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**THE SECOND WORLD WAR:
SHELLSHOCK TO PSYCHIATRY**

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Good afternoon everybody – thank you very much for coming along. Today, as has just been explained, I am going to be talking about psychiatry in the Second World War. More specifically, I will be talking about the work of British military psychiatrists in the Second World War and I will be focusing mainly on the British Army, and I will be looking at the range of activity in which they were involved – that is everything from personnel selection to the actual treatment of casualties. I will try to give you some sense of where progress was made during the War, and I will argue, I am afraid, that not a great deal of progress was actually made, although there was, as I will explain too, there was considerable innovation.

I have got 45 minutes or so, and it will just be broad brushstrokes really. I will talk first about the state of British military psychiatry in 1939/1940, the outbreak of the War, and when it was first put to the test. Then, I will move on and look a little bit at selection and screening, and I will talk about that and the contribution made by British psychiatrists to selection and screening of candidates for military service. Then, finally, I will wind up by talking about the treatment of psychiatric casualties who, during the War, was pretty much the primary cause of medical casualty and comprised between 30% and 40% of those who were diagnosed with disease and were discharged from the Army as a consequence.

Now, this topic is actually quite under-researched. You will all be aware of shellshock as a concept. The First World War has been very much a focus of research for some time. The Second World War has been somewhat different: there have been some outstanding studies of it, particularly the work of Ben Shephard, who wrote a book called “A War of Nerves”, with which some of you may be familiar. Edgar Jones, Professor of Psychiatry at King’s, has done some really excellent work as well, and I will be drawing on their work as I go along, and also the work of Nafsika Thalassis, who was a doctoral student, wrote a PhD on British military psychiatry, in the Second World War too. But the statements I will be making here are all my own, the opinions are my own as well, and I will also, you will have to forgive me, I will indulge my own research as well and I will actually talk a little bit about my research at Oxford, as an example of how psychiatry worked on a particular unit and the way that British psychiatrists and psychologists were employed in a particularly elite British unit.

What I am going to do, however, is I will begin with this story. This story appeared in an Australian newspaper in September 1940, and it was based on an article in the Lancet that had just been published. I have the transcript here, and I will read it out – and you can read it too. Actually, this is quite interactive – you will also have to do some reading yourselves here, and I will read you through this.

“Dunkirk Soldiers Cured by Hypnotism”

London, July 30: Soldiers back from Dunkirk have been cured of nervous disorders by means of hypnotism. Remarkable results were reported this week by Dr William Sargent, a well-known London psychiatric specialist.

One patient puzzled the doctor. With infinite care, he took the man back to the frightfulness of the hours on the French beach. Still there was no clue that might provide a basis on which to formulate a cure. Then hypnotic treatment was tried. Under hypnosis, the soldier, a nervous wreck,

gave Dr Sargent a clear picture of his ordeal on the beach beside his soldier brother. The brother was mortally wounded. The soldier, heartbroken at the agony of his brother, shot him to hasten his death.

Tortured Mind

Back home, subconsciously, he was torturing his mind about what he had done, though he could not remember, except under hypnosis. Knowing all, the doctor was able to reassure the stricken man, who was quickly restored to health."

The article goes on to describe a similar treatment that Sargent delivered to a Royal Navy sailor who had experienced losing a friend and considered himself at fault for losing his...for his friend's death as well. And then the article continues...

"Behind these stories of successful treatment lies a scheme which the British War Office has instituted to mobilise psychological experts throughout the country for this work. Shellshock exacted a heavy toll in the last War. Today, the most advanced treatment, including hypnosis, suggestion and other forms of psychotherapy are used.

They are also interested in prevention as well as cure. Every recruit undergoes a minor form of psychoanalysis at his medical examination to discover if he has any history or symptom of nervous disorder which might affect his discipline in the frontline.

Thus, men who might crack up under strain or, as in the last War, might run the risk of being shot for cowardice, in reality due to some neurosis, will be found in time."

The impression of this article, I think, is a positive image of the state of British military psychiatry in 1940. There is talk of remarkable results, successful treatments... Sargent has restored that soldier's health after one of the possibly worst imaginable tragic, traumatic experiences. The article talks about experts being mobilised by the War Office – today's Military Defence really the equivalent – to deliver advanced treatment, and this is hypnosis, suggestion, psychotherapy. There is also talk of prevention as well as cure, and this hints at the screening that is in place to weed out vulnerable characters, vulnerable personalities who might breakdown in combat. There is also reference to men being shot in the First World War due to some neurosis, and this of course implies that there is understanding now, in 1940, that men do break down because of strain and that it is wrong to shoot them.

Something not mentioned in the newspaper piece is that Sargent had also used drugs as part of his treatments. Since the 1930s, increasing use had been made of drugs by British psychiatrists to assist with sedation and abreaction techniques – abreaction being the reliving of an experience in order to purge it really of its emotional excesses. In the soldiers' case, Sargent administered an injection of sodium amytal as a sedative and to assist with his hypnosis.

On the strength of this upbeat newspaper article, you might expect that British military psychiatrists were well-prepared for the War, and the British military was well-prepared, and that, subsequently, they may have had great success in dealing with psychiatric casualties during the Second World War. This is also the impression that you sometimes get from reading official histories of the Second World War, official histories of the medical contribution that was made by the British Army. But the reality, as I will discuss now, was somewhat different. Certainly, there were some interesting innovations made, and I will discuss some of those, and certainly some good work was done, but in many respects, the degree of success was far more modest than you might expect by reading an article such as this.

In 1939, Britain was certainly better prepared than it was in 1914. In 1914, the British military had been totally unprepared for the tidal wave of psychiatric casualties that came back from the frontline in France and Belgium. One estimate is that the British suffered 200,000 psychiatric casualties during the First World War. Now, as well as being unprepared, there was also great confusion as to what the causes were of all of this, which was not helped at all by the vast range of symptoms that traumatised soldiers were exhibiting, and these ranged from paralysis to being struck dumb, to no hearing, to muscle spasms, to nightmares, being unable to speak, and of course exhaustion and tiredness and great fatigue.

The very first interpretations seemed to be viewing shell-shock, as it was termed, as an organic, with an organic explanation, and the idea here was that it was concussive, toxic impact of a shell explosion and that this shell-shock, as it was called by the soldiers, was always confined to soldiers who had been in close proximity to an exploding shell.

This is Charles Myers, on the left, and this is an article he wrote in 1915, on the right. It appeared in the *Lancet* and this is really the first appearance in print of the word "shell-shock". In time, it became clear that this interpretation was not satisfactory. Symptoms of shell-shock, first of all, were being displayed by soldiers who had been nowhere near a shell explosion. Many physicians, in time, began to see the symptoms were functional and related to the stress of combat, which was both real stress and imagined as well, and some believed that from analysing the sufferers as well that vulnerability to psychiatric difficulties could be exacerbated by poor upbringing, by previous psychiatric disorders before individuals had

joined the Army, and by poor health, and by fatigue. Eventually, some even also came to believe that all soldiers really were vulnerable and that breakdown would occur to anyone, given the worst possible circumstances.

Myers himself actually came to see the word “shell-shock” as outdated. Although he was responsible for it first appearing in print, he very soon decided that it should be struck out of official wording of incidence such as this, and, later, the Army also followed suit and declared that it should be struck out of all formal diagnosis. Despite this of course, shell-shock has become very much associated with the popular image of the First World War, conceptions of wartime casualties and remains in common use as a catch-all term really to describe all First World War mental psychiatric casualties and distress. It is even described today as a forerunner, if you like, of post-traumatic stress disorder, even though the diagnosis or the description of PTSD in the DSM is very, very different these days to how shell-shock was interpreted and related to conditions in the First World War.

Responses to this epidemic of casualties were many and various. As the War developed, emphasis came to be placed on treating psychiatric casualties as close to the frontline as possible. Now, this was for various reasons, but to stop people becoming accustomed to how they felt and to stop the condition becoming more ingrained, the suffering becoming more engrained on their minds. It was also to stop them from becoming too comfortable as well with their condition and to malingering. The further that people came away from the frontline, the more reluctant they were to go back. But the overall aim really was to increase the chances of getting them back to the frontline. One of the early proponents of this forward psychiatry was Charles Myers, again. He was drawing on what the French were actually doing at the time.

Myers was also a medical officer who recommended therapeutic treatments, so he was very much in favour of hypnosis, an atmosphere of calm, talking to the individual, going through his experiences and trying to aim for a cathartic effect by discussing and raising awareness in the individual of what had actually caused him to break down.

Another proponent of that kind of therapeutic treatment was Captain William Rivers, who was working at Craiglockhart Hospital, and many of you will be familiar with his work with Siegfried Sassoon, which was immortalised in a book by Pat Parker and a film in the 1990s.

There were other doctors who felt more physical response was effective with certain symptoms and one of these was a chap called Lewis Yealland. Yealland was a neurologist based mainly in London, who favoured the use of electricity, and this he applied with electrodes to various parts of the body. So, for example, if a man was struck dumb, he might apply the electrodes to the throat, hoping to stimulate the voice-box, and if he was paralysed in a limb, then the electrodes would be applied to the muscles of the arm or the leg. Now, his methods may seem brutal, but they were undoubtedly successful in some cases, particularly with physical paralysis and also loss of speech, but of course they never really engaged with the underlying cause of mental distress and did not aim for soothing the mental stress the sufferer was also affected by.

Despite this practice and all these measures that were in place in the First World War, these different types of thinking and different types of approach, and despite also a great deal of wartime medical research, it is a mistake to assume that the lessons and the experience of the First World War left the British, and the British Army in particular, well-prepared for the coming conflict in 1939 and future waves of psychiatric casualties.

Between the Wars in fact, 1919 to 1939, it is fair to say that British military psychiatry more or less stagnated. By 1939, there were only six British doctors in the British military who really had any kind of psychiatric training at all.

After the War broke out, this situation did improve. In 1942, for example, a dedicated directorate of psychiatry was set up in the War Office, and by 1944, as opposed to six psychiatrists at the beginning, there were over 200 working for the British Army, about half of which were attached to British units overseas. But in 1940, when the British expeditionary force went to France, it had just a couple of psychiatrists attached to it and there was no system of providing forward advance psychiatry – that was the system that had been found to be effective in some ways in the First World War. Nor was there any tier system in place, and this was a process where you had the forward psychiatry first of all, and then casualties, if it was felt they needed further treatment, would be sent back to a hospital slightly further away from the fronts, and if it was felt that they required further treatment still, then they had be evacuated even further behind and perhaps to the UK. In 1940, in France, however, psychiatric casualties were evacuated straight to Britain, although, to be fair, in May/June 1940, the campaign was moving so swiftly that, in many cases, there was no real alternative. But this flood of casualties straight back to Britain explains why, in Sutton Emergency Hospital in Surrey, where William Sargent was working, that is why he was confronted with Dunkirk survivors in the summer of 1940.

I will talk to you about screening and selection now. In the late-1930s, instead of packing the Army with psychiatrists, the British Army felt that it wanted to apply itself more to selection and screening. Now, the RAF, Royal Air Force, and the Royal Navy, their procedures were a little bit more sophisticated for recruitment. At that stage, they did include, for

example, a sit-down interview, in the very first stage of joining either the Navy or the RAF. For the British Army, beyond a medical, there was no other real system of assessment.

So, it was with the intention of improving this situation that, when war broke out, the British Army mobilised and recruited various British psychiatrists and put them to work devising and developing a series of tests for recruits into the Army. The point of all this was to increase efficiency, to improve the quality of the Army too, that is to put the right man in the right job, and also to reduce wastage. The Army's senior officers had an eye on the fallout of the First World War and they wanted to minimise that happening again. It was also a common belief, by the late-1930s, that certain individuals were mentally deficient, in a way, and were more likely to suffer from psychiatric problems in a wartime environment.

Several tests for the other ranks, first of all, as opposed to the officers, were devised, and these included a verbal intelligence test, a mathematical test, reasoning tests, and an interview with a psychiatrist, again a sit-down interview with a psychiatrist, which was new, and this was to explore the man's background, and psychiatrists would ask him about his interests and try to explore his mental stability, his past mental health. Also, at this stage, they would look into the man's employment record, his education as well, and also his previous work experience before joining the Army, what he had done for a living, again to try to assess what he was like in his perhaps vulnerability to future stress.

Now, was this successful? It seems to have had limited efficiency really. The intelligence testing was undoubtedly the most useful and efficient tool because it was at least based on evidence. The other tests were mostly predictive and the conclusions were based on guesswork really of the conditions that a particular individual would find once he had joined the Army.

Tests for officers were more in-depth, and these were known as the War Office Selection Boards, and these were introduced in 1942. These required prospective Army officers to attend a three-day assessment course, where they underwent a series of tests. Some of these tests were designed to assess physical stamina, physical fitness. Others though sought to assess character, initiative and resourcefulness. Again, there was an interview with a psychiatrist, and this was to assess mental stability, as it was again for the other ranks as well. There were also tests to assess intelligence, again as for the other ranks. And there were new tests too that were psychological and physical to get a more rounded picture of the individual being tested.

For example, there was a group discussion to test verbal and social skills, so the candidates would be grouped together, sat in a room, and given a topic to discuss. There was a word association test, which was originally devised by Jung. There were outdoor group tasks. These were designed to see who would emerge as a natural leader. They were leaderless tasks so the group together was put to work over a particular test, for example to manhandle a log over a wall or over a fictional minefield, and the instructors and the psychiatrists would watch to see who would emerge from the group as the natural leader, who had perhaps shied back from commitment, who was a follower, who was a kind of reluctant follower.

There were also more focused tests of leadership, where, again, a group would be put together, given an outdoor task, but then one of them would be put in charge, and his job of course would be to manage the others and see them try to accomplish the task at hand.

Again, was this successful? It is hard to assess. The later training reports appear to stress that the assessment was useful and beneficial, but again, it is mainly because of the intelligence testing, and it did help to gear people towards selecting soldiers for particular jobs.

The biggest flaw, again, was that all the tests were predictive. It was especially problematic when considering a man's susceptibility to breakdown in the future because of course the key variables that actually have a role in breakdown – these are moral, the intensity of the battle, preparedness of an individual for a battle – these things cannot be tested or predicted when a man is just being inducted into the Army at the beginning.

There are also other little flaws as well that is important to acknowledge and these are cultural flaws and cultural opinions in particular individuals who assess...who go through these assessment processes. This can be seen, quite neatly, by a letter to *The Times* in January 1941. Now, the author of this letter was a colonel who worked at an officer training unit – this was the unit to which officers were then sent after completing the War Office Selection Board. This colonel's rather novel argument was that only the upper classes had the right skills to be Army officers, because they had grown up with servants and therefore they knew how to handle the responsibility of dealing with people! This argument went on and he felt that everyone else, pretty much, had been reared in an atmosphere where "...the State spoon-feeds everyone from the cradle to the grave, and no one feels any responsibility for his fellow man." Now, that letter actually got the colonel sacked, perhaps unsurprisingly, and it is an extreme viewpoint. Nevertheless, there were still plenty of people who felt that education, good education, experience of being an employer, all of these actually mattered.

Of course, these tests have also had an enduring legacy. Those of you perhaps who have had experience of a Commissioning Board for the British Army will recognise things such as the group discussion, the leaderless tasks, the command tasks, the verbal assessment tasks, and also the interview, which are still in place and still used to assess officer candidates for the British Army.

Now, military psychiatrists were also employed in selecting and screening for other military work, and it is at this point that I am going to indulge you with my own recent research that I am doing at Oxford at the moment, which is on the contribution made by professional psychiatrists and psychologists to the selection of personnel for British special forces, and in particular an organisation called the Special Operations Executive, which was known by the acronym SOE, which is how I will refer to it.

SOE is small and it is just a small example, a small little study that I will give you here. So, 100,000 individuals went through the War Office Selection Boards for officer training, around about 2,000 went through SOE's particular form of selection. But it does give some impression, I think, of the levels of sophistication that were reached in the British Army, or the British military environment, in the world of selection training during the War, so I think it does have some value here to be looked at, for being looked at.

So, SOE was a secret British organisation, as some of you may know, that was set up in 1940 to encourage resistance and carry out sabotage in enemy-occupied territory, and it did this by sending agents into enemy territory to work with local resistance groups and to carry out individual tasks. This rather unique line of work was high-strain, it was very solitary, it was very dangerous – this was behind the lines work, remember, so this was people working alone right under the noses of the enemy – and men and women were required who had particular qualities and particular abilities. It took a while, but after a time, SOE began to get some idea of what these qualities might be. I am just going to read out an account here by the Head of SOE's Norwegian Section. SOE was split into country sections, devoted to dealing with different countries. This was a Scotsman called John Skinner Wilson, I should stress that, and he is writing about the agents he has sent into Norway.

“At first, men of the commando type were recruited, but however brave and efficient these men were, it began to be realised that other abilities and qualities were required. The tough gangster of detective fiction was of little use and in fact likely to be a danger. Help and support to Norwegian resistance could only be provided by men of character who were prepared to adapt themselves and their views, even their orders at times, to other people and other considerations, once they saw that change was necessary. Common-sense and adaptability are the two main virtues required in anyone who is to work underground, assuming a deep and broad sense of loyalty, which is the basic essential. Without some stability of character, no man could work with any chance of success, for any length of time, in the most difficult and dangerous tasks.”

Now, you might think that an organisation like SOE, which is engaged in such specialist modern warfare, would have recourse to talented, specialist professionals to help it with its recruitment and selection processes. In fact, until 1943, its recruitment processes were very ad hoc, very amateur, dangerously so in fact. It had not been uncommon, for example, for an existing member of SOE to recruit somebody over a drink.

According to Cabinet Office records, that had been classified for pretty much over half a century, the decision to introduce an improved selection was precipitated by a concern that too many agents or candidates for working as agents were failing during the training stage, so that is between recruitment and going into the field, but SOE's own records, which have been released over the last fifteen years or so, and are still being released in stages, do suggest that in fact it was a worse situation than that, that people were breaking down actually on operations, which of course was a very different kettle of fish.

Looking through the files, there are plenty of examples of agents who were considered, in the light of how they acted, to have broken down as psychiatric casualties. Just to give you a couple of examples, in 1943, one agent, a Frenchman, parachuted into France and broke down immediately and went to live with his wife, within days, weeks of arriving, and did no work whatsoever. In his case, he was betrayed – it did no good, he was betrayed and arrested, and was later executed in a concentration camp, which gives you some idea of the threats that agents were under, and they all knew that that was a fate that they risked by going into enemy territory in the first place. Another example, a Danish agent who parachuted into Denmark was assessed to have reacted so badly that two fellow agents radioed London for permission to execute him since he had contacted the enemy and was acting strangely. It was a threat to their own safety. In fact, permission was granted and he was indeed killed and his body was dumped in a lake. A similar case occurred in Belgium, where an English agent was dropped in, and, again, very similar to the first one, panicked, went to a hotel where his sister was working, but his colleagues, again, his SOE colleagues, were so concerned in Belgium that they actually shot him and pushed his body down a well.

For a long time, SOE had no alternative really but to recruit in this ad hoc way. They had very limited resources, there was a concern for security as well, and they were ignorant really of alternative methods, and eventually, a fresh system was

introduced in 1943 and this was called the Student Assessment Board. It was based quite closely on the War Office Selection Boards which I have just described. Again, there were three-day tests, employed psychologists and psychiatrists, who were present during the testing. They repeated also a few of the War Office Selection Board tests as well, so these were reasoning tests, an interview, group discussion, outdoor group tasks. SOE also developed its own tests – for example, a group test to assess frustration, students’ reaction to frustration and failure. The testing staff would sometimes insert in a group someone who had been deliberately tasked to be as obstructive and as obnoxious as possible, and psychiatrists would watch to see how somebody dealt with that. A variation on that was called a construction test, where a candidate was taken alone and given a cube in parts or some sort of model to construct, and he was also given two assistants to help him. Now, what he did not know was that these two assistants had been tasked to be as unhelpful as possible, and then of course the psychiatrists would watch that and just see how he reacted.

Now, once again, this was very much a preliminary selection process, like the War Office Selection Boards, but nevertheless, SOE seems to have been pleased with it. It compared very well with the system beforehand, or at least that is what it felt. But, again, there was still a very heavy predictive element to it, and it was still largely guesswork about what conditions agents would face in the field, what could possibly cause them to break down, and again it was very much based on their assessment at the time of a candidate’s psychiatric make-up. A few agents did return and they did feed in knowledge of the field, conditions in the field, to try to improve the recruitment process, but there was still a lot of feeling their way forward in the dark really.

Rather like the War Office Selection Boards of the British Army though, there is another quite a long-term legacy of SOE’s recruitment process. In 1942/1943, the American OSS - which some of you may have heard of, which was almost an American equivalent, very broadly, of what SOE was – came over and it looked at the War Office Selection Boards and it looked at what SOE was doing and came up with its own system, which it developed in the US, and that, today, if you read histories of assessment centres, generally the historians of the modern-day assessment centre tend to look at the American, the OSS form, the schools that they developed, which was very closely based on the British model, they tend to see those as the grandfather of today’s assessment centres. Many of the tests are the same, the content of group discussions and these sorts of things. But, in fact, the heritage of the assessment centre does go back beyond the American system, and it does come back to the British system, comes back to the SOE system, the War Office Selection Boards, and also, actually, if you take it all the way back, it does go back to German systems as well from the 1920s and 1930s, who were also trying to explore individuals and get an all-round image of what they were like.

In fact, this photograph on the right, I was in Washington last week, and this photograph on the right, which, again, some of you, any of you of British military background will identify that as a group task, outside, and these individuals are trying to take various planks over a wall and across what seems to be just a sandy area, but they are obviously under instructions not to tread on it. This actually comes from American records. It is a 70-year old photograph and this is very closely modelled on what the British were doing.

This is another one. This is the Rorschach test. This, again, comes from an American secret OSS file, showing how individuals were tested by their reaction to the Rorschach test, which is the inkblot test, with which some of you may be familiar, to sort of assess abstract reasoning.

A final thing I will say about the employment of psychiatrists in selecting military recruiters is that their advice was not always taken. In 1943, the War Office decided that psychiatrists should be removed from the work of the War Office Selection Boards. There was a feeling that they were not particularly needed, they were not particularly helpful, and I think this reflected, I think it would be fair to say, that there was a certain wariness at the time of the contribution that psychiatrists could actually make and doubts about their value and the value of their opinions and contribution.

Now, existence – this is second-guessing really, also comes through from the work that I have been doing on British special-forces, and I will just briefly give you an example of that. I will read you through this. Do not be too horrified – I will read it out! Now, this comes from an SOE file, an assessment of a Belgian candidate for operations for clandestine work inside Belgium. This is written by SOE’s in-house psychiatrist. It is quite unusual to find case studies like this. These are case notes really, and it is quite unusual to find these existing today in any sort of form, not just with SOE but with the military at all because, for various reasons, medical notes tend to be either still classified, for data protection reasons, or they have been destroyed, which unfortunately is the case for most. I will take you through this, and, as you will be able to tell, it is quite a negative report.

Examination: A tall, fair Belgian, with little personality and few leadership qualities. He is a cautious depressive type, with little internal mental stamina, and has little ability to stand on his own feet. He may therefore, at times, appear moody and temperamental. He is very dependent on others. He lacks initiative. He is not likely to inspire confidence in others. Though he is not lacking in guts, there is little of the fight in him and he has little capacity for an aggressive attitude. He is generally apprehensive, fearing the worst, and is rather lacking in self-confidence. On the whole, he is ineffectual and he has not been a great success in life. His life history bears this out. There is also a marked

streak of nervous instability. He lives on his nerves and though this may help in the short-term, I do not feel he is likely to last any great length of time.

That means that he is looking forward – what he means by that, his “length of time” in the field as a clandestine agent. Then he goes on to talk about childhood, his emotional make-up again, and, at the bottom: “Recommendation: I do not recommend that he should be used in the field.”

Now, later on in this file, it is recorded that this agent in particular was actually sent on operations into Belgium, and a little bit later in the file is this:

“Arrested on 14 September 1943, whilst returning from inspecting a landing ground. When interrogated, he stated that he was a deserter returning from Portugal. Was sentenced to three months in prison because his papers were not in order. He was imprisoned, sent to France, escaped by train and went home. Tried but failed to contact London. In July 1944, he came across a German patrol and, convinced that they were after him, took to his heels and was shot. “

There is no way of knowing whether this particular agent’s mental psychiatric make-up had any contribution to his arrest and his ultimate fate. What is clear, however, of course, is that the warnings of the psychiatrist were not taken into account, and this was for reasons of manpower. SOE’s Belgian section had nobody else. They needed a man for a particular job, they took him, and they sent him.

Now, this perceived need for manpower, this is the need to make men available for operations of a war-like character, also characterises and shapes the work of those military psychiatrists who were involved in the treatment of casualties, and it is that that I will talk about now.

The first major employment of psychiatrists among psychiatric casualties occurs not really in France in 1940 but in North Africa and in the Western Desert. For three years, from 1940 until spring of 1943, the Western Desert, North Africa, and for a little short time East Africa too, these were the principle theatres in which the British Army was involved in the Western Hemisphere. It is also in North Africa, in this theatre, that the British begin to rediscover the concept I referred to earlier of administering treatment to casualties, psychiatric casualties, as close to the frontline as possible, and then evacuating them back by stages according to the severity of their condition and their ability to respond to treatment.

The Australians seem to have tried to do this first. This was at Tobruk in 1941, although, to be fair, Tobruk, in 1941, many of you will be familiar with that, Tobruk was under siege and they did not really have much alternative again but to pursue immediate treatment of casualties, pretty much right by the frontline.

Now, the idea of this tier system takes some time to become standardised, and it is only really after El Alamein – this is October ’42/ November ’42 – that dedicated, advanced, forward psychiatric units come to be established to deliver quick, immediate support to British units advancing through the desert. Now, the underlying principles of this came to be known by the acronym of PIE. “P” stood for “proximity” to the battle, the “I” stood for immediacy of action, the immediacy of treatment, and “E” was the expectancy of recovery. This PIE model was then repeated in Italy and later in North-West Europe.

Later, if you read the official accounts of the War, and also the official reports at the time, contemporary reports, there is considerable exaggeration perhaps of the success of these sorts of treatments and procedures that were in place. For example, late July 1944, official claims were being made that 65% of psychiatric casualties in Normandy in the first six weeks of the fighting had been returned to normal duty – this is combatant duty. But in fact, the real figure, on close analysis, is closer to 10%. In fact, in every theatre throughout the War, the return to duty, combat duty, frontline duty, was very low.

It began to be sensed too that psychiatric casualties increased when the War was going badly, the Army was in retreat.

Also, again, this idea that men with low intelligence and with neurotic psychotic backgrounds are more vulnerable, more likely to break down. There was a belief, again, that greater strength should be put to screening and selection to stop this, to stop unsuitable men, if you like, reaching the frontlines.

It was also appreciated that a man’s sense of responsibility, and duty, should be stressed, so a sufferer, a man suffering from psychiatric trouble, it should be stressed to him that his duty was to his friends and his unit, and that this could make a difference to his mental resilience.

It also began to be seen that men with excellent fighting records could break down. Again, this was the idea that every man had a breaking point, and, again, this was something that had been seen in the First World War.

It was also becoming clear that the only effective way of reducing battle exhaustion really, as it was becoming called, was to lower the intensity and the frequency of combat.

Now, the treatment too varied, and it often took the form simply of delivering a sedative just to calm agitation. Better food and perhaps insulin and glucose to help gain weight. There was also some occupational therapy and some physical teamwork to boost confidence and instill a sense of duty and community.

Pressure of work, however, frequently meant that abreaction, perhaps assisted by hypnosis, was just not possible – it was just too time-consuming and impractical. And then there were some psychiatrists who did not really see psychotherapy as useful at all. William Sargent, for example - if you remember, he is Dr William Sargent, and he was referred to in the newspaper article I showed you at the beginning – Sargent felt that sedation was important for stopping trauma becoming engrained in an individual's personality. If severe anxiety continued, then he would perhaps also induce a coma that could last for several days to destroy what he felt were conditioned fears. William Sargent really had a very low opinion of psychotherapy, which he called “talk, talk, talk” and that is how he referred to it and it does not feature at all in the work that he was doing.

In fact though, the work of individual psychiatrists like Sargent did vary considerably, and what is striking from their accounts is the absence really of any systematic uniform form of treatment. Certainly, their overall purpose in every case was to treat individuals with a view to returning them to the combat duty – that is the ideal. It is certainly what the Army wanted. But there was a great variety of approach, a great variety in opinion as to what caused soldiers to breakdown, how to treat them, and what could be done to actually get them back into the battle. To illustrate this, I am going to talk about three contrasting examples.

First is the work of Lieutenant Colonel Harold Palmer. Palmer was an Army psychiatrist who was working in Tripoli in 1943. He was considered extremely able at what he was doing and certainly his work, on the face of it, seems to be extremely effective. For the Army, the ultimate gauge of success was the amount of soldiers who could be treated successfully and actually returned to the fighting line, fighting duty, and Palmer actually claimed an extremely high return to unit rate. He claimed that just 2% of his casualties were evacuated to the next line, 98% returned to full duty, and 30% of those actually returned to full battle duty. That might not seem so high, but, at the time, that was an extremely high proportion. Also, his results were achieved in very intense conditions. His level of success should be qualified though by a few observations. He was actually working about a thousand miles away from the next tier in the line, so he was under great pressure to keep psychiatric casualties to him and within him and not depend on the hospital facilities and the hospital ships to get people back to Alexandria, further away in Egypt, because these were expensive and were required for more serious physical injuries.

Palmer was totally focused on persuading the sick to return to action, to return to military duty. This was central to his form of treatment. He also considered most of them to be actually curable. He was also open to new ideas, new practices and new treatments. His principle approach was to remind patients of their military duty and their responsibility. His techniques ranged from therapy, with the use of ether, which was really to relax the patient so that he could bring back memories and encourage a degree of catharsis, to more persuasive methods. This is Palmer describing some of his methods:

“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.”

The next example is Colonel Dugmore Hunter. Hunter was senior psychiatrist to the 8th Army when it moved from North Africa into Italy, so 1943, 1944. Hunter's results in treatment were also quite good comparable to Palmer's – 30% of his patients, he claimed, actually returned to combat duty, and just 1% had to be evacuated all the way back to the UK. Unlike Palmer, however, Hunter's focus was not on treatment, and certainly not on therapeutic treatment. Instead, he was very much focused on selecting those who should be withdrawn from the fighting line to prevent them from becoming casualties, psychiatric casualties, so his emphasis was on selection and prevention, but much of it close to the front. He classified soldiers into various types: these are sufferers, patients, and various types, so these were soldiers who had broken down due to a traumatic experience, or perhaps a series of traumatic experiences; then there were soldiers who were exhausted; but there were also soldiers who Hunter felt – this was his opinion – who were just not capable of coping because their personality was weak and their background was inadequate. What Hunter wanted to do was to treat curable men – that was his great emphasis on treatment. He felt that if they could be evacuated quickly, if they could be evacuated fast and treated, then they were much more likely to return to action eventually. This is Hunter explaining his stance:

"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 [he means evacuated to the next stage and eventually perhaps to the UK if they had to be] only when they become a positive embarrassment."

Now, Hunter's immediate treatment for those he considered inadequate or embarrassing or incurable was somewhat different to the techniques employed by Palmer. This is him again explaining some of his techniques.

"Hysterical screaming and jabbering 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 as common-sense forms of first-aid. 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 salutary, both to the individual and to others."

These kind of statements undoubtedly seem harsh. It is important to keep in mind though the pressure that was on psychiatrists, military psychiatrists, to return men to the fighting line. That was what their job was, and to deal also with vast numbers of casualties that were coming through. Psychiatrists like Hunter were Army officers as well – they had a duty to the war effort. This, I think, explains really the value, or the perceived value, of suppressing a man's mental distress rather than actually addressing the causes and his therapeutic needs perhaps.

The final form of treatment I will mention is that that was carried out at Hollymoor Hospital, at Northfield in Birmingham, which was generally known as Northfield. This is Northfield. This photograph dates from the First World War – it is quite an old one. It is the treatment carried out here at Northfield that is often associated with perhaps some of the greatest successes in psychiatry, military psychiatry, in the Second World War.

Northfield had been transferred to use by the military in 1942 for psychiatric patients and carried out various physical forms of treatment. This included narcosis, in other words, the use of drugs, as both a sedative and also a relaxing agent, and also ECT was used – this was the use of electricity. But there were psychological measures too, and it is these that become well-known and with which Northfield becomes associated, or famously associated.

Psychiatrists there were faced with hundreds of patients and the job of dealing with them and it was decided to gather patients together for ease of use, ease of treatment, in groups. Now, group psychotherapy was not a new idea, but its application to British military casualties was a fresh approach. So, the wards were structured as democratic communities, so they elected representatives and they held discussions about how they should work and operate, and this was to encourage patients to offer each other support, build relationships, and regain a sense of community and duty to each other. Group discussions were held, again, with the same sort of effect, to examine and understand the process, and also discuss the problems that they had. In short, the whole community really was both the patient and the means of treatment, and the main goal was to educate the whole community in the problems that men had and created a therapeutic atmosphere, where individuals were encouraged to believe they were part of a soothing and social community.

The two key individuals who were involved in this, Wilfred Bion, formerly of the Tavistock Clinic and who also had played a very important role in setting up the War Office Selection Boards, and also John Rickman, but the work of these two, Bion and Rickman, has tended to monopolise writing about Northfield, but there were other psychiatrists working there, and these other psychiatrists also introduced new measures, therapeutic measures, which did have some impact.

So, for example, Harold Bridger took up a senior position there towards the end of 1944, and he introduced such things as organised a swimming pool, a hospital club, also a system of mentoring so that new patients would come under the helpful guise and friendship and guidance of an old-hand, a patient who had been there some time. He also opened a hut for art therapy. Things like a theatre was developed, sculpture. These sorts of innovation, as some of you may know, have become swept up after the War and did become a feature, many of them are features of NHS-provided psychotherapy.

However, records of Northfield are few and far between and it is not really possible to determine the degree of success that these had. It seems unlikely, in fact, that these kind of therapeutic processes, however adaptable and suitable they were for a peacetime world, did not achieve a great deal when the ultimate aim was to get men back into the fighting line.

So, I will close now. What I have tried to do really, in the last 50 minutes or so, is to give you an idea of the variety of work in which psychiatrists were involved. Now, there were certainly forms of important innovation, I think – psychotherapy is certainly one of them – and there was the use of drugs, which had not been used to that extent before in a conflict. So, the First World War, drugs had been used, but never to this extent. I have also tried to give you an idea of the level of success, and it is my opinion that it was very limited, despite these forms of innovation.

What the War did, I think also, was to re-educate people, psychiatrists and the military in general, about what had happened in the First World War and some of the conditions that were confronted then and some of the techniques of treatment that were adopted.

Also really just the approach to psychiatric casualties, that some men were more vulnerable than others, that all men had a breaking point, and also there is the concept of forward psychiatry, which was found to be useful and had some effect, did have some effect, certainly did, on getting men back into the fighting line.

Also too, that these less benevolent methods, those that were adopted by men like Hunter, and also by Palmer, to a degree, by focusing on a man's duty and his responsibility to his friends, trying to urge him, explain to him and reason with him, to get him back to fighting status and capable of fighting, as opposed to dealing with his psychiatric problems, that as well was appreciated as an effective way, to some extent, of actually getting them back into the front.

As I say, I do not think there were any great strides, no great leaps really forward in the treatment of psychiatric casualties, and I think, when you look at the work of psychiatrists, military psychiatrists, it is also important to recognise that they were confronted with a vast number of casualties, certainly, in the form of numbers, and also it was impractical really for many psychiatrists, or at least that is how they felt, to actually use the more drawn-out psychotherapeutic treatments that you might find today and that were certainly employed in the more civilian environment.

Above all, I think it needs to be kept in mind that there was very much an emphasis, a military emphasis, on returning men to the fighting line. So, this was not focused really as such on the wellbeing of the individual's mind, but really it was just to fashion him, re-fashion him back into a weapon.

What this also, I think, and I will finish with this, is that what the War does show really is the intractable conflict between psychiatrists and the Army. So, the everyday role of psychiatrists of course is to treat and to work on an individual's health, but the Army here is very much focused on action, very much focused on the individual, has its own needs, and the needs, in wartime, are to actually win the war against the enemy, and it is only later really in the twentieth century that adequate empathy can really be detected I think in the treatment of psychiatric casualties.

Thank you.

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