks of death in battle. Sentimentality and anger about neurotic soldiers, therefore

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[362] Ibid, p.130.

commonly influence clinical judgement in prognosis and disposal.[363]

This chapter will discuss how all these pressures influenced psychiatric practice. In particular, it will analyse the influence on psychiatric practice caused by whether a psychiatrist saw his job to be to primarily treat patients or to select patients (for treatment, evacuation, downgrading, or discharge). In the majority of time, psychiatrists who invested more time in treatment and developed new methods of treating patients did not favour constitution as an aetiological explanation for psychiatric breakdown. Although they accepted that their patients were to some extent predisposed to nervousness, they emphasised other causes for their breakdown such as low morale and battle stress. This approach made treatment purposeful and hopeful because it accepted that patients were essentially curable.

On the other hand, many psychiatrists, either by choice or due to the nature and location of their employment, followed the mantra that 'Prevention is better than Cure' and worked mainly by filtering out for evacuation and Base duties, soldiers perceived to be incurable. These psychiatrists evacuated from the front line not only men who had become psychiatric patients but men who they predicted would become so in the future; men who scored low in IQ tests, made a nuisance of themselves or who were diagnosed as having a psychopathic personality.

In order to decide which men would go on to be efficient soldiers and which would not, these psychiatrists invariably relied on the notion of constitution or predisposition. Neither the term 'constitution' nor the term 'predisposition' implied a necessarily biological or genetic approach and were often used by psychiatrists who favoured a psychoanalytic approach. These terms merely implied a belief that the cause of breakdown in most

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[363] T.F. Main, (1945) 'Discussion: Forward Psychiatry in the Army', *Proceedings of the Royal Society of Medicine,* 39, pp. 140-41.

patients lay in the past, buried in their fundamental personality and intelligence. While psychiatrists tended to agree that intelligence was genetically determined, many thought that personalities were formed as a result of early childhood influences. In order to assess the soldiers' constitutions, psychiatrists looked to the men's pasts and 'inherent' qualities; the soldiers' IQ scores, medical and psychiatric history, work record, childhood fears and behaviours were all scrutinised for evidence of a long-term constitutional problem. Importantly, no psychiatrists believed that *all* soldiers who experienced psychiatric breakdown were constitutionally inadequate (although perhaps inferior); the entire point of examining patients' pasts was precisely to separate those constitutionally adequate (the curables) from the constitutionally inadequate (the incurables).

The psychiatrists' aetiological approach was also influenced by whether the breakdown was thought to be justified. It was accepted that all men had their breaking point and that it was quite normal to break down under some circumstances. Men who had seen front line action, and had endured particularly harrowing situations were therefore regarded with greater sympathy than those who broke down at Base. In the former cases, no great aetiological analysis was needed, as the stress undergone by the soldiers made the cause of breakdown self-evident. In contrast, when men broke down in situations which were held to be less stressful, elaborate aetiological explanations regarding the patient's constitution were deemed necessary. Psychiatrists varied in what they regarded as stressful circumstances so while some for example regarded the Dunkirk evacuation as not necessarily a severe stressor, others regarded motor accidents in the Army as a valid cause of breakdown. Furthermore, when there was a shortage of manpower or when the military stakes were high, the value of stressful situations was deflated and front line experience was not in itself sufficient guarantee that a patient would not be perceived as fundamentally inadequate.

Furthermore, psychiatrists who were more interested in treatment and favoured a present-centred aetiological approach tended to favour symptom-based medicine, while psychiatrists working on selection, using a constitutional approach focused more on history taking. In the former, patients were classified according to the type and intensity of their symptoms (e.g. black-outs, anxiety, memory loss) while in the latter, symptoms displayed by the patient were seen as a culmination of problems exhibited ever since the patient was born and possibly even by his family members before that. Patients were therefore classified according to the prevalence of an abnormal personal and family history.

The Middle East Force and the History of the Medical Services

The official history of the Medical Services contains one account of psychiatry overseas. This is the history of psychiatry in the Middle East Force and is based on an account written by G. W. B. James, Consultant in Psychiatry. As the senior psychiatrist in the Middle East Force James' job was to set up psychiatric services, supervise them and liase with the DMS.

The Middle East Command included Egypt, Palestine, Syria, Eritrea, Abyssinia, Libya, Cyprus and originally also Iraq and Iran. The fighting began in September 1940 when the Italians under Graziani attacked Egypt. Wavell and the 4th Indian Division stopped Graziani's advance and in December, the Western Desert Force under Richard O'Conner virtually annihilated the Italians and had by February 1941 cleared Cyrenaica (Libya), destroyed 10 Italian divisions, and captured 130,000 prisoners at the cost of less than 500 killed and 1,500 wounded. Wavell was able to eject a pro-German government that had seized power in Iraq and take Syria from the French authorities that had remained loyal to Petain's government in Vichy. Then, however, Hitler decided to help the Italians keep Libya while Churchill decided to send troops to Greece. The Italian and German troops under Rommel attacked in March 1941 and had reached

Egypt by the end of May. The British kept Tobruk (Libya) under siege. Wavell launched a counteroffensive in July 1941 that failed. He was then replaced by Auchinleck who undertook an offensive in November 1941. This succeeded and by the New Year, Rommel's forces had withdrawn to El Agheila. However, Rommel's second offensive from 21st January to the 7th July 1942 re-occupied Tobruk, capturing 30,000 British and South African troops, and drove the 8th Army back to El Alamein (Egypt). Finally, in October 1942, Montgomery who had replaced Auchinleck began a British advance, which drove the Germans and the Italians right out of Egypt and Libya to Tunisia.

The troops fighting in the Middle East before El Alamein were known to suffer from particularly low morale. According to the official medical history, the worst period for fighting was between May and July 1942.[364] In the same period, the incidence for desertion was so high that the Commander-in Chief Middle East, C.J.E. Auchinleck, recommended to the War Office the reintroduction of the death penalty.[365] In the British Army as a whole, the incidence for desertion was highest in the period between October 1940 and September 1941 (22,248 men deserted, 1.0% of the Army's total strength), followed by the period between October 1941 and September 1942 (20,834 men, 0.8%) and dropping in the period between October 1942 and September 1943 (15,824 men, 0.6%).[366]

The incidence of psychiatric casualties in the M.E.F. was estimated to have been 8.5 per thousand troops in 1940, 24 per thousand in 1941, 21.2 per thousand in 1942 and 15.2 per thousand in 1943.[367] These figures show an inverse correlation between the success of the fighting and the

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[364] F. A. E Crew, (1957) 'The Army Psychiatric Service. Middle East Force. 1940-1943' *The Army Medical Services, Campaigns, vol. II,* HMSO, p. 487. (Based on the diary of G. W. B James).
[365] R.A. Ahrenfeldt, (1958), 'Appendix B', *Psychiatry in the British Army in the Second World War,* London: Routledge & Kegan Paul, p. 272-273.
[366] Ibid p. 273.
[367] F. A. E Crew, (1957) p. 491.

incidence of psychiatric casualties; during the more successful campaigns in 1940 and 1943, psychiatric casualties were reduced.

The Consultant in Psychiatry in the Middle East, G. W. B. James had already served as a doctor in the First World War and had won the Military Cross twice. He was appointed Consultant in Psychological Medicine (Brigadier) and was sent to the Middle East in September 1940. His services were made available to the Royal Navy, the Royal Air Force and to the Dominion and Allied contingents in the Middle East Command. As a consultant, James was an adviser to his Director of Medical Services (D.M.S). All the consultants appointed to the M.E.F. formed a panel of the organisation of the D.M.S. at General Headquarters and possessed no administrative powers. When recommendations made involved administrative action, it was essential to consult with all medical and other officers involved.[368]

The psychiatric facilities in the Middle East grew in small steps. Initially James was the only psychiatrist in the Middle East but gradually more psychiatrists were sent over and more beds became available for psychiatric patients. The first psychiatric centre was instituted in 64 British General Hospital (B.G.H). in Alexandria. In October 1940, a specialist in psychiatry was attached to this hospital and he was able to carry out psychiatric first aid and early treatment. Patients from this centre, were either passed on to general hospitals in the base areas with a view to being evacuated to the Union of South Africa and from there to the U.K. or were sent to Convalescent Depots with a view to either being returned to their units or found alternative non-combatant duties.[369]

More accommodation for psychiatric patients was provided in several 'observation wards' attached to general hospitals in Tel el Kabir, Nazareth and Jerusalem. However, there were not sufficient psychiatrists to

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[368] Ibid p. 440.
[369] Ibid, p. 441.

attend the patients there. With the exception of Alexandria, psychiatric patients could be attended to by a psychiatrist only in Cairo where James operated an out-patient clinic twice a week. Although James did travel to all the hospitals that housed psychiatric patients, the majority of care was provided for by regular R.A.M.C. doctors.[370]

In the summer of 1941 two more psychiatric centres were opened, one attached to 19 B.G.H. near the Bitter Lake on the Suez Canal and the other attached to 23 B.G.H. on the plain between Jerusalem and Jaffa. These had 170 beds each. By November a 600 psychiatric hospital was sent to the Middle East and was established in Kantara finally accepting patients in March 1942. From 1942 onwards, the numbers of the psychiatric staff and the hospital beds available increased dramatically. By January 1944, there were 26 psychiatrists in the Middle East including 8 Area psychiatrists and 17 specialists working in hospitals. Furthermore, Malta was appointed its own Adviser in psychiatry and was no longer dependent on the Middle East Force, and three more psychiatrists were sent to the Middle East to form Selection Boards for the selection of new officers from the ranks. Psychiatrists were able to do more outpatient work (by 1943 out-patients outnumbered inpatients) and return many men to their units.

James was characteristic of psychiatrists who believed that soldier-patients could be divided into two groups: a large group who were fundamentally inadequate and useless to the Army; and a smaller group of good soldiers who had experienced enormous stress coupled with physical exhaustion and had resisted the breakdown for as long as possible. James's job, as he perceived it, was to distinguish between these two kinds of men, evacuate the former and treat the latter. This analysis pervaded James's writing on the Middle East and the official account of psychiatry overseas.

When outlining who were the soldiers who would be of no further use to the Army, the easiest group to classify were the psychotic patients.

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[370] Ibid.

Psychotic illnesses were widely regarded to be completely unrelated to wartime experiences and while it was thought that a stressful situation may occasionally trigger a psychotic episode, it was believed that those who developed psychosis would have done so eventually in civilian life as well. Psychotic symptoms affected a small minority of psychiatric patients, however in the Middle East, James decided that:

> The psychotic group, for administrative purposes and especially for evacuation purposes, was made to include cases of mental deficiency, psychopathic personality and the diagnosis temperamental instability. While this was unfortunate from the point of view of the clinician it was a practical method of dividing the casualties. The psychotic group amounted to nearly 30 per cent., a high figure of comparatively useless personnel.[371]

The psychotic group, therefore, by including mental defects, psychopaths and chronic neurotics lost its clinical meaning and became another way of distinguishing those who were of value to the Army from those who were not. James's distinction between patients who were constitutionally adequate and those who were not became enshrined into the psychotic/neurotic distinction and became part of official policy.

Furthermore, James believed that the way to assess whether a patient was constitutionally adequate or not was by investigating his personal and family history. In contrast, he seemed to have very little interest in the patients' symptoms. In the official history, James argued:

> The examination of many samples of breakdown revealed that constitutional factors were present in a great number of individuals, and it was a matter of constant surprise that so many officers and men had managed to get into the Army or other Services in the face of so many obvious danger signals in their personal and family histories. It was repeatedly found among case material that men had suffered previous breakdown of a neurotic or psychotic character in civilian life, that employment records were poor, indicating defect or instability or a mixture of both, that far too many men had been unable

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[371] Ibid, p. 495.

> to manage their lives in a social sense and had experienced financial, marital and other troubles as a chronic accompaniment to living as civilians. Childhood and adolescence were often loaded with undesirable personal traits, the most frequent being somnambulism, enuresis, anxieties and phobias, truancy at school, delinquencies of various types, broken homes and the story of having been 'under the doctor' or 'delicate as a child'.[372]

According to the official account therefore, a poor constitution was a major aetiological factor of psychiatric breakdown in the military. Furthermore, the above quote shows that commitment to a constitutional aetiology was linked to the procedure of history-taking and to history-based medicine. In fact, a poor constitution was demonstrated by a broad variety of events in the patient's history, ranging from having experienced psychotic episodes to having been unemployed, or 'delicate as a child'.

Furthermore, James wrote in the official history that over 20% of their patients showed 'a family history of 'psychotic, neurotic or social and behaviour disorders'[373] and mentioned in particular that many men had said that their fathers or uncles had broken down with shell-shock during the previous war and were still in receipt of a pension.

The main implication of the link between personal history, inadequate constitution and psychiatric breakdown was that it was possible to predict to a large extent who would break down and who would not and that a more efficient selection process would have reduced psychiatric casualties to a minimum. According to the official history:

> Admissions to psychiatric centres or hospitals showed an unduly high proportion of men who had previous psychiatric illness or who were mentally subnormal. It was the consultant's considered opinion that 40 per cent. of psychiatric casualties in the Middle East could have been foreseen by a careful psychiatric survey or even a reasonably careful medical history. Many of these patients received in psychiatric centres showed evidence of psychopathic

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[372] Ibid, p. 506.
[373] Ibid, p. 507.

traits in their previous history which would have been easily recognised if any accurate case history had been taken.[374]

During an inter-allied conference on war medicine James expressed views similar to those found in the official history. He said:

> Experience has shown me that a ruthless selection is the best way of reducing these casualties to a minimum ...The reinforcements arriving in the Middle East Force for long showed a complete absence of psychiatric screening even of a primitive kind. I remember talking to a man in the hot summer of 1941 and asking him what his chief interests had been in his childhood. He replied that he always loved skipping, knitting and talking with the girls! Yet this man, a determined homosexual, was sent halfway round the world as a representative of the armed forces of his country at a very critical period in that country's history. The first great and essential lesson of experience is the necessity for selection. There is no room in an army calling itself modern for dullards or lifelong neurotics.[375]

Dullards, lifelong neurotics, and homosexuals together with the men with psychopathic personalities and the psychotics were all categories of men who were deemed constitutionally too inadequate to be in the Army. Placed together in the psychotic group for 'administrative purposes', they were evacuated and discharged without their actual disorders ever being made explicit.

As mentioned earlier, James did not believe that psychiatric breakdown was exclusively caused by constitutional reasons and in the official history, he also discussed other factors that could precipitate breakdown such as the separation from home, the climate, battle stress and the cumulative effects of war. Even in these sections however, several references of the soldiers' personalities were made. For example, in the discussion regarding climate it was suggested that the headaches which the soldiers attributed to sun stroke were in fact hysterical and were suffered by

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[374] Ibid, p. 481.

[375] G.W.B. James, (1947) 'Inter-Allied Conference on War Medicine 1942-1945', *Neuropsychiatry,* London: Staple Press.

men who were unwilling to fight and who seized upon any somatic disorder to avoid doing so. In the discussion regarding 'battle stress', the effect of bombing was pinpointed as the commonest factor in creating breakdown, and this was followed by a discussion of the enemy's most feared weapons. While the effects of loss of sleep, lack of food and physical illness were discussed, the death of comrades was barely mentioned and the psychological effects of a 'near miss' were not discussed at all. These omissions are striking since other contemporary psychiatrists believed that the main causes of psychiatric breakdown were 'near miss' experiences and grief over the death of comrades. By not discussing such factors and focusing on more mundane issues such as food, rest and the climate, this discussion on the environmental causes of breakdown became somewhat trivialised.

James's views that that in many cases there was little point in trying to treat psychiatric casualties and that it was better to discharge them were influenced by his military situation –he was stationed at Base where opportunities for evacuation were good, and where many of his patients had not experienced battle. It is unclear however, to what extent he was guided by the views of the Director of the Medical Services and combatant officers. In James' account in the official history, he portrayed himself as fighting *against* the opinions of combatant and medical officers. In discussing so called inadequate men, James argues that:

> Experience has shown beyond all doubt that such men can influence to a grave extent the morale of the unit to which they are posted. They create problems and disturb the efficiency of others, sometimes very gravely. It is because so many officers, sometimes highly placed, fail to realise the gravity of the problems that such individuals are often posted from one unit to another in the hope that eventually one will be found in which they will become more efficient or, at any rate, less tiresome. Proper disposal is hospital care and evacuation, yet even medical officers would be found who

> regard the evacuation of dullards and psychopaths as 'soft' or even as an 'injustice'.[376]

The opinions expressed by G.W.B. James in the official history were very much in agreement with those of Lieutenant-Colonel H.B. Craigie, psychiatrist to 1 Psychiatric Centre in Suez. In his writings, Craigie also used patients' previous histories as a means of classification, and concluded that a significant proportion of the men who broke down had had a history of psychiatric breakdown, and/or personalities that were 'markedly abnormal' or were dull and backward. His articles were littered with statistics, with estimates for the proportion of the constitutionally inadequate group ranging from 21% to 79% depending on whether the men had experience of battle, were officers or men etc. Craigie, concluded that:

> A faulty personal history, a constitutional predisposition to neurosis, was the most important single factor in the causation of breakdown: if associated with a broken home life, or a faulty family history, the prognosis was so much the worse. "The qualities of a man that make him the best citizen" said Marshal Foch," are those that make him the best soldier"; and this underlies the principles of personnel and officer selection employed in the Army since 1941.[377]

Craigie also examined the role of non-constitutional factors in the causation of breakdown. Interestingly, Craigie, like James in the official history systematically played down the effects of battle stress:

> ... it was found that battle stress alone was neither the most common nor the most important cause of breakdown in forward areas, and in base areas; there was in fact no fundamental difference between the causes of breakdown in forward and in base areas. Brigadier James said very aptly—"men break down for fear of life, not of death": and indirect mental or physical stresses were

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[376] F. A. E Crew, (1957) pp. 481-482.
[377] H.B. Craigie, (1945) 'Discussion: Forward Psychiatry in the Army', *Proceedings of the Royal Society of Medicine* p. 140.

> often much more significant on their effect upon the soldier than combat itself.[378]

Furthermore, in his writings, Craigie consistently played down the importance of treatment. In fact, in the section of his article regarding treatment he began by saying 'In no field of medicine, and more particularly military medicine is the dictum "Prevention is better than cure" more applicable than in the handling and treatment of cases of psychiatric breakdown.'[379] Almost a third of this section discussed *selection* rather than treatment, and when treatment was discussed, the focus was on the treatment that ought to be provided by the regimental medical officers. Undoubtedly, Craigie did use various treatments on his patients but he was not optimistic about their role in reducing psychiatric casualties. The reduction of psychiatric casualties was the remit of the preventive methods, of mental hygiene (which he argued was more significant than physical hygiene):

> ... in the elimination of the misfits, of the chronic neurotics, and of the psychopaths lies the most direct and most hopeful method of prevention available to us. Very little can be done in an actual battle area to limit or alleviate the stresses ... or to alter the adverse environment; and, given sufficient stress and strain, *any* person *may* break down. We can, ... and we should, sift out those who are likely to break down early—the weaker brethren, those who can cause difficulties and disharmonies and perhaps even disasters out of all proportion to their numbers, and whose presence constitutes a continued if only a potential menace to the morale of the group as a whole.[380]

Nonetheless, the statistics provided by Craigie show that most of his patients did return to duty and that during a period in 1942 he returned more

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[378] Ibid, p.140.
[379] H.B. Craigie, (1944) 'Two years of military psychiatry in the Middle-East', *BMJ,* p. 108.
[380] Ibid, p. 106.

patients than during 1941, indicating perhaps that he was under more pressure to do so.[381]

Harold Palmer in Tripoli, 1943

Craigie's attitude can be compared and contrasted with that of another RAMC psychiatrist, Lieutenant-Colonel Harold Palmer. Palmer was the Area Psychiatrist in Tripoli. He was considered to be a very able psychiatrist and had received ample praise from the Consultant in Psychiatry J.R. Rees when the latter visited the unit.[382] The Adjutant-General, himself referred to this unit as an example of the achievements psychiatrists were capable, when able to administer treatment to patients as quickly as possible.[383] The grounds of all this praise were Palmer's results. Palmer reported that he was able to return 93% of men back to full duty within a month and 98% within two months. Although only 30% returned to full battle duty, but these were nonetheless successful results.

The military pressures on Palmer were much more intense from those on James and Craigie. As Tripoli was situated 1300 miles from the base in Alexandria, land evacuation of casualties was out of the question and hospital ship facilities were extremely limited. It was therefore imperative to reduce evacuation of cases to an absolute minimum.[384]

In contrast to Craigie, James and the official history, Harold Palmer, emphasised the role of enemy action in breakdown. In the aetiology section

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[381] In a series of 350 cases of neurosis between Jul to Dec 1941, 71.5% were returned to duty (53.7% to full, 17.8% to base duties). In the period April to June, 1942, 625 neurotic and 216 psychotic cases were discharged from the hospital: of the former group 92% were returned to duty (61% to full, 31% to base duties); of the latter 70% were returned to duty (48% to full, 22% to base duties). According to Craigie, follow-up suggested that not more than 5 or 6% of cases required readmission. (Ibid, p.109). It is unclear whether "full duty" actually means "battle duty" but this is unlikely. Palmer, for example, in his statistics gives very different figures for battle duty and full duty, see below.

[382] J. R. Rees, (1943) *Report by Consulting Psychiatrist to the Army on a visit to the overseas forces in Gibraltar, North Africa and Middle East.* p.12.,CMAC, GC 135 B1.

[383] R. F. Adam, (1943) *The Health of the Army,* London: The War Office, p.5, CMAC, RAMC 466/38.

of his article, he stated that: 'Enemy action provokes breakdown much more often than does the most intense physical discomfort'.[385] Although Palmer agreed with James and Craigie that there was a constitutional element in the breakdown, the language he used was considerably more moderate. Palmer wrote: 'Most of these men have a hereditary constitutional predisposition to breakdown, with a history of previous minor neurotic traits and of emotional trauma in early life; hence they may be classified as insecure persons who have always been dependent on their families'.[386] He then went on to say 'The most common precipitating cause is the real or imagined "near miss"; the most common contributory factor is the death of a close comrade or platoon officer.'[387] Significantly, the aetiology section of Palmer's article was much shorter than Craigie's. Overall, Palmer focused a lot more on how to treat patients than on discussing what caused their breakdown.

There were other differences between Palmer and the psychiatrists discussed previously, most notably in the categorisation of the patients and the focus on treatment. Palmer did not make any calculation regarding the percentage of men who had a history of personal or family mental illness. Furthermore, he did not classify patients according to the standard clinical nomenclature, which would have resulted in an implicit aetiological categorisation (mental defect, psychosis, psychopathic personality, psychosis and chronic neurosis are all clinical diagnoses which imply an overwhelming constitutional element, aetiologically). Instead, Palmer classified patients according to two criteria: firstly whether the patient had a high or low morale and secondly whether he responded to stress with anxiety or dissociation. Men were judged to be genuinely sick if their

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[384] R.F. Barbour, (1943).
[385] H. A. Palmer, (1945), 'Military Psychiatric Casualties, experience with 12,000 cases' *Lancet,* ii, p. 454.
[386] Ibid, p. 454.
[387] Ibid, p. 454.

symptoms did not abate once they found themselves in a secure environment.

For Palmer, the division of patients in to those with high morale (35% of the total) and those with low morale (65% of the total) was really a division of those who cannot continue fighting and those who simply refuse to continue fighting. According to Palmer, men with low morale reported sick fairly early on, before they were really sick. Because they were demoralised, these men accepted the role of the invalid easily, and because they were not really sick, their symptoms disappeared once they were taken away from stressful situations. The predominant symptom of these men was 'an unwillingness to fight'. Palmer named the syndromes under this category *'Simple "Wind up" or Loss of Grip', '"Wind up" with Signs of Mild Anxiety: Scare', '"Wind up" associated with Vague Features of Dissociation: False Blackout', 'Simple Motor and Sensory Hysteria'* and collectively termed them 'Panic Reactions' to contrast them with the 'Anguish Reactions' of men of high morale, who reported sick because they suffered unbearable mental pain.

Palmer was interested in treatment, to the extent that he developed his own version of abreaction by using ether.[388] Although from some informal statistics regarding treatment it appears that a large minority of Palmer's patients received no treatment besides rest,[389] Palmer was keen to provide treatment for everyone if for no other reason but 'to give the patients the idea of something being done for them'.[390]

So why did Palmer's aetiological account and psychiatric practice differ from that found in the History and in the writings of James and Craigie? Firstly, Palmer was situated much closer to the front than either James or Craigie and was under pressure to evacuate as few patients as

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[388] R.F. Barbour, (1943); H. Palmer, (1948) 'Recent Technique of Physical Treatment and Its Results', *Modern Trends in Psychological Medicine,* (ed) N.G. Harris London: Butterworth.
[389] R.F. Barbour, (1943).

possible. The majority of his patients (although by no means all of them) had some experience of enemy action, which rendered their breakdown morally justified. Being in some danger himself, Palmer may have had more sympathy with the soldiers' fears and was therefore less likely to emphasise any constitutional element in their breakdown. By choosing to focus on low morale as a major aetiological factor, Palmer to some extent, exonerated individual patients, as soldiers and particularly the men, were not held personally responsible for their own morale.[391]

Secondly, Palmer differed from James and Craigie by his emphasis on treatment. The absence of a constitutional aetiological focus in Palmer's work went hand in hand with a belief that the vast majority of the patients were essentially curable (as shown by the fact that he discharged 98% of his patients as eligible for full duty) which in turn was associated with Palmer's interest and focus on treatment. Although no direction in causality between these different aspects of Palmer's psychiatric ideology and practice can be shown, it can be said that for psychiatrists to believe that a treatment is potent they must first believe that the patients are essentially curable, and such patients are by definition patients who are not constitutionally fundamentally damaged.

Palmer perceived the soldiers' incapacity to fight in mainly psychological rather than medical terms. He perceived his role in relation to his men to be to *persuade* those with low morale to return, and cure those genuinely sick to enable them to return. An essential part of persuading patients to return to the front was to constantly remind them of their military role and duty. Palmer wrote that in his ward 'the patient was not allowed to forget that he was a soldier and not a half trained civilian.'[392]

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[390] Ibid.

[391] On the other hand, the historian Ben Shephard, (2000) describes Palmer as a tough hard-liner and has quoted psychiatrists S. MacKeith and R.S. Morton, as saying that they were "wary of his [Palmer's] 'rather dramatic, very simplistic ideas' and the way he talked about 'cowardice.'" p. 217.

[392] R. F. Barbour, (1943).

One of the core elements of treatment was to convince patients that 'something was being done for them'. For example, the hospital ward was constructed on the model of the factory production line so as to give patients a sense of progress:

> At the near end of the ward new arrivals were kept as far as possible on the leftside and patients completing treatment on the right hand side. Throughout treatment every attempt was made to give the patients the idea of something being done for them and this progression round the ward—admission (left hand side)—treatment (lower end)—recovery (right)—was definitely helpful.[393]

Besides medical treatment, other persuasive methods were used:

> Every form of psychotherapy was used, persuasion, suggestion, re-education, analysis. On occasion a man might be "dressed down" in public, but at the same time another man would be singled out for praise and encouragement. Only the psychiatrist was permitted to use the more aggressive forms of persuasion, but in certain cases, it undoubtedly had the desired effect.[394]

For Palmer, an essential element of the patient's treatment was an induced breakdown from which the patient would rise repentant having been converted to Palmer's way of thinking: i.e. knowing that he must return to his military duties. The following description of the typical patient's experience through the wards shows that Palmer perceived his role, not so much as that of doctor but as that of a preacher who condemned the sinners who gave up their duty and rewarded those willing to resume it:

> ... he [the patient] is ushered into the office, not in the manner of a patient visiting a doctor, but in the manner of a soldier parading before his Commanding Officer. ... The interview commences with a quiet sympathetic examination, but the atmosphere gradually alters, so that by means of question and answer, the patient is left in some doubt as to whether his present absence from the front line is consistent with his duty as a soldier. He is told that he can be

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[393] Ibid, p. 2.
[394] Ibid p. 2.

cured and warned that no terms can be made with his responsibility to his comrades. He is then subjected to the Ether technique, his Amnesia recovered, an emotional Catharsis induced, and strong suggestion exhibited regarding his symptoms. ... Following the Narcosis regime 48 hours convalescence is allowed. During this phase the Sister's personality has ample scope,[395] following which the patient receives his final interview with the Psychiatrist. *The Psychiatrist's interview can only be compared at this stage to the methods of the successful Salvation Army Evangelist in which the sinner is first knocked sideways and then exalted to repentance, finally being admitted to the group to be saved.* Once this stage of grace has been induced he is fit for rehabilitation and is received into the arms of an understanding but soldierly N.C.O. at the rehabilitation centre whose job it is to prevent backsliding and recultivate a soldierly bearing, discipline, self-respect and pride.[396]

Prior to the process of repentance and forgiveness inherent in the final psychiatric interview, patients were expected to break down. During the emotional peak of the abreaction Palmer stopped the administration of ether and tried to get the patient to break down in tears:

> I invariably attempt to induce tears at this point, using if necessary the most intensely maudlin suggestion. With my military material I never had any doubt that it was the induction of this emotional catharsis which was a condition of the cure, and I have seen patients who fought the onset of tears retain their symptoms pending a second interview when, their resistance being broken down, tears were obtained and a remission of symptoms occurred.[397]

Treatment itself could also include an element of corporal punishment as for example, in the abreaction of psychotic patients:

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[395] Apparently the 'Sister was particularly successful with those "Agin the Government", [sic] men who were "fed up to the back teeth". H. Palmer, (1943) quoted by R. F. Barbour, (1943) p. 2.

[396] Ibid p.3. My italics. The description in the last few lines resemble the descriptions found in Sargant's monograph *The Battle for the Mind* regarding the process of brainwashing and religious conversion which he also compared to psychiatric treatment.

[397] H. Palmer, (1948),'Recent Technique of Physical Treatment and its Results' in N. G. Harris, *Modern Trends in Psychological Medicine,* London: Butterworth &Co, p. 242. This approach can be contrasted to that William Sargant, who required that the patient become stunned during the emotional peak of the abreaction. William Sargant will be discussed in more detail in chapter 5.

> It has often been asserted that Warfare produces no increase in Psychosis ... I am in no doubt that certain cases of depression I have seen, even allowing for constitutional factors, were precipitated by Battle experience.[398] ... These patients suddenly become terrified and are subject to intense visual hallucinations. They are acutely paranoid and feel that every enemy gun is trained upon them and may develop ideas of reference towards their own comrades. They proceed to run amok and are often extremely violent. The condition often subsides without interference, failing which they should be subjected to the Ether Technique, which rapidly reactivates all the features of the acute phase. At the height of this re-enacted fantasy, Ether is stopped and the patient smartly brought back to reality by vigorous face slapping. He will probably remain in a dazed state for a few minutes, and should be then given a twenty-four hour's Narcosis Regime.[399]

Alternatively, many psychiatrists who were engaged with selection rather than treatment were more likely to classify patients according to their constitution and their history rather than their symptoms. Major MacDonald, for example, who was the forward psychiatrist in the Eighth Army and was responsible for deciding who should be sent back to the front and who should be sent further back to Palmer for treatment, used such a classification. MacDonald's figures show that he classified patients into six distinct categories according to their history of previous psychiatric and non-psychiatric treatment in both civilian and military life.[400] So unlike Palmer, MacDonald, who examined soldiers with experience of battle and was himself very close to the front, classified patients according to what he believed was their constitutional abnormality.

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[398] Here Palmer again diverges from mainstream psychiatrists to adopt a battle-centred aetiological approach.
[399] R. F. Barbour, (1943) pp. 10-11.
[400] Ibid, 'Appendix H: Analysis Of Disposal Of Cases Seen By Forward Psychiatrist With Eighth Army, 16 March-13 May 43'.

American Psychiatrists in Algiers, 1943

The American psychiatrists Roy Grinker and John Spiegel were based in Algiers, and like Palmer, they treated psychiatric casualties within a few days of their breakdown (casualties from the Tunisian Campaign were air-lifted to Algiers). Because Grinker and Spiegel were Americans, they were under considerably less pressure to minimise manpower wastage. Consequently, although Grinker and Spiegel recommended approximately 70% to selective non–combatant service, they recommended less than 2 per cent of men to the front line.[401]

Grinker and Spiegel shared a similar aetiological approach to Palmer. Although they classified patients according to the standard clinical nomenclature, they did not use the terms 'psychopathic personality, 'chronic neurotic' or 'mental defect', which imply a fundamental constitutional problem. Like Palmer, Grinker and Spiegel focused on treatment rather than on selection and they developed an abreactive treatment using Pentothal, which they named narcosynthesis. Similarly to Palmer, Grinker and Spiegel accepted that "constitutional factors and the individual's life history are very important" aetiological factors in war neurosis but also argued that "many observers have given these factors undue weight"[402] and that "the most compelling etiological factors are psychological. Continued threat of injury and death, and repeated narrow escapes produce a cumulative effect".[403]

Furthermore, Grinker and Spiegel did not give credence to statistics reporting that psychiatric patients were very likely to have pathological personal and family histories. They argued that:

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[401] R. Grinker & J. Spiegel, (1943) *War Neuroses in North Africa, the Tunisian Campaign,* CMAC, GC135/B.2 (file 2 of 4) p.163. This volume was published by Josiah Macy Jr. Foundation, New York.
[402] Ibid, p.102.
[403] Ibid, p.100.

> After the last war it was written that 65 per cent of patients with war neuroses had a personal or family history of nervousness while only 45 per cent of non-neurotics gave such a history. We are not satisfied that the history of past neuroses can be evaluated fairly. Men who develop war neuroses have their attention directed to nervousness and "remember" more of similar events in their past than more normal soldiers unconcerned with the problem at the moment. The latter have a tendency to deny all previous anxieties or phobias. Their pasts are too healthy to be true.[404]

Instead, Grinker and Spiegel hypothesised that having a history of anxiety may be beneficial to soldiers and provide an insulating effect from the anxiety of warfare. They wrote: "Anxiety is nothing new to these people; they have always had it, and know how to deal with it."[405]

Like Palmer, Grinker and Spiegel also played on the patients' feelings of guilt in order to get them to return to duty. In contrast to Palmer however, Grinker and Spiegel believed that the vast majority of their patients were genuinely very sick. Although they believed that their treatment was very effective in restoring men to normality, they did not believe that men who had broken down were, in the majority of cases, able to return to the front.

Consequently, Grinker and Spiegel used techniques, which although very similar to Palmer's, sought the opposite result. In the majority of cases, Grinker and Spiegel aimed to appease their patients' feelings of guilt. In doing so, they provided themselves as role models of useful non-combatant personnel with whom the patients should identify with if they were to overcome their crippling sense of guilt.

To begin with, Grinker and Spiegel encouraged patients to stop identifying with their comrades:

> ... it is the task of the therapist to attack, at the earliest possible moment, the super-ego itself at its most salient points; the identification with the ideal of the former combat outfit. So long as

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[404] Ibid, p. 95.
[405] Ibid, p. 97.

> the super-ego maintains its identification with the spirit of friends on the battlefield both dead and alive, it will remain angry and demanding.[406]

Ginker and Spiegel then encouraged patients to identify with non-combatant personnel such as themselves:

> The unreasonable demands of the outraged super-ego must be combated by the therapist whose task is to substitute a new identificator. This task is made easier through the already growing transference identification with the Medical Officer, who is himself a member of the large group of non-combatant personnel with which the patient must identify himself in the future. The patient is repeatedly told that a useful and important job awaits him as soon as he is well enough to be reclassified. ... The Medical Officer tells the patient that he has nothing to be ashamed of; that he has actually "stuck by his guns" as long as possible, which is all that duty could require of him.[407]

Lastly, Grinker and Spiegel were able to treat patients in such a way because they did not suspect the patients' motives. Unlike other psychiatrists, who believed that patients became sick consciously or unconsciously in order to avoid combat, Grinker and Spiegel felt that patients stood to loose from their neuroses:

> Commanding officers, medical officers and even psychiatrists consider that the illness is developed in order to avoid combat duties ... These same psychiatrists attempt to make the hospital environment more disagreeable than battle experiences and devise a wide range of punishing methods.
> Patients with severe anxiety states have no "gain" from their illness but instead a loss. They suffer considerably more from their anxiety than from their fears on the battle field and anxieties are continuous night and day not subsiding at the end of a battle ...
> We believe that no neurotic consciously becomes ill to gain freedom from combat, but whatever gain arises is unconscious and consists of a satisfaction of a passive dependent state to which the patient has regressed by virtue of his neurotic process. Punishment

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[406] Ibid, p.185.
[407] Ibid, pp. 187-188.

> serves only to increase his internal resentments, hasten and increase his regressions to still more dependent status.[408]

The comparison between Palmer and Grinker and Spiegel demonstrates how military requirements altered clinical practice. Palmer was under pressure to return as many patients as possible to their units so he did –Grinker and Spiegel did not have that pressure so they returned considerably fewer men. On the other hand, all these psychiatrists had an interest in developing new treatments and were dealing mostly with men who had battle experience –so they followed aetiological explanations that focused on the experiences of war rather than constitutional inferiority.

Italy, 1944

Early in February 1943, Rommel's forces retreated to Tunisia. By the following summer, the Allies, including Montgomery's Eighth Army, had captured Tunisia and had begun the invasion of Sicily. On the 25th July 1943, Mussolini fell from power and Eisenhower was authorised to invade mainland Italy. By June 1944, the Anglo-American Fifth Army entered Rome and by August 1944, allied troops invaded Marseilles.

The Adviser in Psychiatry in Italy was Lieutenant-Colonel Stephen MacKeith. Like James, he also established a 3-tier system of evacuation where treatment was provided at a Corps Exhaustion Centre, an Advanced Rehabilitation Centre and at an Advanced Base Psychiatric Centre. If a soldier had not recovered after treatment at all these levels, he was sent to base and then evacuated to the United Kingdom. Overall, the morale of the British troops was reported to be high and MacKeith argued that psychiatric cases were milder than had been in the Middle East and North

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[408] Ibid, p. 127

Africa due to the speed with which casualties received psychiatric treatment.[409]

Psychiatrists in these therapeutic centres practised a range of treatments particularly sedation and some abreaction, but also selection – choosing which patients were to be evacuated and which were to be sent back to the front. One psychiatrist, who was under enormous pressure to reduce wastage from psychiatric casualties but who responded differently to this pressure than Harold Palmer, was the corps psychiatrist H.D. Hunter, the senior psychiatrist of the Eighth Army. Hunter felt under particular pressure to maintain men in a fighting position as it was felt that at this stage all non-combat jobs were already being done by personnel who were unsuitable for combat –i.e. it was no longer possible for downgraded men to free up fit men for a combat role. In August 1944, Hunter wrote:

> We are now entering the last phase of the war in Europe. The value of downgraded soldiers is thus much less than it was. The manpower problem remains acute. It is therefore essential that we get the last ounce that every man is capable of giving before we discard him as a fighting soldier. The wastage from psychiatric casualties can, and must, be diminished.[410]

Hunter felt that his job was primarily to stop soldiers becoming psychiatric casualties. He was successful in this as only 10% of patients were sent back to the UK and 30% were returned to combatant duty –these results were almost as good as those achieved by Palmer.[411] However, unlike Palmer, Hunter did not concentrate on treatment but on selecting who should be withdrawn from the front-line. Hunter classified patients into five types which ranged from soldiers who suffered from simple exhaustion and soldiers who had broken down either due to a very

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[409] S.A. MacKeith (1946) 'Lasting Lessons of Overseas Military Psychiatry', *Journal of Mental Science,* 92, pp. 542-550.
[410] H.D. Hunter, (1944) 'Eighth Army Memorandum No.1, (Ref.Hdh/110/8/44), Psychiatric Casualties in Battle', GC135, B1 (File 4 of 4).

traumatic experience or due to an accumulation of trauma from a number of campaigns (such men were dubbed 'the willing horse') to soldiers who were either chronic neurotics or persons with inadequate personalities. According to Hunter, those who should be evacuated quickly were the soldiers who were likely to return soon –curable patients. The others, who were constitutionally inadequate, should not be evacuated until they broke down completely:

> In psychiatry, almost everything depends on the basic personality of the patient. Thus one can afford to evacuate a good man early, knowing that he will return to the unit with high morale, having clearly benefited from rest and treatment. The poorest human material is like a cheap car, which must be run to the limit and then discarded.
>
> The psychiatrist cannot make good fighting men out of inadequate individuals. These should be sent back only when no further useful service can be obtained from them, or when they become a positive embarrassment to the Unit. In general there is a tendency for the poor stuff to be evacuated too soon, and the willing horse too late.[412]

Hunter made therefore a constitutional distinction between different types of patients, on the basis of which, he analysed the benefits of treatment.

Hunter wrote this report towards the end of the war when as he pointed out the shortage of men was acute. In these situations, men with ample combat experience also came to be viewed as inadequate men; their breakdown was no longer justified by their front-line experience. They were described in similarly unflattering ways as the men who broke down upon arrival to the Middle East were described by James and Craigie:

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[411] H.D. Hunter, (1946) 'The work of a corps psychiatrist in the Italian campaign', *Journal of the Royal Army Medical Corps,* 86, pp. 127-130.p.127.
[412] H.D. Hunter, (1944).

> These men have never been much good either at school, in civil life, or in the Army. They may be discarded colloquially as "wet fish", and have sometimes been labelled "Men of Poor Moral Fibre". ... They are often very selfish individuals. When sent into action they commonly vanish at an early stage in the fight, to reappear from nowhere, looking very busy, as soon as the danger is over. They show a compassionate longing to assist a wounded man on his journey to the RAP, and even beyond it. They are to be found on multitude of mysterious and unnecessary errands. Or else they dig a deep slit-trench with commendable rapidity, and stay in it till the battle is finished, never firing their weapons lest they attract unkind retaliation. Some of them spend years in the Infantry without firing a shot. When shells fall near, they panic.[413]

Hunter concentrated on selection rather than treatment and his description of what treatment befits such inadequate men is clearly disciplinary:

> 'Hysterical' screaming and jibbering can often be stopped at once by means of a sharp command, a gallon or two of cold water, or the abrupt application of the flat of the hand to the side of the face. These are to be regarded purely as common-sense forms of first-aid.
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> There is no treatment for "Poor Moral Fibre" beyond such rough and ready measures as can be administered on the spot. Detention is accepted as a rest cure. A firm insistence on the proper performance of duties in the line, reinforced by whatever sanction ingenuity can devise, is always salutory, both to the individual and to others.[414]

These men were defined as incurable because the source of their breakdown was not seen to lie in the conditions of warfare but imbedded within their personality.

Ultimately, Hunter was able to withdraw from clinical practice altogether and focus instead on what he termed the 'positive' side of psychiatry: prevention. Key to this was a positive relationship with combatant officers. Hunter visited combatant units both when they were

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[413] Ibid.
[414] Ibid.

active and during rest periods and advised combatant and medical officers on how to handle their men. His advice, he claimed, was asked on a variety of issues including compassionate leave, disciplinary problems and rehabilitation. Keen to be a true member of the military, Hunter appeared to have much preferred this aspect of his work than the clinical practice.

A number of other front-line psychiatrists chose to focus on preventive aspects of psychiatry. Those who focused on selection as a way of increasing military inefficiency were inevitably disappointed by the quality of the average soldier. For example, the Divisional psychiatrist A.A. Martin, who practised in Burma in 1945 sought to rectify the problems of a battalion by interviewing and administering intelligence tests to the NCOs. He found that that the majority were of low intelligence, were "lacking in confidence and had poor personalities of neurotic type almost completely lacking in the qualities of leadership".[415] After testing some of the men, he was appalled by what he considered the constitutional inferiority and particularly the low intelligence of front line soldiers. In his report, he wrote: "Some of the material removed at this time was appallingly bad, and it was a constant source of wonder to me that the Bn. had previously been able to carry such a large number of dull and backward men, and still conduct itself favourably in action during the previous campaign."[416]

Providing some contrast with the aforementioned psychiatrists were two Corps psychiatrists Major F.P. Haldane, and Capt. J.L. Rowley who were working at the Corps Exhaustion Centre in Italy. Their role was also to select patients –they interviewed psychiatric patients very close to the front and chose who had to be returned to the front and who should be sent further back for treatment and/or evacuation. Like Palmer, Haldane and

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[415] A.A. Martin, (1945)'Psychiatric Report', CMAC, RAMC 1900 18/1.
[416] Ibid, (1945).

Rowley did not regard the majority of the men they saw as sick or neurotic. They wrote:

> Many lists of clinical types have been published. We have no wish to add to these. We merely wish to observe that these often tend to suggest a lack of the sense of proportion. They often fail to make it clear that the great bulk of these men are not ill with a neurosis at all. They may be said to have had their "anxiety threshold" lowered –a recurrence of the anxiety reaction facilitated. They may be said to be men whose initial "anxiety threshold" was not high. They may be said to be men whose "anxiety tolerance" is low. But "low anxiety threshold" and "low anxiety tolerance" are not neuroses. … They are simply men who have been very badly frightened, and are, in fact, too incapacitated by fear to be capable of effective action under fire. But their fear is appropriate to the conditions in which it arises. It is not in the narrow sense pathological. Some Psychiatrists talk about a "phobia of shells". This sounds to us like a bad joke, on a par with saying that a man is allergic to bullets.[417]

When it came to selecting which men should be returned to the front, Haldane and Rowley, also sought to ascertain constitutional differences between the men. Haldane and Rowley belonged to the psychoanalytic school and so the quality they looked for was 'strength of ego', which they argued, was formed in the early years of a child's life. A strong ego, they argued, was the same quality other psychiatrists referred to as having 'guts':

> Some Service Psychiatrists talk openly of "guts"; others covertly think about them. While deploring the emotional and subjective attitude implied in the use of the term "gutlessness", we have to admit that the reality to which this appellation refers is the central problem in the type of psychiatric casualty under discussion. This, in fact, is the condition, the degree of which has to be estimated at the psychiatric interview at the Exhaustion Centre. The condition is not, however, a legitimate target for sweeping and harsh abuse. Obviously it is simply a condition with which we have all for long

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[417] F.P. Haldane & J.L. Rowley, (1944) 'The Principles and Functions of the Psychiatric Interview at the Corps Exhaustion Centre' CMAC, GC135 B1 (file 4 of 4) p.1. (It was later published in the *Lancet,* 1946, ii, pp. 599-601).

been familiar—weakness of the ego...[418]

The most significant thing about Haldane and Rowley however is that in contrast to the aforementioned psychiatrists, they completely rejected the technique of history-taking as a way of selecting their patients. They rallied:

> ... Must we simply, with our tongues in our cheeks, settle down to filling pro-formas with symbols and point-ratings on "family-history", "Background", "Civil Adaptation" and so forth, and cynically hand on our patients, duly ticketed and docketed in a quite worthless manner, to our baffled colleagues at the next level? We trust not.[419]

Haldane and Rowley chose instead to let each patient talk for 15 minutes (which was all the time that was available for each examination) on a subject that was likely to bring about an affective response from the patient. The majority of soldiers talked either of their last battle experience or of their families. Based on their intuitive reaction to each patient, Haldane and Rowley decided who would be able to return to the front after four or five days rest or who needed to be evacuated further back for more treatment. The large majority of the patients Haldane and Rowley interviewed were evacuated further back for more treatment.[420]

It is difficult to know why Haldane and Rowley rejected history-taking but they were certainly an exception. When Haldane and Rowley published their views they received a scathing review from Hunter, who was the senior psychiatrist in the Eighth Army. Hunter defended the 'historical approach' and berated Haldane and Rowley for assuming that their colleagues 'do not know what they are about' and concluded that

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[418] Ibid, p.2.
[419] Ibid, p.3.
[420] F.P. Haldane & J.L. Rowley, (1944) Psychiatry At The Corps Exhaustion Centre. A technique of Rapid Psychiatric Assessment', CMAC, GC135 B1 (file 4 of 4).

'seldom has a useful contribution been presented so deplorably garnished with garbage'.[421]

Conclusion

The aim of this chapter has been to explore the different clinical practices in theatres of war and examine how these were influenced by different military circumstances such as the pressure to retain or remove men, and the patients' battle experience. Such circumstances influenced the psychiatrists' commitment to particular aetiological explanations, as did the psychiatrists' enthusiasm for developing new therapies and their affiliations to particular psychiatric schools.

Overall it has been argued that psychiatrists who developed treatments of their own, like Harold Palmer, R. Grinker and J. Spiegel, tended to emphasise morale, battle stress and other psychological aetiological explanations to breakdown, although they recognised that the majority of their patients had some constitutional inadequacies. However, the patients who were treated by Palmer, Grinker and Spiegel were all front-line personnel whose breakdown was perceived as justified. In conjunction, such factors influenced and promoted each other: the belief that patients were not fundamentally damaged was aided by the psychiatrists' situation of treating patients whose breakdown was justified by their front-line experiences; meanwhile the presence of curable patients encouraged psychiatrists to develop new treatments.

Most importantly, Palmer, Grinker and Spiegel did not divide their patients into constitutional categories; Palmer classified patients according to their morale and their symptoms while Grinker and Spiegel used standard clinical nomenclature but without using the terms that implied fundamental constitutional inferiority (mentally defective, psychopath, chronic neurotic).

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[421] H.D. Hunter, (1944) 'Scrutinising the Ego' CMAC, GC135 B1 (file 4 of 4).

The main contrast between Palmer and Grinker and Spiegel was that while Palmer regarded the majority of his patients as demoralised men who were not sick and who could be returned to duty, Grinker and Spiegel thought that the majority of their patients would never be able to fight again. Palmer perceived his role to be to persuade men to return to the front, while Grinker and Spiegel concentrated their effort on reassuring their patients that they need not feel guilty about not returning to the front and that there were other useful jobs for them to do. This difference between Palmer, and Grinker and Spiegel may have been partly based on ideology but it was undoubtedly facilitated by their practical circumstances; Palmer was under much greater pressure to return men to the front than were Grinker and Spiegel.

In contrast with Palmer, Grinker and Spiegel, some psychiatrists either by choice or by circumstance spent their resources in selecting men rather than in treating them. These psychiatrists generally professed that 'Prevention is better than Cure' and classified patients by both the standard clinical nomenclature (making full use of terms which conveyed a constitutional inferiority) and by a further classification according to the patients' history of previous treatment and adjustment. This classification served to segregate soldiers who were thought to be constitutionally too damaged to be of any use to the Army from the men who were thought of as fundamentally normal and curable. Although some psychiatrists who favoured a constitutional aetiological approach, such as G.W.B. James and H.B. Craigie, were stationed a long way from the front and treated many men whose breakdowns had not been legitimised by experiences of battle, (which may have encouraged their notion of a constitutional predisposition to breakdown) these views were also shared by front-line psychiatrists. Major MacDonald, H.D. Hunter, and A.A. Martin all had experience of front-line troops but they nonetheless favoured the constitutional aetiological model with regard to at least some of their patients. MacDonald

classified patients primarily according to their history of previous illness. Hunter divided patients according to five personality types that included men who were either chronic neurotic or had inadequate personalities, whom he compared to a 'cheap car, which must be run to the limit and then discarded'. Martin was appalled at the number of dull and backward soldiers his battalion had carried. It has been argued that the process of selecting men encouraged a constitutional aetiological model because in making a prognosis psychiatrists had to distinguish between men who were essentially normal and curable and men who were essentially abnormal and incurable. In most cases, this prognosis was reached through the process of history–taking.

The psychiatrists Haldane and Rowley had a different approach. They too looked for a constitutional difference between men (for the characteristic, which they said other psychiatrists called 'gutlessness', but which they called weakness of the ego). They argued that history-taking was an inadequate way of assessing this, and instead they allowed patients to talk freely to them and then made an intuitive decision. Their approach however, was strongly criticised by Hunter.

Finally, some psychiatrists including Tom Main recognised that psychiatrists working overseas had difficulty in being objective, and were influenced in their judgement by feelings of fear, guilt, frustration and anger. The way with which psychiatrists resolved aetiological issues was related to these feelings, for in resolving what caused a breakdown, psychiatrists could pinpoint who or what was to blame for the psychiatric casualties. With the passing of each patient for whom a constitutional aetiological explanation was found, psychiatrists became convinced that breakdown was a question of inherent weakness. When low morale, poor leadership, an inadequate diet or the absence of mail were used aetiologically, the blame was placed on inadequate military logistics and training. However, when aetiology was seen to be inherent within the

horrors of battle, the grief over dead comrades and the separation from loved ones, then the blame for psychiatric casualties lay firmly within the *nature* of warfare. This meant that psychiatric casualties were *not* preventable. Most psychiatrists faced with the task of being useful to the Army, shied away from such an explanation and sought to place blame with the inadequate personalities of the soldiers and the inadequate logistics and training of the Army.

Chapter 6: Northfield Military Hospital 1942-1945

Introduction

> The legend of Northfield is one of those myths of creation. Everyone who works in group psychotherapy, the therapeutic community, art therapy, therapeutic social clubs or a number of other related fields knows where their origins were. Northfield Military Hospital in the early 1940s was populated by Olympian psychiatrists and psychotherapists. We can treasure this fabled past, and know we are the descendants of gods.[422]

As the above quote shows, Northfield Hospital was the one psychiatric innovation that ensured that the Second World War came to be seen as a turning point in the history of psychiatry. Of course, only therapists interested in social treatments have invested Northfield and the Second World War with such significance; for the more medically/physically minded Northfield was an irrelevance on the eve of the pharmaceutical age of the 1950s. For social therapists however, Northfield Hospital marks the beginning of a new psychiatry which was free from the medical paradigm and which took its therapeutic value not from drugs and other medical interventions but from the study of social relationships. Therapy in Northfield was strongly based on principles such as empowerment, democracy, honesty, openness and social interaction. But the most significant values espoused in Northfield were those with particular relevance in wartime: personal and social responsibility and the greater importance of the group over the individual.

Northfield Hospital is the most written about aspect of military psychiatry in the Second World War. All the main participants have written accounts of their time there, and in 2000, the psychiatrist Tom Harrison

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[422] B. Hinshelwood, (2000) 'Foreword' in T. Harrison (2000), *Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front*, London: Jessica Kingsley, p.7.

wrote a book-length comprehensive account.[423] As a result, it is not necessary to describe Northfield in full detail; however, it is hoped that in retelling the story emphasis will be placed on the proper context and the result will be less progressivist and more historical than in previous accounts. Precisely because histories of Northfield to date are written either by the protagonists themselves or those whose who work in the same clinical tradition, it is important to write a more critical account in which the participants' rhetoric is recognised to be just that. In the following chapter emphasis will be placed on the same themes that have been discussed in previous chapters: the relationship between psychiatrists and the military, the nature of the psychiatric treatment and the methods of selecting patients for this treatment, the psychiatrists' focus and classification of patients and the psychiatrists' attitude towards patients with a low IQ. In addition, an attempt will be made to sketch out the ideology of the Northfield psychiatrists which will include, as well as the above, their attitudes towards the responsibility of the individual to society. Finally, some of the tensions arising between staff will be discussed.

The Setting

Prior to the Second World War, Northfield Hospital in Birmingham had been known as Holymoor mental hospital, and as such it had functioned since the late nineteenth century. At the onset of the war, its patients were transferred to other psychiatric hospitals and it was converted to an Emergency Medical Service hospital intended for use by the local civilian population. It was then requested by the War Office and on the 1st of April 1942, it became Northfield Military Hospital. According to much of the secondary literature Northfield was specifically created to improve the rate of return to the front line –it was felt that patients in military

[423] T. Harrison, (2000).

hospitals would do better than the patients in civilian E.M.S hospitals.[424] Furthermore, according to one account, psychiatrists in Northfield were specifically "invited to try out new forms of treatment" in order to increase the rate of casualties returned to military duties.[425] It is clear that Northfield was intended to cater specifically for men of whom there was a reasonable expectation of recovery. The patients who were sent to Northfield, had been selected prior to admission as the men most likely to return to active service.[426]

The hospital, with an official capacity of 800 beds was split into two. The first wing, of two hundred beds was used for treatment and was for patients who were ostensibly sick; the other 600 beds were in the 'training wing' where men were rehabilitated. The idea was that men would be initially admitted into the medical wing, progress to the training wing and then return to the Army.

The nature of the training wing with its paramilitary nature was been inspired from an experiment carried out by the psychiatrist John Rickman at Wharncliff hospital.[427] There, Rickman had introduced paramilitary occupational therapy to substitute the more feminising occupational therapy traditionally found in mental hospitals which tended to be centred around arts and crafts: basket and rug making, painting, embroidery etc. This paramilitary occupational therapy was available to all the patients and that in itself was a cause for disagreement. In particular, the psychiatrist

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[424] This is frequently referred to in the secondary literature for example W. Holden, (2000) *Shellshock*, London: Channel4 books, pp.118-119 but it has not been possible to find a reference to it in War Office records.

[425] H. Bridger, (1990) 'The Discovery of the therapeutic Community,' *The Social Engagement of Social Science, A Tavistock Anthology Vol. I: The Socio-Psychological Perspective,* (eds) E. Trist & H. Murray, London: Free Association Books. Unfortunately, historical accounts written by psychotherapists are rarely adequately referenced so it is unclear where this information comes from.

[426] R. Ahrenfeldt, (1958) *Psychiatry in the British Army in the Second World War*, London: Routledge & Kegan Paul. p.150; T. Harrison (2000), p.155

[427] This experiment is thought to have originated from a memorandum written by W. Bion for his analyst J. Rickman. However, the memorandum has never been found. See

Eliot Slater (see chapter 4) visited Wharncliff where he had admired the scheme, yet had written a rather critical report of it:

> The method has a specific value only in a proportion of cases, principally in those whose return to military duties is expected and desired. ...
> The method would seem to be best applied as a form of convalescent treatment to men of good personality and good prognosis. It would not appear to have many advantages as a method of general application to all cases. Results would probably be even better than at present if only those cases were treated where there was good hope of return to military duties. The method is one of building up morale and is accordingly susceptible to unfavourable influences from unsuitable neurotic cases that inevitably require invaliding.[428]

In response, Rickman wrote to Slater to say that the report had been unfair. Slater acknowledged he had been harsh and disclosed that he was preparing to copy the scheme in Sutton. In Sutton however, the scheme would be open to selected cases only and Slater would be personally responsible for the selection; a job which he said would suit him temperamentally.[429] By contrast, in Northfield (following from Wharncliffe), the dominant view was that treatment was for everyone. This was part of the ideology that made Northfield distinct from contemporary psychiatric establishments. Nonetheless, even in Northfield some patients were excluded from some treatment and these exceptions will be discussed later.

From the start, the staff in Northfield were psychiatrists of good repute who were interested in advancing new treatments. A good deal of physical therapy went on: mainly ECT, continuous narcosis and modified insulin therapy, although there has been some suggestion that leucotomies

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W. Bion, (1961) *Experiences in Groups* London: Tavistock Publications, p. 83 (footnote);

[428] E. Slater, (1941) 'Report on visit to Wharncliff emergency hospital, 13th and 14th January 1941', Archives of the British Psycho-Analytic Society, CRR/F16/09.

were also carried out.[430] Drugs were used both as sedatives and as relaxants during abreaction. In addition, a variety of psychological methods were used including hypnosis, psychotherapy and occupational therapy. While Tom Harrision has found that in subsequent interviews with Northfield patients the most common perception was that there was no treatment,[431] Northfield was from the start (relative to the standards of the time) therapeutically active and innovative. Even excluding the main protagonists of what came to be known as the Northfield experiments, the other psychiatrists were on the whole men and women who viewed their patients with respect and with optimism; they believed that on the whole it was possible to cure patients and make them useful members of society once again. Among these psychiatrists was Joshua Bierer who had been, prior to working in Northfield, the first person to experiment with group therapies. While working in a mental hospital, Bierer had experimented with the creation of a social club that was radically different. As he put it: "Entertainments for patients are arranged in all modern hospitals. The basis of the social club is just the opposite: nothing is arranged for the patients but everything is arranged and governed by them".[432] The purpose of the social club was to empower patients but also to help them accept responsibility:

> ... we forget that when patients are admitted to a mental hospital they are stripped of all their responsibilities, deprived of all independent action, and are in no way self-governing –in fact, they are made into "tools". The social club should be the first important

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[429] E. Slater, (7/3/41) Letter to John Rickman, Archives of the British Psycho-Analytic Society, CRR/F16/12

[430] The author and ex Northfield patient Rayner Happenstall wrote an autobiographical novel in which the narrator recalls how in his time in Northfield, another patient taken away for an operation and subsequently died. The narrator concludes that the operation must have been a leucotomy. Harrison, however, has argued that there is no definite evidence that leucotomies were ever performed at Northfield. T. Harrison (2000), p. 141; R. Happenstall, (1953) *The lesser infortune,* London: Jonathan Cape.

[431] T. Harrison, (2000), p.173.

[432] J. Bierrer, (1942) 'Group Psychotherapy' *BMJ,* 1, p. 215.

> step towards making the patient change his position from that of being an *object* to being a *subject*.... Patients in mental hospitals become independent, active, and "self-deciding" which helps a great deal in speeding up their cure.[433]

Also significant was the didactic form of group therapy instituted in Northfield by D. Blair.[434] Acting originally for the purpose of saving time Blair made two changes in his normal routine: Firstly he encouraged patients to write a history of their lives "with special reference to any events which may have affected their mental welfare"[435]. This served the purpose of saving time that would have been spent on eliciting information, but according to Blair provided relief for patients who were thus able to unburden themselves. Secondly, Blair designed a 10-lecture course in which he educated the patients on biology and psychology in order to help them understand their symptoms: lectures were conducted on topics ranging from anatomy, sex and the instincts to how mental conflicts may arise, an understanding of fear and the relationship between the body and the mind. Blair noted that to his surprise most patients were able to understand the lectures and as a result develop an insight into their own disorders.

The main protagonists of the Northfield experiments are usually identified as the psychiatrists John Rickman, Wilfred Bion, Sigmund Foulkes, Tom Main and the non-psychiatrist Harold Bridger. Tom Harrison has elaborated on the influences of the thinking of these men, particularly the former three, and has noted that they shared an interest in psychoanalysis and a perception of groups as positive rather than negative influences. Rickman and Bion had personal experience of putting groups to good use in their work in selecting officers from leaderless groups (see

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[433] J. Bierrer, (1942) pp. 215-216.
[434] D. Blair, (1943) 'Group Psychotherapy for war neuroses', *The Lancet*, 1, pp.204-205.
[435] D. Blair, (1943) p. 204. Blair however makes it clear that there were "certain obvious exceptions" from whom he didn't ask such biographies such as "low-grade mental defectives".

chapter three). Bion, Foulkes and especially Rickman were influenced by Melanie Klein (Rickman was in analysis with Klein prior to the war) Ronald Fairbairn and object relations theory.[436] Furthermore, Rickman had for some years been writing about the implications of psychoanalytic theories on the structure of society and was interested in what types of society are more healthy, apparently favouring the British model of a democracy as a society which by virtue of permitting differentiation permits its members to mature. With regard to S.H. Foulkes, Harrison identifies some slightly different influences but which lead to the same results: the works of the neurologist Kurt Goldstein and the sociologist Norbert Elias. Foulkes as a Jewish immigrant from Germany also had rather different life experiences from the other psychiatrists. According to de Mare, Foulkes was influenced by the Frankfurt School as the Institute of Social Research in which they worked was housed in the same building as the institute of psychoanalysis in which Foulkes was working.[437] Furthermore, Foulkes had experience of group psychotherapy long before he started working in Northfield; his first group sessions took place in Exeter in 1939 where he worked with Eve Lewis. Foulkes and Main were also influenced by American psychotherapists such as Trigant Burrow, Louis Wender, S.R. Slavson, P. Schilder and L.J. Moreno.[438] In general, it seems fair to say that the Northfield participants were familiar with the various notions of group psychotherapy in both small and large groups and of the idea of using the environment as a form of treatment. The most explicit theoretical acknowledgment made by the participants was to Kurt Lewin and his social fields theory which was described later by the Northfield psychotherapist Patrick de Mare as a "Gestalt quasi-Marxist

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[436] T. Harrison, (2000) pp.50-51.

[437] It is possible that de Mare who at the time described himself as a communist exaggerated this influence. De Mare also said that Foulkes used to tell him that "he had not yet analysed a communist whose political stance was not based on some form of neurotic conflict." P. De Mare (1983) 'Michael Foulkes and the Northfield Experiment,' *The evolution of group analysis* ed. M. Pines, London: Routledge & Kegan Paul.

approach"[439]. The significance of Lewin's field theory lies in its optimism; it implies that by changing the social fields, i.e. the environment to one that is beneficial and encouraging, one can achieve a lasting effect on patients.

The First Northfield experiment

The 'First Northfield experiment' came to be known as such in the 1970s[440] when it became established as the precursor of what was originally known as the Northfield experiment (and then later, as the Second Northfield experiment). It took place when the psychiatrist Wilfred Bion was posted as CO of the Training Wing at Northfield in the autumn of 1942 after having worked in the War Office to establish the War Office Selection Boards for the selection of officers and in particular the leaderless groups. Our knowledge of it arises from two articles published by Bion in 1943 and 1946 during which time it was referred to as an experiment only by Bion and Rickman. The discussion of the first Northfield experiment which will follow here arises from an analysis of these two articles.

The purpose of the articles was threeforld: Firstly Bion redefined military psychiatry, arguing against the hitherto accepted exemplar of civilian general medicine. For Bion, the aim of military psychiatry was to unite failed and demoralised soldiers into a unit capable of combat – therefore his role model for this task was not the civilian doctor but the combatant officer. This demonstrates the commitment he felt to the war effort which led to his willingness to supplant traditional medical values which focused on the patient's welfare for the superlative value of maintaining military strength and manpower. Secondly, Bion and to a lesser extent Rickman suggested a new psychiatric rationale –cure from

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[438] T. Harrison,(2000) pp. 58-64.
[439] P. De Mare, (1985) 'Major Bion', *Bion and Group psychotherapy,* M. Pines (ed), London: Routledge & Kegan Paul, p. 112.
[440] The first written reference to the first Northfield experiment that I have been able to find is by Tom Main, (1977) 'The concept of the therapeutic community: variations and viscissitudes', *Group Analysis,* 10, pp. 2-10.

neurosis could be achieved through a process of re-socialising the neurotic patient and that this results from getting patients to examine themselves, and their relationships with others critically. Finally, the articles were a vehicle for Bion and Rickman to proclaim their fury with the authorities who six weeks into their experiment had removed them from Northfield, ostensibly because they were unable to maintain military discipline –the very thing they had been trying to foster.

The first of these points is the most salient and explicitly stated: Bion lamented the way Northfield was run when he first started working there because it was not fulfilling the aims of military psychiatry as he saw them. Furthermore, for those in the know, Bion pointed out why it was that his perspective was different from the run of the mill psychiatrists –he had combatant experience from the First World War where he had served as an officer in the Tank Corps and had been awarded the Distinguished Service Order. He described Northfield as follows:

> An observer with combatant experience could not be help being struck by the great gulf that yawned between the life led by patients in a psychiatric hospital, even when supposed to be ready for discharge, and the military life from which their breakdown had released them. Time and again treatment appears to be, in the broadest sense, sedative; sedative for doctors and patients alike. Occupational therapy meant helping keep the patients occupied – usually on a kindergarten level. ... a few [patients], usually the most spectacular, were dosed with hypnotics. Sometimes a critic might be forgiven for wondering whether these were intended to enable the doctor to sleep ...[441]

In addition, Bion identified as a key problem for psychiatry's lack of success: the identification between mental and physical illness. This flew completely against the direction of the majority of psychiatric thinking which held that psychiatry could only achieve results when it became fully integrated into general medicine, mental patients were treated in general

hospitals, and the stigma associated with mental illness had been explained away by the fact that mental illness was a disease like any other[442]. In contrast, Bion argued:

> Unfortunately ... psychiatry has already accepted the doubtful analogy of physical maladies and treatments as if they were in fact similar to neurotic disorders. The apparatus of the psychiatric hospital, huge buildings, doctors, nurses and the rest, together provide a magnificent smoke screen into which therapists and patients alike disappear when it becomes evident that someone may want to know what social function is being fulfilled, in the economy of a nation at war, by this aggregate of individuals.[443]

According to Bion what was required was:

> The presence of an officer who... know[s] what it is to be in a responsible position at a time when responsibility means having to face issues of life and death. He must know what it is to exercise authority in circumstances that make his fellows unable to accept his authority except in so far as he seems able to sustain it. He must know what it is to live in close emotional relationship with his fellow men. In short, he must know the sort of life that is led by a combatant officer.[444]

Bion also claimed that this experience was necessary in order for the psychiatrist to understand that men must be returned to their units as willing, responsible adults who accept their military duty. And it was the same moral framework of accepting one's duty that would protect

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[441] W.R. Bion, (1946) 'The leaderless Group Project', *Bulletin of the Menninger Clinic,* Vol. 10. No.3. p. 78.

[442] For example, the Mental Treatment Act 1930, which was widely held to have brought huge benefits by permitting voluntary treatment was based on the notion that "that there is no clear line of demarcation between mental illness and physical illness" and that therefore treatment for mental illness must, where ever possible, be informal, readily available and not constrained by the delays and legalities of the process of certification. *Report of the Royal Commission on Lunacy and Mental Disorder* (HMSO, 1926, Cmd.2700) p.15.

[443] W.R. Bion, (1946) pp. 78-79.

[444] W.R. Bion & J. Rickman, (1943), 'Intra-group tensions in therapy, their study as the task of the group', *The Lancet,* ii, p. 678.

psychiatrists from feelings of guilt for playing a non-combatant role while returning other men into action.

> A psychiatrist who knows this will at least be spared the hideous blunder of thinking that patients are potential cannon-fodder, to be returned as such to their units. *He will realise that it is his task to produce self-respecting men socially adjusted to the community and therefore willing to accept its responsibilities whether in peace or war.* Only thus he will be free from deep feelings of guilt which effectually stultify any efforts he may otherwise make towards treatment.[445]

In this passage, Bion made a crucial link between self-respect and social adjustment on the one hand and willingness to accept responsibility (in this context the responsibility of active combat) on the other. This was at the crux of his approach which perceived unwillingness to fight in the war as a neurotic symptom. Using the ongoing metaphor of a battalion in action, Bion argued, that the training wing required a common enemy and that in their situation the enemy was neurosis. Patients needed to see that 'neurotic behaviour adds to the difficulties of the community, destroying happiness and efficiency.' In particular, 'Communal distress' should be shown to be a 'neurotic by-product' so that 'neurosis itself would be seen to be worthy of communal study and attack.'[446] The underlying difficulty that Bion faced, and was certainly aware of, was that the exact opposite could be argued: neurosis was in fact very useful because it kept both patients and doctors out of harms way. However, Bion felt this was not an honourable position and that once the patients realised this was their motivation for being ill they would willingly give it up.

Neither Bion nor Rickman gave many details as to the nature of their experiment. Initially, it seems that Bion reduced regulations so that the neurotic behaviour of the patients would become evident. Secondly, he introduced compulsory group meetings: one daily meeting for the entire

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[445] W.R. Bion & J. Rickman, (1943) p. 678. My italics.

unit, and other activity group meetings of which soldiers had to attend at least one and were expected to form their own if none of the offered activities were suitable. One such activity group had the job of mapping out the programme of all the groups and their activities; in this way the expansion of activities was documented and provided a guide for the morale of the hospital. However, while the number of groups and activities constantly expanded Bion suggested to the patients that very little genuine activity was taking place as most patients did not in fact join in any of the activities and that this was hypocritical considering the patients most common complaint against the army had been the 'eyewash'.[447] According to Bion, after this, the training unit became self-critical. When some men complained that the wards were getting dirty, they organised a group who would keep the wards clean. Some men continued to complain that only 20% of the men were working hard, while the other 80% were shirkers. Instead of solving this problem, Bion suggested that this was a problem not just with the hospital but with society at large and asked the patients to come up with solutions themselves. According to Bion gradually the morale of the unit improved and even though patients were constantly changing the good conditions remained. Gradually the groups began to operate well and military offences were reduced. In typically self-aggrandising language Bion concluded that: "The atmosphere was not unlike that seen in a unit of an army under the command of a general in whom they have confidence, even though they cannot know his plans".[448]

These articles were radically different from most other contemporary articles describing military psychiatry. Bion did not discuss any of the common themes found in such articles: the medical histories of the patients, their symptoms and military experience, or the cause of their neurosis. His entire emphasis was instead on his relationship with the

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[446] Ibid, p. 678.
[447] Ibid, p. 679.

patients and his success at making them self-critical and raising their morale. Furthermore, the treatment, as described, included everyone and was present in everything the patients did.

John Rickman also described the group therapy he instituted in his ward of 14-16 patients. Group therapy consisted of having a group discussion every morning from which patients could raise issues that they discussed privately with the psychiatrist in the afternoon. As described by Rickman the main theme in the discussion was "their personal difficulties in putting the welfare of the group in the first place during their membership of the group" summarised by Rickman as "the social implications of personality problems".[449] Again, this section is free from any discussion of the patients' histories, intelligence or symptoms and focused entirely on treatment. The decision as to who gets treatment was made entirely by social rather than clinical criteria; treatment was limited to those in the ward; just like Bion's mode of therapy was limited to patients residing in the training unit. The essence of treatment was learning to cope with putting the welfare of society before that of the individual –and its natural conclusion was the patient's acceptance that he must become a soldier again.

Finally, Bion used the 1946 article to point out that his dismissal from Northfield had been a tragedy in which he had behaved heroically. He drew a parallel between himself trying to stop a retreat into illness and a combatant officer trying to stop an actual retreat. About the latter he said:

> His prominence at such a time will certainly mean that he will be shot at by the enemy; in extreme cases he may even be shot at by his own side. Outside Nazi Germany psychiatrists are not likely to be shot for doing their jobs, though of course they can be removed from their posts. Any psychiatrist who attempts to make groups study their own tensions, as a therapeutic occupation, is in today's

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[448] Ibid, p. 680.
[449] Ibid, p. 680.

> conditions stopping a retreat and may as well be shot at. But he will lose some of his feelings of guilt.[450]

Bion's rhetoric about the heroic part played by the First Northfield experiment in which he was effectively shot by his own side has succeeded in giving those six weeks at Northfield an unprecedented status in the history of social therapy.

The purpose of the first Northfield experiment was to increase the number of patients who were rehabilitated and returned to combat service. Bion's central criticism of Northfield had been that prior to his arrival the hospital was run far too much like a general hospital and not enough like a combatant unit. So considering that his aims were explicitly pro-military, why had he been sacked by the military? The most commonly cited explanation is that the hospital military staff could not put up with the chaos caused by the lack of discipline during the initial stages of Bion's experiment. Patrick de Mare, a psychiatrist on the Northfield staff wrote in the 1980s that Bion's radical approach "produced a cultural clash with hospital military authorities. The fear that Rickman's and Bion's approach would lead to anarchy and chaos occasioned War Office officials to pay a lightning visit at night. The chaos in the hospital cinema hall, with newspaper—and condom—strewn floors, resulted in the immediate termination of the project."[451] However, it can be argued that it was not so much a culture clash between Bion and military authorities that resulted in his dismissal, but a clash between him and the other psychiatrists – furthermore, in practice, the distinction between military and psychiatric staff is nonsensical since all the psychiatrists involved held military rank. Tom Main later argued that the problems started when Bion quarrelled with his commanding officer who was responsible for liasing between the

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[450] W.R. Bion, (1946) p. 81.
[451] P. de Mare, (1985) cited in Bridger, (1990) p.73

professional and administrative staff.[452] The commanding officer was also a psychiatrist and he too was sacked only a few weeks after Bion and Rickman. The decision to remove these psychiatrists was taken in all probability by psychiatrists in the Directorate of Army Psychiatry, which having been formed on the same day as Northfield was responsible for psychiatric personnel. In practice therefore, it appears that it was not a conflict of cultures between the military and psychiatry, but a conflict between psychiatrists that led to the ending of the first Northfield experiment.

The non-psychiatrist Harold Bridger has offered another explanation for Bion's sacking, which suggested instead that Bion's approach was far too pro-military for the other psychiatrists to bear. According to Bridger, Bion had caused a drift between himself and the other psychiatrist because he was *too* military minded and was " facing ... the hospital professional staff with the responsibility for distinguishing between their existence and purpose as a military organization and their individual beliefs that in the majority of cases health entailed a return to civilian life".[453] In other words, the staff resented Bion because he discouraged the invaliding of patients and enforced an attitude that returning men to the front was the doctors' primary duty.

The Second Northfield Experiment

After Bion and Rickman were dismissed, the hospital is reported to have stagnated. This picture has to some extent been compounded by the portrait of Northfield drawn in the autobiographical novel by Rayner Happenstall, an ex-Northfield patient. However, experimental therapeutic work was going on in the hospital, such as that described earlier by Blair

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[452] T. Main, (1983) 'The concept of the therapeutic community: variations and viscissitudes', *The evolution of group analysis* ed. M. Pines, London: Routledge & Kegan Paul, p. 205.
[453] H. Bridger, (1990) p.73.

and then later in the form of the group-therapy practiced by Foulkes and Bierer who arrived at the hospital in 1943. Remarkably, the hospital permitted the patients an astonishing degree of freedom of speech, which was expressed in the hospital newspaper *The Psyche.* The newspaper had a specific section entitled ruthless rhymes in which readers were invited "to give free expression to their latent sadism (thus considerably facilitating their psycho-therapeutical treatment at Hollymoor) by composing verses of this kind[454]" the editors later stating that "we will sail as close to the wind as we dare in the publishing of them."[455] One can only guess what the psychiatrist FRC Casson had to say when he read the following poem published in the first edition of *Psyche*:

> I venture to remark on passant
> that a certain young doctor named Casson
> should be left in a cove
> with his head in a stove
> and the tide coming in and the gas on.[456]

The newspaper provided anti-authority commentary on all aspects of hospital organisation and the disciplines of Psychiatry and Psychology were mocked repeatedly. On one occasion, the editors reported that the astrology section of the paper would be discontinued because "as a harmless sedative and as a cheap means of bringing comfort to the millions, astrology cannot hope to compete with behaviourist psychology".[457] The newspaper also published radical political commentary criticizing Churchill:

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[454] PP/SHF/C.3/25 *Psyche* 1, May 1943.
[455] PP/SHF/C.3/25 *Psyche* 4.
[456] Pat Byrne, *Psyche* 1. The fact that in 1945 Casson referred in a private letter to 'the chronic neurotics, psychopaths, and defective unstable Pioneer Corps fellows' he had encountered at Northfield may to some extent explain why patients had felt the need to write such a poem but also why Casson may have kept a grudge. F.R.C. Casson, 2.7.45, *Letter to John Rickman*, Archives of the British Psycho-Analytic Society, CRR/F20/22.

Before the war, numerous intellectuals spoke of themselves as "Good Europeans". After the war, it looks as though any Englishman whose sympathies extend beyond the tribe will have to call himself "A Good Anglo- Saxon". We wonder whether in the end Mr Churchill will settle in Washington or whether he will rule us from Whitehall as a sort of U.S. Viceroy. But perhaps the common man's distaste for American soldiery and his strong feeling for Russia will keep us attached to Europe after all...[458]

This comment became even more radical by stating that Viceroy was 'Anglo-Indian for "Gauleiter"'[459] thus drawing a parallel between the Nazi occupation of Europe and the British Empire and another parallel between the relationship between Britain and its empire and between America and Britain.

The origins of the Second Northfield experiment are difficult to pin point to a specific moment. According to Bridger, it began with his arrival at Northfield towards the end of 1944. As described by Foulkes, there was a precursor to the experiment some six months earlier created by the sense of emergency caused by the imminent opening of the Second Front. This allowed the administrative divisions in the hospitals to relax in order to facilitate therapy. This change was made possible by a change in the type of patients coming to Northfield. The initial patients had no combat experience, they were

> unwilling soldiers with long-standing difficulties; their chief preoccupation was discharge from the Service. The key to the "pearly gates" into civilian life was the patient's neurotic symptom, and as like as not if he had nothing dramatic to show when he set out from his unit for the hospital, by the time he ... had had a chance to talk to the other patients he was well equipped with

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[457] *Psyche* 1. As this is the first edition of the paper, it would seem that there was never an astrology section to be discontinued; the whole thing is a set up for the jibe.
[458] R. Happenstall, *Psyche* 1.
[459] Ibid.

> agents for promoting his civilian freedom which he would use in the battle with his psychiatrist to come.[460]

This contrasted with the patients arriving later on in the war who had had combat experience:

> Soon we were dealing with young, active soldiers who had seen battle. The staff, many of whom had not been active in the fighting, had to respect these men who were ill and exhausted. The boot was now on the other foot; the less active soldiers on the staff felt guilty and discovered a real sympathy for the patients.[461]

The difference in the type of patients took place partly because the Directorate of Army Psychiatry decided in December 1943 that patients sent to Northfield would be even more stringently selected than previously. Rather than admit patients "where it appeared probable that, after a short course of treatment, they would be fit for further military service in some capacity"[462] they now admitted only cases where "there was a high probability of return, after treatment, to high grade military duties".[463] The explanation offered for this change of policy by the Directorate of Army Psychiatry was that 'chronic neurotics with a poor constitutional background' did not generally give effective service to the Army and had subsequently to be discharged. All positions that could be economically employed by such men were already filled and therefore considering the shortage in medical manpower it was best to reserve Northfield to treat those men most likely to be of greater service.[464]

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[460] S. H. Foulkes, (1948) *Introduction to Group-Analytic Psychotherapy, Studies in the social integration of individuals and groups,* London: William Heinemann Medical Books, p.45.
[461] Ibid, pp.46-47. However, according R. Heppenstal's novel, patients with combat experience had begun arriving since 1943 when the casualties from the 8th army had been evacuated.
[462] F.A.E. Crew (ed), (1953) 'The Army Psychiatric Service' p.473.
[463] Ibid.
[464] Ibid.

Without a doubt, the appointment of Harold Bridger as CO of the training wing was crucial to the development of the Second Northfield experiment. Bridger had been a mathematics teacher prior to the war and had no experience in psychiatry, however, during the war he had worked with the Directorate for the selection of Personnel in selecting officers. When he was selected by the psychiatrist Ronald Hargreaves of the Directorate of Army Psychiatry to take over the training wing at Northfield, Bridger was someone who could be depended on to be loyal to both the military staff (of whom he was one) and to the psychiatrists. In practice, however, Bridger became treated more as an honorary psychiatrist.

Bridger's input was to follow in the line of Bion and Rickman while explicitly trying to maintain a positive relationship with all the staff – professional and administrative. He appointed himself as a Social Activities organiser, and in that role encouraged patients to take responsibility in the running of the hospital. For example, Bridger famously organised a hospital club by not organising it –after emptying a ward and naming it 'The Hospital Club' he waited until the patients organised a protest about the waste of resources involved in the empty space before telling them that it was up to them to organise it. Apparently, the hospital club was frequently smashed up, but the disorder was tolerated and it was up to the patients to put it together again. There was also an explicit education in democracy, where each ward elected representatives, who met with the other staff to make decisions for the hospitals in what were named "constituency meetings" and "house of commons meetings".

Bridger's appointment was followed by that of the psychiatrist Tom Main early in 1945. Main had previously been the psychiatric adviser to the 21st Army Group and so had plenty of experience of front-line psychiatry in the invasion of Europe. Furthermore, he had a history of meeting the military staff on equal terms, for example, when he had been called out to the Middle East to give advice on problems of morale in the Parachute

Regiment he had insisted on getting wings himself.[465] In Northfield, he supported Bridger's work but also explicitly tried to smooth relationships with the military staff in an attempt to break administrative barriers and create a *therapeutic community* –the first use of this term. Main would later describe his time in Northfield as a voyage of self discovery, where he learnt to put himself in the position of the military staff and comprehend why it was that they were unhappy with how Northfield was being run. The ultimate cause of disagreement appeared to be discipline:

> There was much indiscipline in the patients. Their psychiatrists tolerated this and excused it on grounds of illness, but my non-psychiatrist commanding officer and his non-psychiatric military staff throughout the hospital were far from content with the psychiatrists' tolerance and sought to have soldiers who got drunk or got out at night or were violent or mutinous or had untidy wards to be put on charges and sent to the orderly room. I had a difficult time with my (superior) commanding officer over such cases almost every morning. I also had a difficult time with my (inferior) officers [who thought that]... As a senior doctor I should protect the patients from the insensitive mind of the military so that my psychiatrists could get on with their important therapeutic work.[466]

This situation apparently made the military staff insecure, as they were aware that the previous commanding officer had been sacked for failing to maintain discipline. Main began to fear that he too would be sacked but chose to resolve the situation by getting the military staff more involved – not just with the psychiatrists but with the social aspects of the patients' therapy:

> In the few more months I was there military staff began to participate in examining tension systems. They slowly but increasingly joined crisis-groups and ward discussions, and now task-groups and hobby-groups with patients. It became ordinary for orderly room clerks, staff sergeants, Matron's staff, secretaries, military cooks and orderlies and night staff, yes, and sometimes

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[465] B. Shephard, (2000) p. 248.
[466] T. Main, (1983) p. 204.

my commanding officer and his adjutant, to be seen in groups alongside patients and psychiatrists. ... The military staff's grumbles and ideas and problems were given equal status to everybody else's and they themselves were seen increasingly as people working in legitimate and inescapable roles and inevitably contributing to constraints and freedoms in the whole system. They now argued and discussed with patients and others and came to recognise their own total usefulness, *People* of individual style and potential and work needs were better recognised where *Stereotypes* of the sensitive sick and the insensitive staff had tended to exist.[467]

Main did not claim that relations with the military ceased to be antagonistic altogether, but did recognise that it was essential for military psychiatrists to fit in the ethos of the army. Nonetheless, the tone he adopted when describing relations with the military staff never ceased to be that of patronising superiority. Still, the remarkable achievement of the Second Northfield experiment was the promotion of inclusiveness –this time not just meaning inclusiveness of all the patients but also of all the staff professionals and administrators alike. This was (and still is) a revolutionary premise.

S.H. Foulkes[468]

Although the Northfield experiments have been Northfield's most longstanding contribution, much of what was going on in Northfield was unrelated to the experiments. One example of this is the work of the psychiatrist Sigmund Foulkes. He was one of the most remarkable psychiatrists in Northfield but his contribution did no fit in easily with the ideology of Bion, Rickman, Bridger and Main. Fundamentally, there were two disagreements: the first related to the style of therapy and the second to attitudes towards the military and to what Main and the others called the "real life situation".

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[467] T. Main, (1983) pp. 211-212.
[468] S.H. Foulkes was also known as Michael.

With regard to therapy, Foulkes' main interest was to conduct psychotherapy in small groups without much regard for the larger environment –the hospital as a whole or the country at war. The technique he used was that the patients sat in a circle together with the therapist and had a discussion, which was not directed by the psychotherapist (the equivalent of free association in individual therapy). The idea was that this helped patients because it provided support, it allowed patients to gain insight into their own conditions by observing the same problems in others and it provided invaluable information to the psychiatrist because it permitted patients to act out their social problems. This meant that rather than the psychiatrist having to take the patient's word for how he related to others with only his own relationship with the patient as a guide he could observe the patient in genuine social interactions. This form of group therapy was backed by individual therapy; where the patients could discuss the issues arising in private.

Group therapy as instigated by Foulkes shared some attributes in common with the schemes introduced by Bion, Rickman and Bridger. Among these was the emphasis on the therapeutic effects of social groups and the emphasis on the present rather than the past. The central differences however was that patients were selected for group therapy (not everyone was regarded as suitable) and once in the group, there was no emphasis placed on the wider community. Furthermore, Foulkes's groups tended to be directed by him to a wider extent than was thought acceptable to others, although this would have been denied by Foulkes.

Unlike Bion and the others, Foulkes did not aim to work with all the patients but with ones he had selected –although admittedly selection was not vigorous. The quality of the patients was an important issue to him –as shown for example by his claim that the change in the kind of patients was a determining factor for the instigation of the Northfield experiment. Although in the above passages Foulkes attributed the change of attitude to

the other staff, his own focus on distinguishing between good and bad patients remained throughout his time in Northfield. This attitude was suppressed by the dominant ideology of Main and Bridger which did not permit such distinctions, but it remained as a distinctive feature and found resonance in other staff who shared Foulkes' perspective. For example, in the staff discussions Foulkes (and other psychiatrists) make frequent references to two types of patient. Foulkes in particular, referred to "those who have a positive aim to be ill" and "those who want to get well"[469] or "the 25% good cases and the remainder"[470]. Foulkes was happy to share power with patients but he preferred working with the very best; and when at the end of the war Foulkes had taken over from Bridger as social therapist he formed a 'co-ordination group' from the most intelligent patients to form a steering group for the hospital.

The types of patients who were generally considered unfit for group therapy were the depressed, those with low intelligence and the psychopaths. In practice, once a group was up and running, patients who did not fit in where de-selected: in the group discussions one Captain Essex said that it was a question of eliminating the people who do not 'do very well in general'.[471] The notes from the group discussions contain many tantalising hints about the nature of selection such as references to defining the 'treatable patient'[472] and to group psychotherapy being 'intensive treatment for a few' but the notes are not sufficiently clear for these themes to be pursued.[473]

While the issue of how to select patients for a group preoccupied the therapists, the main guidance given by Foulkes was to avoid large disparities in intelligence, social background and probable disposal. With regard to patients with low intelligence, Foulkes proclaimed: "A group of

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[469] S.H. Foulkes Discussions on Group therapy, 26/4/45, PP/SHF/C.3/8.
[470] Ibid, 10/5/45,
[471] Ibid, 8/8/45
[472] Ibid, 10/5/45

dullards would be very interesting but we usually leave them out."[474] And later he added: "One couldn't have the same type of conversation with an SG4 as with an SG1. ... It is much more difficult to talk to people of low intelligence."[475] On the other hand, the psychiatrist and communist Patrick de Mare said that "People who according to the tests are below average intelligence, often have deep insight." Foulkes brought up the example of a group where contrary to expectations, a patient with very low intelligence seemed not to have any difficulties coping in a group with very intelligent patients. Foulkes nonetheless concluded: "By and large we prefer fairly even levels. We would prefer an intelligent group to a stupid one."[476]

In practice, there did not appear to be a specific selection process for a group, but patients were picked out of the group if they did not appear to be fitting in. In addition, it was concluded that patient who did not fit into a group were unlikely to benefit from any other kind of treatment either.[477]

When years later, the other staff discussed Foulkes's uncomfortable relationship with the military, they gave as an example his incapacity to perform a proper military salute. It was also reported that he told patients to look upon him as they would "a doctor in a white coat and not as someone in uniform", an attitude which totally contradicted Bion's approach of getting the patients to regard themselves as members of a combatant unit.[478] Foulkes also had unrealistic expectations of the army; on one occasion when members of a particularly successful group had been released from the hospital, Foulkes wrote to request that the men not be separated. While this did prove feasible in the short-term it did question the extent to which Foulkes prepared his patients to face the real world. However, within the

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[473] Ibid, 10/5/45
[474] Ibid, 1/11/45
[475] SG stands for selection group and refers to the group a patient has been placed according to his intelligence. SG1 refers to the top 10% while SG5 to the bottom 10 %. SG4 refers to the 20% above SG5.
[476] 1/11/45
[477] For example, 8/8/45
[478] Bridger, (1990) p. 74

hospital, Foulkes had many supporters. This prompted Main in a letter to Rickman to describe Foulkes's supporters as a 'cult' of 'Foulkes-worshippers' and the outsiders as 'an out-group of emotionally reacting sceptics wondering whether christ was as phoney as he seemed.'[479]

The notes from a series of group psychotherapy sessions reveal a number of issues with regard to the patients and psychiatrists' perspective on treatment. For example, it is noted that the patients regarded group psychotherapy as a privilege and that members were keen to attend.[480] On the other hand, the psychiatrist James noted that patients resented Foulkes. In fact, the group he took when James was away on leave was poorly attended and eventually had to be dropped.[481] Patients complained about being asked personal questions by Foulkes[482] and being told what to do.[483] When during a meeting on the 5th December 1944, James announced that Foulkes would not be attending

> This was greeted with cheers. There was a very free and active discussion immediately involving all but two members of the Group (12 were present). F was thought to exert a sinister influence and there was general agreement that the atmosphere was improved when he was not present. His piercing glance was singled out particularly ...[484]

According to the notes, one patient stated that Foulkes "was Jewish and ungenerous as opposed to J" and James identified two "resistances" towards Foulkes which were suggested by the patients: firstly that "he was too clever for them" and therefore patients could not understand him and secondly that patients were frightened of his attacking them. "When you

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[479] T. Main 7/9/45, Letter to J. Rickman, Archives of the British Psycho-Analytic Society, CRR/F20/35.
[480] Saturday 4/11/44, *Group Discussions,* PP/SHF/C.3/2.
[481] Ibid, Saturday 21/10/44
[482] Ibid, 28/10/44; 04/11/44, 05/12/44.
[483] Ibid, 04/11/44
[484] Ibid, 05/12/44

begin you don't know where he'll make it lead."[485] One patient said at a private interview that he was frightened of being questioned.[486]

Further evidence that Foulkes was inadvertently guiding the discussion comes from the notes made on a group which had veered into discussing political issues:

> F. talked for a long time on individual responsibility and the evolution of society, from groups dependent on a despotic leader to self-governing groups. Subsequent interviews suggest that the point of this was not fully appreciated by the Group. Negative feelings to F. are still manifest. Mason developed a stomach ache and a stammer as he thought he would put his foot in it if he told F. what he really thought, e.g. his inability to follow the argument about social evolution. Braithwaite manifested his resistance by saying that the Government was fattening us up for the next war. King did not speak. He explained later because he could not follow the thread and what he wanted to say did not bear on F's topic. ... Randall's only interjection (that the Beveridge report is just propaganda) was discouraged by F. ... Further selection of the Group members is needed. Possibly Braithwaite should be dropped as unlikely to cooperate. J feels that he can help by taking a more prominent part and thus minimise negative feelings to F. which are a problem. ... Dye's remarks about Beveridge later proved to be defensive. He was concerned that he might be asked personal questions by F and insists that this could never happen at a Group with J alone such as he had attended prior to J's leave.[487]

The note that an uncooperative member should probably be dropped was a recurrent theme in staff discussions on group therapy. It was thus set out that the welfare of the group was more important than the welfare of the individual patient.

Conclusion

The Northfield experiments were not a success in terms of increasing the numbers of men who could return to active duty. The first experiment

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[485] Ibid, 05/12/44
[486] Ibid, 05/12/44
[487] Ibid, 28/10/44

lasted only six weeks and the second took place when the outcome of the war was already certain and there was no high demand for men who had already broken down so severely as to require evacuation to Britain. So unlike Harold Palmer's experimental work in North Africa the Northfield experiments have no dramatic statistics demonstrating their success.

Where the Northfield experiments did succeed in is in providing an alternative model of psychiatry and military psychiatry, in particular. This change affected both the methods and the aims (although not necessarily the results). The change in methods came with the refocusing of psychiatric intervention away from individuals and their histories and onto their social relationships, their wider environment in the here-and-now frame. At a time when there was extraordinary pressure on people to stand together and sacrifice themselves for the common good, these psychiatrists told their soldier-patients to do just that –and tried to support them in this by examining what was going wrong with their relationships with others and giving them practice in accepting their social responsibilities. The change in aims came with realignment with the values of the military and a separation from civilian medicine. Bion, Rickman, Bridger, Main and even Foulkes perceived psychiatry's role in the war effort to be to return men to combat and to coexist harmoniously with the military staff –there is certainly no story here of liberal psychiatrists protecting patients from the authoritarian military. However, the most truly revolutionary aspect of the psychiatric treatment at Northfield was its inclusiveness. Aside from particular exceptions, treatment was for everyone and everything was treatment. This set Northfield apart from hospitals like Sutton.

What made the Northfield experiments possible was firstly the psychiatric interest in meetings and groups which had its roots in the social psychology of the 20s and 30s but was also influenced by the war and the army's own dependence on group units. Secondly, it was a group of ambitious and dedicated psychiatrists who were willing to take big risks

with their reputation and who held fundamentally optimistic views about their patients. Thirdly, it was due to the military background which was tolerant of psychiatric self-government and which for all the psychiatrists' complaints, interfered little with how Northfield should be run. Finally, it was the patients that Northfield received. Especially selected to be the most likely to recover, they justified their doctors' optimism and hence encouraged the experimentations with democracy and self-governance.

In September 1945, Main remarked to Rickman about the 'hideously bloated reputation'[488] of Northfield. While Northfield has been a disappointment to many of its participants who have felt that its innovations have not been realised in post-war psychiatry, the reputation of Northfield itself is firmly established.

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[488]T. Main, *Letter to J. Rickman,* 7/9/45

Conclusion

This dissertation has explored the role played by British psychiatrists during the Second World War. In so doing, it has asked a number of questions such as: How important were psychiatrists to the military? How much power did psychiatrists have? Were there significant ideological differences between psychiatrists and the military? Why were the particular selection procedures in recruitment and officer selection instituted, and what were the circumstances that facilitated their use? What were the therapeutic regimes devised by psychiatrists during the Second World War and did they vary according to their military settings? To answer these questions, this dissertation has examined the history of the medical responses to trauma prior to the Second World War, the administration of psychiatry during the war at the War Office and abroad, and the development of new selection procedures and new therapeutic regimes in Britain and in the theatres of war. Evidence has been sought from a variety of primary and secondary sources: archival material including reports and correspondence from the National Archives, the Contemporary Medical Archive Centre, the Liddell Hart Centre and the Archives of the Psychoanalytic Society, articles, monographs and textbooks published by contemporary psychiatrists, the official histories of the medical services and the few current historical volumes that deal with this topic.

The research has shown that psychiatry was indeed a highly valued specialty to the military and that psychiatrists were given considerable independence and authority. The value of psychiatry was recognised in the organisation of the Army Medical Department, in which an independent directorate for psychiatry was formed, and in the organisation of the Directorate for the Selection of Personnel which although run by a regular soldier functioned according to the advice of psychologists and psychiatrists. In addition, throughout the war, the Army continued to

employ increasing numbers of psychiatrist thus permitting truly forward psychiatric treatment to take place, as well as the forward selection of personnel. Crucial to the establishment of psychiatry in such a powerful position was the patronage of the Adjutant-General Ronald Adam and his deputy F.H. Vinden, and the backing of the Director-General of the Army Medical Services Sir Alexander Hood, and the Director of Army Psychiatry H.A. Sandiford. Such support was there because these officers became convinced that psychiatrists had a valuable role to play in treating early cases and returning them to the front, evacuating unsuitable personnel, creating psychological tests that could indicate the jobs each soldier was suitable for and recognising which men would become good officers. Thus, psychiatry was used in treatment but even more so preventively –mostly in the selection of personnel, but also in advising officers in disciplinary cases and issues of morale and rehabilitation.

This wide use of psychiatrists also indicates something about the nature of the British Army as an army which relied heavily on the morale of its troops rather than on more overtly disciplinarian methods. Arguably, psychiatry gained momentum in the Second World War because psychiatrists promised to vouchsafe the troops' morale –to ensure that the soldiers were happy in their jobs and in their ranks, that they were led properly, and to minimise all the other frustrations that proved to be destructive to morale. Their most significant job was to remove individuals who suffered from low morale, and who might 'infect' others. As a result, the British Army appears to have been one in which it was not particularly difficult to get discharged –and a number of psychiatrists acknowledged that the majority of their patients were not actually sick but suffering from a loss of morale. Psychiatrists who were committed to maximising the number of men who could be returned to the front such as Harold Palmer or the Northfield psychiatrists were involved in treatments with a significant social component designed to foster morale –in the case of the

Northfield experiments this was an explicit aim while in Palmer's case it was more covert.

The fact that psychiatrists were given considerable independence can be demonstrated from the fact that psychiatrists mostly carried on their own inspections. War Office psychiatrists, particularly the consulting psychiatrist to the Army, J.R. Rees, visited a number of facilities both in the UK and abroad and wrote reports on their findings.[489] In addition, consulting psychiatrists abroad inspected the relevant treatment facilities. One non-psychiatrist who carried out inspections was the Director of Psychiatry, H.A. Sandiford but he was always sympathetic to psychiatrists and argued to increase their numbers, rank and administrative status.[490] On the one occasion where an inspection led to the sacking of psychiatrists – when Wilfred Bion and John Rickman were removed from Northfield Hospital and found alternative jobs in Personnel selection— psychiatrists from the Directorate of Army Psychiatry had probably been directly involved.

Overall, it also appears that there were few conflicts between psychiatrists and military officers or military doctors. There are some examples: the physician to the Prime Minister, H.M. Moran spoke out against psychiatry to the extent that he was described by Adam as 'the prosecutor'[491] of psychiatry and later wrote in his book that psychiatrists had been responsible for a huge waste of resources.[492] Also, when the psychiatrists John Wishart and Coleman Kenton arrived in Algiers they received a distinctly hostile welcome by the medical staff who expressed

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[489] For example, 'Report to the Director General of Army Medical Services on Tour to Malta, Paiforce, India, A.L.F.S.E.A., M.E.F. & C.M.F. By the Consulting Psychiatrist to the Army' (December, 1944 - March, 1945), CMAC, GC135/B.1 (2 of 4).
[490] For example, H.A. Sandiford, (1942) War Diary, TNA, WO165/129; H.A. Sandiford (1942) Report on Visit to 21 A.G., B.L.A By D.A.Psych. and Consulting Psychiatrist to the Army; H.A. Sandiford, (1944) Report On Visit To C.M.F. By Director of Army Psychiatry December 1 to December 23, 1944, TNA, WO32/11550
[491] R. Adam, (1942)18A 'Extract from the conclusions of the 103rd (42) Meeting of the War Cabinet held on 4th August, 1942.'TNA, WO32/11972.

very negative views about neurotic patients, suggested that the psychiatrists should pretend to the patients that they were regular doctors and imposed illegal monetary penalties on patients.[493] Nonetheless, the relationship improved and DDMS Major Cantlie told a conference in psychiatry that whereas he had initially told Wishart that "he was the most unwanted man in the corps" he quickly changed his mind. What was probably instrumental in improving the relationship was that Wishart had asked for, and was given, the opportunity to take part in an attack.[494]

On the whole, therefore, relations appeared to be positive. The psychiatrists themselves reported few conflicts with combatant officers but greater problems with administrators and medical men back at home.[495] Part of the difficulty appeared to be that there was no consistent military doctrine about what the psychiatrists should be aiming for –to return as many psychiatric casualties to front-line duties as soon as possible or to discharge men who had found it impossible to adapt to military life. Rees, suggested that the administrators who argued against "the discharge of men who were obviously too dull or too unstable to soldier" were out of touch with the pressures faced by combat units while "the fighting soldier is in no doubt at all as to the kind of man he wishes to have with him".[496] The Divisional psychiatrist P.J.R. Davis reported that COs in infantry battalions were "extremely enthusiastic" at the idea of getting rid of many men who they considered a liability rather than an asset.[497] On the other hand, psychiatrists also received praise for returning patients to full duty –the

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[492] H.M. Moran, (1946) *In My Fashion,* London: Peter Davies.
[493] 'Meeting of Allied Psychiatrists B.N.A.F. Held at 95 General Hospital June 5th 1943.', CMAC, GC135 B1 (2 of 4).
[494] Report of a Conference on Psychiatry in Forward Areas. Held At Calcutta Aug. 8-10. 1944. TNA, WO32 11550.
[495] For example, J. R. Rees, (1945) pp. 27-28.
[496] Ibid.
[497] P.J.R. Davis, (1946) 'Divisional Psychiatry. Report to the War Office', *Journal of the Royal Army Medical Corps*, 86, p. 259.

psychiatrist Harold Palmer became famous for succeeding in returning 93% of his patients to duty within one month and 98% within two months.

Psychiatrists also appeared to have made an easy adjustment from civilian medical values –where the welfare of the patient should always come first— to military medical values where the individual's welfare was subsumed within the welfare of the Army as a whole. As an example of such adaptation, the psychiatrist Tom Main (the Adviser in Psychiatry to the 21 Army Group, who later took part in the second Northfield experiment) argued that it was important to send soldiers back to the front line even if one knew that at some point they would break down again:

> With the differing functions, differing standards are needed. If a sergeant can recover his poise for one month, it can be regarded as a satisfactory therapeutic result in an Army fighting for its very life, though such a result would not be worth having in civilian life.[498]

A few psychiatrists found such re-alignment of values difficult. For example, the American psychiatrists Roy Grinker and John Spiegel who worked in Algiers recommended approximately 70% of their patients to selective non–combatant service, and less than 2 per cent of men to the front line.[499] Most of the time, they told patients "that a useful and important job awaits him as soon as he is well enough to be reclassified." ... "that he has nothing to be ashamed of; that he has actually "stuck by his guns" as long as possible, which is all that duty could require of him.[500] Other such exceptions can be found among some of the psychiatrists treating patients in the UK. For example, in Sutton, the psychiatrist

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[498] T. Main, (1945) 'Discussion: Forward Psychiatry in the Army', *Proceedings of the Royal Society of Medicine,* 39, p. 141.
[499] R. Grinker & J. Spiegel, (1943) *War Neuroses in North Africa, the Tunisian Campaign,* CMAC, GC135/B.2 (file 2 of 4) p. 163.
[500] Ibid, pp. 187-188

William Sargant reported that he and his colleagues had learnt "the folly of trying to patch up soldiers and expect them to face again the stresses that had caused their breakdown".[501] In Northfield, Bion complained that prior to his arrival, the hospital made no attempt to foster military morale but instead sheltered patients and doctors from military life.[502] On the whole however, the examples of the Northfield experiments and the psychiatrists working overseas show how keen psychiatrists were to serve the military. As the corps psychiatrist Dugmore Hunter proclaimed, it was widely felt that the psychiatrist "must indeed feel himself to be genuinely part of that Army and not an outsider, looking on".[503]

From examining the history of the medical responses to trauma, it has been shown that there is a long history of armies discharging soldiers who although not insane were unable to function in the military. From the 19th century onwards, some of these diseases such as nostalgia, and hysteria, were regarded as mental illnesses albeit with an organic component –nostalgia was psychogenic but could lead to death, while hysteria only manifested itself in persons with a hereditary taint. Others such as neurasthenia, windage, shell shock, and soldier's heart (and its various reincarnations such as Da Costa syndrome and effort syndrome) had longer careers as organic illnesses for which no organic cause could be found –otherwise known as functional illnesses. They too, however, were increasingly interpreted in psychological and psychogenic terms and provided the means for medically discharging soldiers. Since the invention of the unconscious, such disorders were re-formulated as unconscious malingering –where soldiers desiring an exit from the horrors of war, unconsciously made themselves sick in order to escape. At the same time, a

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[501] W. Sargant, (1967) *The Unquiet Mind, The Autobiography of a Physician in Psychological Medicine*, London: Heinmann, p. 117.
[502] W.R. Bion, (1946) 'The leaderless Group Project', *Bulletin of the Menninger Clinic,* Vol. 10. No.3. p. 78.
[503] D. Hunter, (1946) 'The work of a corps psychiatrist in the Italian campaign', *Journal of the Royal Army Medical Corps,* 86, p.130.

more biological, psychiatric paradigm interpreted these illnesses as signs of inherent constitutional instability as the contemporary social darwinist paradigm prescribed that war was the ultimate test of character.

Furthermore, in the early 20th century, intelligence became re-formulated as a definable, heritable and easily measurable quality. Eugenic societies across the Western world, supported by scientists, doctors, politicians, philanthropists and social activists spoke out against the dangers of an ever increasing population of mental defectives and their sub-normal yet not quite defective relatives. This 'social problem group' of people who scored at the lowest 10% of the intelligence spectrum were held responsible for the majority of crime, prostitution, alcoholism, infectious disease and social and moral deprivation. Eugenically inspired legislation to combat this threat was formulated across the Western World. In Britain, the 1913 Mental Deficiency Act was moderate compared to the far more extreme legislation taking place in the United States and in Germany. It required only that local authorities ascertain the numbers of mentally deficient persons in their catchment area and provide special segregated housing for them. In practice, many mentally deficient people continued to live in the community. Another bill for the voluntary sterilisation of the mentally deficient was defeated in 1930. However, what became established in the decades prior to the Second World War, was that intelligence was a quality of huge significance and that the lack of it was responsible for the majority of society's ills. In the Second World War, therefore, intelligence became the one trait that would be consistently measured and used to allocate soldiers to jobs. All soldiers were placed in particular intelligence groups, jobs were analysed according to the intelligence they required, and military units were given quotas of soldiers with particular intelligence to match their tasks and balance the unit. This process was thought to eliminate inefficiency and promote the well being of soldiers thus helping also to eliminate military offences, preventable

disease and psychiatric casualties. So, while the dictum formulated in the First World War that stated that given sufficient stress any man may break down was still widely held in the Second World War, psychiatric casualties were also being labelled dullards and defectives.

The introduction of mass intelligence testing in the British Army also had a meritocratic aim –to ensure that all soldiers were placed in the jobs in which they were most suited independently of their class background or personal wealth. This, it was thought, would not only make the Army more efficient, but it would also raise the morale of the troops and the people at home. In particular, the selection of officers had to be based on scientific criteria –this would raise standards and increase the numbers of men volunteering to be commissioned. While the new methods were not suppose to include any element of positive discrimination favouring the working class, they were suppose to tap into natural talent rather than educational achievement and therefore promote the most able whatever their origin.[504]

The task of designing the new methods of selecting officers was allocated by the Adjutant-General and his Deputy to psychologists and psychiatrists who had at their disposal the German methods of selection.[505] The new methods included a battery of intelligence tests, projective personality tests and tests of behaviour in groups as well as an interview with the psychiatrist. Ideally, each War Office Selection Board was to employ one psychiatrist and one psychologist. Furthermore, the responsibility of sending candidates to the Boards to be assessed, no longer

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[504] In 1942, Edward Grigg made the specific point that the intelligence tests which were used in the Army were tests of general intelligence and not educational achievement in order to counter the point made previously by the Labour MP Jack Lawson who had claimed that "candidates were being selected because they had been to secondary schools or universities". Commons Debates, 5th series, 377, 19 February 1942, pp. 1987-1990.

[505] F.H. Vinden, (1977) 'The Introduction of War Office Selection Boards in the British Army: A Personal Recollection', *War and Society, a yearbook of military history,* B. Bond & I. Roy, (eds.), London: Croom Helm.

rested only with Commanding Officers and their Unit Selection Boards but with the personnel selection officers who interviewed all new recruits and earmarked for commission those who had high intelligence, leadership qualities and combat temperament.

In terms of their meritocratic aims, the new methods appear to have failed. Figures show that approximately 25% of successful candidates were from public schools whereas around 60% were from secondary schools and 15% from Elementary Schools. More significantly, figures show that the War Office Selection Boards were *less* inclined to pass elementary school boys for commissions, than were Commanding Officers and the Unit Selection Boards. Figures from a six week period in 1942 show that the proportion of boys educated only at elementary school who were selected to attend the Boards was small (only 24%) the proportion who succeeded was even smaller –only 18% because elementary school boys had a 60% failure rate –compared to 30% for public school boys.[506] Once the system changed so that all those marked as potential officers by Personnel Selection Officers during initial recruitment were sent to War Office Selection Boards independently of their Commanding Officer's recommendation, the supply of candidates became even more socially stratified. According to the Chief Psychologist, 96% of those recommended by Personnel Selection Officers were secondary and public school boys.[507] So while the War Office Selection Boards had been formed partly to counter the problem of Commanding Officers being unable to judge men who were of a different social class to themselves[508] and according to one psychiatrist allowed the Army to shake off the charge of being class-ridden[509] in reality they probably promoted fewer working class men that

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[506] Office of the Adjutant-General (1943) 'Selection of Personnel', p.14, Liddell Hart Centre, Adam 3/4/2.
[507] B. Ungerson, (1953) p. 47, TNA, WO277/19.
[508] This claim was originally made in J. Rees, (1945) p. 64.
[509] Interview with John Bowlby cited in B. Shephard, (2000) *A War of Nerves,* London: Jonathan Cape, p. 192.

would have been promoted by the previous techniques. In all likelihood, the main reason why boys with only elementary education were so much less likely to pass the War Office Selection Boards was the introduction of intelligence tests, as these strongly favoured the better educated.

Moving on from selection to treatment, it is fair to say that, in the initial stages of the war, treatment for psychiatric casualties was piecemeal and inconsistent. The majority of casualties were treated in civilian EMS hospitals in Britain, as military hospitals were at the time only available for psychotic patients.[510] In one such hospital, Sutton, it is clear that patients were treated as if they were civilians and all but 26% were discharged from the Army.[511] Part of the reason for this high rate of discharge was that the doctors held very pessimistic views about their patients and regarded the majority as constitutional neurotics who were unlikely to ever be of use to the Army. For this reason, the majority of the patients received no treatment whilst in Sutton. While this may have been partly due to the constraints of time, space and expense, nonetheless the resources to treat certain civilian patients with radical and time-consuming treatments such as leucotomies were obtained. This shows that when it was thought that patients were likely to benefit from a treatment –because they were not constitutionally inadequate– every effort was put to making the resources available, even in war-time.

The decision about which patients to treat (approximately 40% were treated) appears to have been based on a number of factors such as the patients' symptoms (particularly weight loss and hysterical symptoms), military experience, family history, personality, intelligence and employment record. Evidence of a low sex drive and non-athletic appearance also seemed to be thought of in a negative light and make it

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[510] F.A.E. Crew (ed), (1955), 'The army psychiatric service', *The Army Medical Services, Administration, Vol. II,* London: HMSO, pp. 470-474.

[511] E. Slater, (1943) 'The Neurotic constitution, A statistical study of Two Thousand Soldiers', *The Journal of Neurology and Psychiatry,* 6, Nos 1 & 2, p.12

more likely that the patient would be regarded as a chronic neurotic. Overall, it seems that whether a patient was treated or not, depended on the extent to which his doctors thought that he was a worthwhile young man – and this meant having fulfilled a number of social obligations, including having a reasonably good career, an uninhibited sex life and to have only broken down after experiencing extreme military stress. Most of the patients did not fulfil these criteria.

In the latter part of the war –approximately 1942 onwards, soldiers fighting overseas received psychiatric treatment in hospitals or 'exhaustion centres' near the front line. The treatment they received there was generally very simple –rest, tranquillisers to aid sleep, and sometimes chemical abreaction, ECT, continuous narcosis and insulin therapy.

The psychiatrists who practiced near the theatres of war were put under considerable pressures –to treat very large numbers of patients, to return patients cured and ready for action in a short time and to discharge unsuitable personnel whom the officers regarded as a nuisance. Torn between the conflict of deciding whether to treat patients and return them or to evacuate and discharge them, psychiatrists adopted different aetiological models which focused either on the patients' constitution or on environmental stressors such as battle stress and group morale. Most of the time, psychiatrists who developed new methods of treating patients such as Harold Palmer, Roy Grinker and John Spiegel did not favour constitution as an aetiological explanation for psychiatric breakdown. Aided by the fact that they treated front-line personnel whose breakdown was perceived as justified, they accepted that their patients were to some extent predisposed to nervousness, but emphasised other causes for their breakdown such as low morale and battle stress. This approach made treatment purposeful and hopeful because it accepted that patients were essentially curable. Furthermore, Palmer, Grinker and Spiegel did not divide their patients in constitutional categories; Palmer classified patients according to their

morale and their symptoms[512] while Grinker and Spiegel used standard clinical nomenclature but without using the terms that implied fundamental constitutional inferiority such as 'mentally defective', 'psychopath', or 'chronic neurotic'.[513]

On the other hand, other psychiatrists followed the mantra that 'Prevention is better than Cure' and worked mainly by selecting soldiers perceived to be incurable. These psychiatrists evacuated from the front line not only men who had become psychiatric patients but men who they predicted would become so in the future; men who scored low in IQ tests, made a nuisance of themselves or who were diagnosed as having a psychopathic personality. They classified patients by the standard clinical nomenclature (making full use of terms which conveyed a constitutional inferiority) and by a further classification according to the patients' history of previous treatment and adjustment. This classification served to segregate soldiers who were thought to be constitutionally too damaged to be of any use to the Army from the men who were thought of as fundamentally normal and curable. Although some psychiatrists who favoured a constitutional aetiological approach, such as G.W.B. James and H.B. Craigie, were stationed a long way from the front and treated many men whose breakdowns had not been legitimised by the experience of battle, (which may have encouraged their notion of a constitutional predisposition to breakdown) these views were also shared by front-line psychiatrists. Major MacDonald, H.D. Hunter, and A.A. Martin all had experience of front-line troops but they nonetheless favoured the constitutional aetiological model with regard to at least some of their patients.

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[512] H. A. Palmer, (1945), 'Military Psychiatric Casualties, experience with 12,000 cases' *Lancet,* vol ii, pp. 454-457, 492-4.
[513] R. Grinker & J. Spiegel, (1943) *War Neuroses in North Africa, the Tunisian Campaign,* New York: Josiah Macy Jr. Foundation.

Back in Britain, service patients were increasingly more likely to be treated in military rather than civilian hospitals. One such hospital, Northfield became famous for the 'Northfield experiments' that were conducted there. The Northfield experiments, although not a success in terms of increasing the numbers of men who could return to active duty succeeded in providing an alternative model of psychiatry and military psychiatry in particular, which affected both its methods and its aims (although not necessarily its results). The change in methods came with the refocusing of psychiatric intervention away from individuals and their histories and onto their social relationships, their wider environment in the here-and-now frame. At a time when there was extraordinary pressure on people to come together and sacrifice themselves for the common good, these psychiatrists told their soldier-patients to do just that –and tried to support them in this by examining what was going wrong with their relationships with others and giving them practice in accepting their social responsibilities. This development was coupled with a realignment of values away from civilian medicine and towards the values of the military. The Northfield men Wilfred Bion, John Rickman, Harold Bridger, Tom Main and even Michael Foulkes came to the conclusion that their role was to return men to combat and to coexist harmoniously with the military staff. However, one of the most truly revolutionary aspects of the psychiatric treatment at Northfield was its inclusiveness. Aside from particular exceptions, treatment was for everyone and everything was treatment. This set Northfield apart from hospitals like Sutton.

A lot more research is needed to explore how the military came to evaluate the part played by psychiatry in the Second World War and how that impacted on British military psychiatry after the war. Unlike the shellshock disaster of the First World War which lead to the Southborough enquiry, the expert committee which was set up to investigate the role of psychiatry in the Services during the Second World War exonerated

psychiatrists and psychologists[514]. However, the two subsequent enquiries by Crocker and by Ritchie were considerably more critical. Yet, even though they both suggested a curbing of psychiatric authority in matters of officer selection in the post-war era they did not unduly criticise the part which had been played by military psychiatry during the war. Nonetheless, the enquiries resulted in a diminished role for psychiatrists who thereby ceased to be members of the interview panels that selected officers. However, psychiatrists, psychologists and their methods continued to play a big role in the military. Many of the techniques used in the Second World War such as the intelligence testing and leaderless group tests have since become incorporated in occupational psychology and form part of the selection techniques of the current British Army as well as numerous business firms. The end of conscription changed the needs of selection – while the Army no longer had to deal with persons who were regarded as unsuitable to military life because of their intelligence scores or personalities, it also had to try harder to attract suitable personnel. The nature of preventive psychiatry also changed as greater emphasis began to be placed in early treatment and in ameliorating the circumstances of soldiers –short terms of duty, frequent leave, and de-briefing.

Since the Second World War, the British Army has not had to deal with conscripted men or, since 1962, with National Service men. It is therefore unclear whether in a real national emergency it would deal with the issues of selection differently from the Second World War. The Americans in Vietnam decided to forego the elaborate selection techniques of the Second World War and significantly lower IQ requirements. Instead, the psychiatric focus was placed on rapid psychiatric treatment.[515] This change suggests a re-interpretation of war neurosis with the emphasis aetiologically being placed on the stresses of war rather than the

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[514] *Report of an Expert Committee on the work of psychologists and psychiatrists in the services,* (1947) London: HMSO.

constitution of the individual. Post-Traumatic Stress Disorder, born from the Vietnam War further established this shift as PTSD emphatically places the onus for the disorder on trauma, rather than on the patient's constitution. Furthermore, PTSD places the suffering endured by servicemen at a distance from mental illnesses such as depression and anxiety –although these are frequently symptomatic of PTSD but do not carry the same exonerating aetiological explanations.

Ironically, at the end of the twentieth century, the military was faced with a new illness –Gulf War Syndrome, which carrying on from the tradition of shell-shock has been fought over by those who regard it as a new organic disorder and those who think of it is a new manifestation of war neurosis. Since the stigma attached to anything approaching a mental illness is still intact, this debate has very real consequences for the dignity of those involved, as well as for the surrounding issues regarding pension rights and treatment.

A new study exploring how British military psychiatry has dealt with the challenges of the last sixty years and how these have impacted on the role and status of psychiatrists as well as the treatment of psychiatric casualties is greatly needed.

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[515] B. Shephard, (2000).

Appendix: The Northfield Patients

Among the archives from Northfield Hospital that can be found in the Contemporary Medicine Archives Centre of the Wellcome Trust there are twenty questionnaires which were completed by service patients in the first few days after their arrival to the hospital. These questionnaires are among the papers of German-born Jewish psychiatrist Sigmund H. Fuchs, and bear his stamp, which indicates that they were probably designed and collected by him. It is unclear whether the questionnaires in the archives are the only completed ones or the only surviving ones, and if they were kept for any particular purpose. However, questionnaires 7-14 (according to the order they were found in the archives) belong to patients who were put together in a therapeutic group along with another patient. It is possible that the other patients whose questionnaires have been kept were also allocated to particular therapeutic groups as for example, patients 1-6 and 15-18 have surnames beginning with the letter M which may also have served as a means of randomly allocating patients into therapeutic groups. There is no clear evidence for any other common link between the questionnaires that would justify their particular safekeeping, besides that they are mostly complete, well written, and very interesting and moving.

These completed questionnaires offer a unique insight into how soldier-patients perceived the experience of breaking down. They show how they viewed themselves and their illness, what symptoms they suffered from, and the causes to which they attributed their illness. Furthermore, they show the attitudes they had towards the army and the war and their concerns for their family and for the future.

Interestingly, while other historians have had access to these records and have clearly looked at them, they have not chosen to focus on them, relying instead mainly on medical records and later-day interviews with ex-

patients which focus on the treatment these patients received.[516] The reason for this is probably that these historians were more interested in revealing information about Northfield Hospital itself and its therapeutic environment rather than about the private stories of individual patients. The view taken here, however, is that these records are important not simply because of what they reveal about Northfield hospital and its doctors (which is a significant amount) but because of what they reveal about the experience of being a soldier who has become a psychiatric patient. The men's experience of breakdown, their interpretations of it, their feelings towards their family, their fears for the future, and their disillusionment with the army and the war are all shown revealingly in the men's responses to the questionnaires.

The questionnaires are four pages long and consist of two parts. In the first part various short question are asked of the patient such as whether any member of his family suffered from any mental complaint, whether he, himself, suffered from any mental complaint as a child, how he did at school, whether he had any friends, whether he played sports, and what educational qualifications he achieved. This is followed with questions about the patient's occupation prior to joining the Armed Forces and questions with regard to his military career, including disciplinary offences and time spent in overseas service. Then, patients are asked some fairly revealing questions about their condition. As well as being asked to describe their symptoms, they are asked. 'How has it developed?' 'Have you had any similar complaints before?' and most importantly 'To what do you think it is due?' Although only a very short space is provided for the answers, some patients described traumatic experiences in this section while others ignored these questions altogether, focusing instead on the

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[516] For example, Tom Harrison refers in his book to questionnaires but does not discuss the content, T. Harrison, (2000) *Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front*, London: Jessica Kingsley. Ben Shepherd

description of symptoms. Then, patients were asked questions about treatments they have had but also 'What sort of treatment, would in your opinion help you best?' and 'What sort of treatment do you expect to get in this hospital, and what course of treatment would you suggest yourself?' Finally, they were asked about what occupation they would like to have in the hospital.

In Part II, the patients were asked to write a short life history of themselves. The instructions asked patients to mention any special circumstances, or experiences which have affected them, describe their outlook for the future, and their attitude towards the war and the Army. Patients were also asked to describe themselves including how they imagined their best friend and worst enemy would describe them. (This question had been intended to prompt patients to describe their best and worst attributes. This however failed in the majority of patients, some of whom ignored this part of the question altogether while most of the others wrote that they did not think they had any enemies.) Finally they were instructed not to just answer the questions but to write a full story adding "The freer and more personal you write it the better". Three quarters of the page were left for the patients response, but many went over this, filling in the back page as well.

The questionnaires also offer a limited insight to the psychiatrists' interpretation of the patients' information. Several passages were marked with crayon (probably by S.H. Foulkes) while a few notes, frequently unintelligible can sometimes be found on the first page.

The great majority of the questionnaires are dated between July and December 1944. Two, which have a slightly different format are not clearly dated but are probably from 1945. One questionnaire is dated 31/7/40 but this must be a mistake as Northfield Hospital did not exist then.

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on the other hand does devote some limited space to discussing them, see B. Shephard, (2000) *A War of Nerves,* London: Jonathan Cape, pp. 261-262.

Half the patients were aged between 19 and 22 while most of the rest were in their 20s. The oldest patient was 38. They were quite well educated for the standards of the time. Although most had left school at 14, some had left at 15 or 16 and even 18. Almost half had been educated at a secondary school (some mentioned that they had won a place there) while a handful had been educated in public schools. However, all the patients came from the ranks and most were privates. Nearly all had been in the service for over 2 years, nearly half had been in the services over 4 years. Most had seen overseas service.

It is probable, that the questionnaire was well received by the patients. Only one patient referred to the questionnaire directly, but he did so very positively. Ian,[517] answering the question regarding treatment wrote:

> In my present mood I feel this hospital will do the best for me even if it is not what I feel to be right myself. I feel far more confidence than at the former hospitals, partly from the attitude of the staff, partly from the fact that this questionnaire has been given to me.[518]

While this maybe dismissed as an attempt to flatter the psychiatrists, another indicator that patients had confidence in the process, is that they disclosed information that was very private. For example, patients were remarkably unabashed about giving information about family members who suffered from mental illness and over half the patients declared something in the family history section. Three patients wrote that their father had been shell-shocked, while other patients offered information ranging from a parent who suffered from "nerves" to others who had suffered from "fits" or had had several mental breakdowns and had even

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[517] In this section, in order to preserve the anonymity of the patients but also allow cross-referencing, the patients are referred to with randomly allocated names.

[518] PP/SHF/C.3/16, Contemporary Medical Archives Centre, Wellcome Trust. This material will not be footnoted again as it all comes from the same source. The spelling has not been corrected and is quoted as far as possible exactly as it is in the original

been incarcerated in an asylum. In addition, two patients described how their fathers used to beat their mothers, while one added that his sister was the unmarried mother of two. Furthermore, most of the questionnaires exude a sense that the responses are intimately confessional and genuine.

The only possible exception is Ian, who described frankly his attempts to read up on pacifism in order to avoid the call up and offered a list of the names of authors he identified with, but he nonetheless, gave the reader a sense that something is being held back. One interpretation of what that may be, (although the evidence is far from overwhelming), is that Ian was homosexual. This interpretation arises from the two following passages:

> All through my life I have felt different from other people[519] & I think it led me to choose some rather queer companions. I used to associate either with older or younger people at school as a rule but freinds of my own age seemed to be invariably peculiar & warped in various different ways. This also applies to the majority of freinds in the army.

> It was in the summer of 1942 that I went through a very peculiar state arising from a friendship with L.A.W.[520] It is beyond me at the moment to put all on paper but when it was all over I found I was able to take a positive attitude to everything & my attitude to the army also changed. It is this feeling— I have always been trying to get. It also swept away a feeling of fatalism I had always had.

The interpretation offered by the psychiatrist however, is quite different. On the front page, it is written: '"Schizoid" if not more but taken on my Group might do well.' If, however, Ian was homosexual, this would indicate that some information was considered too private to be revealed to psychiatrists. Nonetheless, this patient revealed very personal information

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although there may be some errors due to the inherent difficulty in making out the handwriting.

[519] The underlined passages were marked in crayon, in all probability by S. H. Foulkes.

[520] These are probably a person's initials.

and stated that he would like to have "a complete analysis" of himself, in order to "complete the job" of finding out about himself.

Another somewhat sulky response was given by George who when asked what he thought might be a suitable treatment for him responded that originally he though rest would suffice but he has had plenty of rest without any noticeable improvement, and went on to add: "Not being an expert in these matters I am unable to suggest any alternative form of treatment."

Overall, however, most responses appear sincere and forthcoming.

The symptoms most commonly described by patients were anxiety, headaches, inability to concentrate, depression, insomnia and nightmares. For example, in the section entitled 'Present Complaint' George described his symptoms as follows:

> Suffer a great deal from insomnia. Also I frequently get a strange sensation as though I were falling and involuntarily my whole body jerks as though to save myself. This is becoming more & more frequent.
> At night I am always waking up in a sweat from some dream or other which I can never remember. Also I dread doying off to sleep because I have some horrible dreams when I am only half awake.

Some patients reported some more unusual symptoms such as James who wrote "I sometimes get in a mood that I want to kill myself or somebody who has said something I dislike", or Henry who wrote "... a contraction of the 5th finger on either hand" or Eric who wrote "Headaches, fear of colosoll things, nightmares, fear of hurting my mother fear of being like my father fear of committing suicide". Still more uncommon was the symptom reported by Cecil: "I cant stand the thought of seeing my wife or family" More significant than the actual symptoms was the interpretation patients made of these and the causes to which they attributed them. Henry, for example, said of his symptom: "I cannot understand how it can be connected with Psychiatry. I am not nervous in any way and I've never had any shock or suffered with nerves at anytime".

The majority of patients however appear to have accepted their psychiatric diagnoses and to have attributed them by in large to enemy action. Brian, for example stated that he was suffering from "Hysterical Amnesia" which "Developed by German dive bombing" while Quentin attributed his condition to: "getting mortared and shelled. I could not stand up to it". Other patients described acquiring the symptoms after being wounded or in one case after suffering an attack of diarrhoea, which resulted in heavy weight loss.

The fact that patients mostly attributed their illnesses to their military experiences did not necessarily stop them from also simultaneously attributing their condition to some inherent personality defect or to acknowledge that that they had previously suffered nervous complaints. Overall, about half the patients, (including approximately half of those who said that their symptoms were caused by enemy action) wrote that they had either suffered from mental complaints before, or that a childhood experience had caused them similar or other problems in the past. For example, Ian wrote: "I think it is due to the limitations of my personality but am trying to avoid this attitude". Cecil wrote "I have always been easily depressed even before I joined the army", and described how even though his childhood was happy he "never could stand noise or upset", while Eric wrote "I have once tried to commit suicide which failed." Most of these statements were underlined by the psychiatrist as they indicated a positive history, which meant that the prognosis would be less optimistic. In some of the patients' accounts, all sorts of reasons and interpretations for their condition were interwoven as in the case of Fred. The underlining indicates the psychiatrist's interpretation as to why the patient is sick; namely the interplay of a history of nerves combined with anxiety at being away from home and military stress:

I have a wife and 2 kidies which I adore and I cannot abear to be away from them. I imagine all sorts of things a bout my Wife and it is always for the worst. And I have lost much sleep over it. I cannot explain fully. My wife is in my mind every minute of the day. I think I have done enough for my country, more than some can say and I will be the happiest man alive to get a steady job here at home. (In England) To tell you the truth I hate the Army more and more each day. I have seen my wife 28 days in 3 yrs. My best friend was killed by the side of me in France. ... My nerves were bad before I went to France I thought the 6 months I was back in England my nerves were better, but as soon as I was back in action I new I was wrong. Infact they were worst than I had them in Sicily. Each time it gets worse, and I have been so bad that I have been on my hands and knees praying to God to let me live, and pull through it all. And it plays on my mind, what would happen to my family if anything happened to me. I have had little sleep for the past 3 yrs.

Another patient who described himself as having always been nervous and having had a history of epileptic fainting fits described how he did not disclose this history to the army medical officers in order to be accepted by the army. When he got there he found that he was as resistant to stress as anybody else:

When I came into the army I didn't know what to expect but what I'd heard of it. I often thought about what affect being in action would have on my nerves but after being in France I find that I could be easily as brave as the next fellow & keep control of myself as far as that was concerned & that my nervousness was not that way inclined. I found that my fits were getting worse & more frequent though & that I was begining to feel weaker.

Two patients, however, expressly blamed their fathers for their conditions. Both had fathers who fought in the First World War, had been "shellshocked", and had been beating the patients' mothers prior to separation. Eric, whose description of his symptoms was quoted earlier, blamed his symptoms primarily to heredity from his father. In his life history he wrote:

> At 2 yrs my father struck me & I must have seen him strike my mother. he struck my mother when she was bearing me, my mother then acquired a seperation & we came to Sheffield to my mothers home, I was taught throughout my life to hate wars because of my mothers' unhappiness owing to my father who had ruined our home.

Patrick, on the other hand, described as the main symptom of his and his mother's condition as pains in the head caused from having received blows from his father. He described his predicament like this:

> ... if I have to continue my duty, I should want to carry it out in my own country Ireland, as my father lefted my Mother, and is not living very far from her, I should like to be near in case he goes round and give her another kicking I think that is most the trouble that is worrying me ...

While these patients blamed their fathers for their conditions, they indirectly blamed war too as they implied that their fathers beat them because they were themselves shell-shocked.

Other patients, particularly those whose fathers were dead and who were themselves unmarried, described how worried they were about their mothers. For example, Eric had thought that the best treatment for him would be "To go & earn for my mother what she has never had" while Robert wrote:

> The only thing I want is to get home with mother & grannie, mother has to support her by going to work & I know it's getting a burden to her now & as I was brought up mostly by my grannie I have every reason I suppose to worry. And I think I ought to be back at home to help my ma. I don't know what treatment is due here but the above is the only thing that would stop me worrying, my mother has been ill once or twice since I have been in the army had to have my auntie look after her but now she goes out to work too.

In the following passage, Oliver displaced his own sense of injustice at having had to return to active service onto his mother, and rather than

complain that *he* has more than played his part in this war, he described his mother as the one who has sacrificed herself, and himself as demanding justice on her behalf.

> ... going on the "Second Front" I braced myself up ... but found a strain and complete tension, – & worry, since Mother at home had to live in anxiety once more through my being on active service with B.L.A. ... it is my place to care for her & I feel she's done more than played her part in this war, in experiencing my long absence from home, & she's getting no younger.

The only bitter note about a patient's mother is by Simon who wrote: "Never new my mother as I should have owing to second marriage Died off heart attack."

Throughout most statements, there is a pervasive sense of a complete loss of self esteem which was sometimes linked to feelings about the family. For example, Cecil wrote: "I have a wife. I love her enough to spare her the disgrace of having to live with me" while Lawrence wrote:

> When I married my wife I had hoped I could have done a lot of things for her, I was confident I could gain her respect, but through no fault of my own as far as I can see, I am always being reminded how somebody else is doing so well, everybody seems to be able to do better than I, I have lost confidence myself that if I was put back to-day in my civilian job I should fall down on it, and bungle it.

Nonetheless, many patients thought that returning to their families would be the best treatment for their condition.

Also indicative of the low morale among patients is that when asked what occupation they would like to have during their stay in the hospital over a quarter replied that there is nothing they would like to do or did not answer the question at all.

With regard to views and attitudes towards the army, most patients expressed a negative view. Brian wrote: "I have no interest in the army at all and completely browned off with it all. The army had no interest in me

then, so I have no interest in the army now I dont care weither we win the war or jerry ... it is all the same to me, and I dont care weither I was dead or not." Cecil wrote "I have always hated the army – I've stood it for 2 1/2 years – I can't stand it anymore." James wrote "I myself hate the army everything about it, I will admit it has some good points, it is a boring, and unthankful job I would like to be back at a job in civie street and settle down and forget everything I have seen in the army". Quentin wrote "My attitude towards the army is its alright as long as you are able to stand up to, but I dont think I can stand up to front line duty, when you are under mortar & shell fire." Robert felt disillusioned: "My attitude towards the army is that I've had enough of it & it surprised me in France how the wrong chaps were in the wrong places & who the best chaps were, I'm afraid for me to be taught anymore in the army the instructor would have to be a chap who'd seen action!"

More positive thoughts regarding the army were expressed by Henry (the patient who denied he had any need for psychiatric treatment) He wrote: "I can say quite honestly that I've enjoyed my 5 mths in the Army and that I've made many friends." Similarly Terence thought there good things about the army: "It was after joining the Army that my character changed, it did not matter then what happened to me but what happened to the lads, rather taught me not to be selfish, it was not until war broke out that I took life seriously. ... The Army I think is a good life for a single person and has plenty of scope for any person ..."

A more analytical approach towards his attitude for the army is shown by Ian:

> When I realised I was going to be called up within about a year I was very alarmed. With a view (unconsciously) to avoiding the army I started to study Pacifism but soon realised I was being dishonest & decided to work out the correct thing to do. In working it all out I got hopelessly tangled up. I haven't room to explain why. I finally decided that the war was a pity but could not be

helped, that I had no feeling in my guts that Pacifism was any good, so in a feeling of apathy I waited until I was called up. I hated the first 7 weeks but after my 1st leave managed to adopt myself a bit better & regarded everything as an interesting experience. ...
My general attitude to the army before "all this" had been that I'm part of it & that it is silly to talk about it as "they" & criticise "their" inefficiency or stupidity when one should regard it as a duty to put these things right if in one's power. I also took the same attitude to politics & Im one of the minute minority in my unit who filled in the proxy voting form.
... When D-day and the landing came I was very excited & exhilarated, & enjoyed looking calm & nonchalant at difficult times.

With regard to the war in general, most patients seem apathetic although only Brian, quoted earlier, suggested that he did not care which side wins. By contrast, Terence said:

> As regards the war I think it is a good thing in the sense that once and for all we can put an effective world wide peace into operation, and know that our children will not be in wars as we and our fathers have been. I think we have done admirably so far, but I do think the some civilians are being complacent and tending to forget that there is a war still to be fought.

As far as returning to the army after they were released from hospital, many patients were adamant that they could not do it. Cecil wrote: "I couldn't face the army as I know it again. I would rather face imprisonment, than go back." George wrote: "If I were ordered back to France again I suppose I should have to go, but after the last month I doubt if I could stick it for long. In short, I honestly think my nerve has gone completely. I know, it sounds silly seeing that some chaps have had a few years of it out East, but I just can't help myself!"

With regard to the future, most patients wanted to return to civilian lives but often felt they have no future. Brian wrote:

> I have been getting 2/9 a day in the army abroad and still am, and when it is finished what will I get nothing, I will have to go and working again, and maybe into the slums, get married with practically nothing. and keep a family on that maybe.

No I want to get out of it all, and try and get back to a normal position, and think a little of the future. What have I now, after being in the army 2 3/12 yrs. Nothing and it is up to me to help myself. If I do have to come back into the army after this I will serve it in blink, and enjoy it.
The best part of my young life has been in the army which I assure you, has been wasted.
My worst enemy in the world today is the Government for dragging me into it. So I have no apologies. I want nothing to do with it, and want to steer clear of it all, because iff I dont, I will forever be in hospitals and jails until I do get what I want. I am only young and I want a chance in life and I am not getting it in the army. So thats that

Cecil wrote "About the future –I don't think about it. How I ask a woman to live with me now? ... In my opinion it is only a matter of time before I crack up" Eric wrote: "[I] have no outlook for the present or future owing to war". James wrote: "my life before I came in the army was uneventful but full of childish dreams like wanting to travell and making a name for myself and starting a biessness. and now all I want is nice steady job with quite good pay and nice home to come home to invite freends and to be proud of."

Among the career aspirations expressed were farming, the Post Office, the Civil Service, and teaching. More bizarrely, George wrote that "Since joining the Army I have decided not to go back to an office job again, but would like some job involving foreign travel, or a job where I could learn some foreign language such as censorship."

To some extent, each questionnaire is different from the others offering a unique portrayal of an individual's life. Looked at as a group however, they portray soldiers who were disillusioned with the Army and with themselves. The soldiers' confidence was to some degree shattered, and they oscillated between blaming the war, blaming their families, and blaming their own personalities for their breakdown. They were worried about their families and longed to return home, yet felt pessimistic about the future.

Records show that at least 8 patients (from those mentioned above: Ian, James, Henry, Lawrence and Oliver) went back to the army in categories C1 and C2.

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