

No Pain, No Gain

Part I. A Brief History of British Army Psychiatry Origins, Experiences, and Understandings

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Introduction

This paper is taken from the first lecture given by an Army Psychiatrist at the Tavistock Institute, London since 1945. It was given as part of their ongoing expert lecture series on Trauma and entitled 'No pain, No Gain'. It is presented in two parts the first covering historical aspects of Army Psychiatry the second clinical practice.

Alien Military Psychiatry

The Swiss in the 18th century, and Americans in the 19th, described a condition termed Nostalgia, the symptoms of which were a mixture of physical and psychological that have latterly come to be known as War Syndromes. The Swiss saw the symptoms in mercenary soldiers, the Americans in raw recruits, management was social, either disciplinary or administrative, e.g. granting leave.

Throughout the medical history of warfare, careful examination reveals the existence of physical symptoms, medically unexplained by the best science of the day, occurring in serving soldiers and veterans. Attempts to conceptualise or manage them as psychosocial are frequently met with antipathy. Subsequent War Syndrome epithets include Soldier's Heart; Disordered Action of the Heart; Rheumatism; Effort Syndrome; Neurocirculatory Asthenia; Dyspepsia and latterly Gulf War Syndrome. These symptom complexes have much in common and change little over the century other than in emphasis, which generally reflects society's current health preoccupations.

Rudimentary psychiatry in the field had existed in the Russo-Japanese War of 1905 but its lessons were not available, read, understood or accepted by the British medical establishment. The Russians described 'Evacuation Neurosis' in which mental illness became 'fixed' in those evacuated from the East to Moscow.

Army Psychiatry

Army psychiatry remains different from civilian psychiatry. It is an occupational service serving about 0.002% of the current UK population. Armies are sub-cultures with unique social-psychological systems distinct from civilian society, yet existing within such a society. Society has perceived a need for armed forces to protect or project its National interests and this continues today. If

armies are to achieve the mission set them, the organisation becomes of pre-eminent concern and Army psychiatrists have, in times of emergency at least, to view the organisation as their patient rather than its the individual soldiers.

It is unfortunately given within society that mental health labels carry stigma. In military societies, this may be magnified and is hardly surprising given the close and mutually interdependent nature of the work especially when undertaken in the uncompromising theatre of combat. Whilst there is plenty of anecdotal evidence that allowances are made for those failing 'mentally' in battle, such acceptance only occurs in groups that have endured numerous hardships and fought together for long periods of time, and then only afforded to those individuals who are deemed 'worthy' of such tolerance, a judgement made on previous experience with that individual. Stigmatising psychiatric labels can only add to stigma, for example in WWII the American use of the term psychoneurosis was transformed by the Soldier into 'psycho', which retains its pejorative nature today. There has, however, been a long history of euphemism in this area and terms such as combat exhaustion or fatigue or battle shock have face validity and explain the normality of such experiences and thereby allow sufferers to obtain help without labelling.

British Culture and Mental Disorders in 1914

From the outset British men enlisted in the Army in their thousands. They were imbued in the heroic and romantic ideals of 'Imperial Man' who, in war, lived up to the ideals and values of the British Empire, the first Stoic Empire since the Romans.

It must be emphasised that, in 1914, there were neither conceptions of external events creating mental illness nor even the existence of the unconscious mind, within lay, medical or military circles. Mental disorder was 'genetic' in origin and sufferers were removed to asylums. Men who 'broke-down', lost control and were unable to function were conceptualised in social terms and dealt with as such, by disciplinary means. Three thousand capital offences were considered by Courts Marshal and resulted in about three hundred executions; sixteen for cowardice.

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Issues of malingering and desertion are ubiquitous problems for all armies at all times and colour conceptualisations of behavioural abnormalities and mental disorders in soldiers – are they mad or bad?

WWI became an industrialised slaughter and as vast numbers were required for its prosecution; only the grossly insane were excluded from service. Sadly, many men with Learning Disabilities were knowingly, or unknowingly, enlisted.

WWI – The War to End All Wars

British Army psychiatry started in WWI. On the first of August 1914 there were 948,965 soldiers in the British Army of which 236,632 were ‘regulars’ i.e. professionals. Between August and the end of November 1914, 1,250,000 men volunteered to fight. By the end of the war, there were 4,970,902 recruits; 1 in 4 of all UK males were in the Army. The casualty figures are equally incomprehensible. On the Western Front alone, there were 2,760,797 casualties of whom 1 in 3 were killed. 5 out of every 9 soldiers became casualties. The Somme alone accounted for 498,054 casualties over 6 months. As in all wars, infantry take the brunt of the physical (and psychological) casualties, in WWI their casualty rates were 86 per hundred - of which 56% were wounded, 17% killed and 12% taken prisoners of war.

From the outset of WWI, that most female of maladies, hysteria, was occurring in soldiers. These breakdowns were primarily hysterical paraplegias, blindness, aphonia and deafness. In January 1915 Captain Mott used the term ‘Shell-shock’ for the first time in a medical journal where he noted *‘the close relation of these cases to those of hysteria seems fairly certain’*, although this was initially dismissed in favour of organic explanations. Shell shock by its nature captured everyone’s imagination with its physical, even heroic, overtones and may be said to be the first psychiatric diagnosis without stigma.

However, only during the Battle of the Somme in July 1916 was mental breakdown afforded full recognition by the British; after it had become epidemic in proportion. The General’s problem was, as ever, logistical - war cannot be waged without soldiers, thus anything that removed men from the fighting was, and remains, a major problem.

This epidemic of male ‘mental breakdown’ threatened cultural and personal concepts of maleness. If labelled cowardice, desertion or malingering, would discipline ‘stop the rot’? The moral arbitration of fitness to fight, mad or bad, fell to RAMC doctors. From 1914, the Allies had to relearn the lessons of the past through trial and error. For example, the return of French psychiatric casualties to their families created a public outcry and resulted in a policy of keeping them near the Front, which serendipitously, revealed that

many recovered and were able to return to duty.

In the UK, pressure grew for a humane way of dealing with mentally damaged soldiers who were perceived as heroes. The effects of stigma were partially mitigated by non-pejorative terms such as exhaustion and, *par excellence*, shell shock. Shell shock went a long way to assuaging the concerns of all involved, except the military hierarchy. In the field allowances were made for those who suffered – but only if they had ‘done their bit’, shown willing to fight or continue at their post. This was encouraged as removal of soldiers from their social groups is psychologically damaging and engenders shame and guilt. By remaining in, or close to, their group a soldier retains his social role and avoids the epithet of insanity or madness.

Army doctors, products of their society and age, have always faced the moral and ethical dilemmas of returning men to duty and possible death, spotting malingerers and adjudicating on cowards whilst at the same time trying to survive themselves. Soldiers were, and remain, expected to adjust to the horrors of warfare; failure to do so may lead to the presumption of cowardice or mental problems. An Army’s concern is whether a soldier is able to function efficiently at his job and not let his comrades down, for each evacuation increases the pressure on those remaining to achieve their goals with less men.

How then to escape the nightmare of combat with honour? Most do not try, bound by group loyalties, friendship and duty and the avoidance of guilt and shame, they remain in their group. But a wound, not too serious, requiring evacuation is an honourable ‘escape’, the so-called ‘Blighty’. Unfortunately, WWI created the myth that such individuals suffer no mental sequelae, and this has taken a long time to dispel.

Despite great similarity in symptoms, the most favoured psychiatric diagnosis for Other Ranks was hysteria and neurasthenia and shell shock for Officers. It was postulated that the rapid induction and training of conscripts enhanced their suggestibility, and therefore ‘predisposed’ them to hysteria. Shellshock and neurasthenia, however, had a heroic association of ‘good’ men being gradually ‘ground down’ by their responsibilities and hard work.

Before the USA joined WWI, it sent a psychiatrist to report on the Allies psychological experiences and practices. He enunciated the fundamental principles of combat psychiatry which may be remembered by the acronyms PIES:

- Proximity
 - Immediacy
 - Expectancy
 - Simplicity
- and 7R’s
- Recognition
 - Respite

- Rest
 - Recall
 - Reassurance
 - Rehabilitation
 - Return to duty
- which remain valid today.

The Interwar Years

Both during and after WWI the doctor-patient relationship had begun to change. The new military psychiatric hospitals were vastly different from the old asylums and treatments existed to attempt the reintegration of the individual back into society, restore confidence and pride and return to work; so different from the understaffed, overpopulated ‘mad houses’ where personal treatment was impossible due to custodial demands - which may ring some bells today. Psychiatric outpatients became available and the movement to empty the asylums started. More people than ever before had access to psychiatric care as the stock of the psychologist and psychiatrist had risen because of the war. I believe the epidemic of shell shock and other mental disorders forced society to attempt to understand how such mental breakdown could happen. Many sought understanding through spiritualism and many more came to understand or accept the concept of the unconscious. In typical British fashion, we took to some of Freud’s ideas, but not the sexual parts.

Mental disorders were the commonest reason for medical discharge from both the British and American Armies; in both wars. The pension bill for shellshock was enormous and rose throughout the 1920s. In 1921, 65,000 British veterans had a pension for shell shock and the costs were worsened by the financial crisis of the Depression. By 1939, the UK pension bill was £22 million. The Germans withdrew pensions for war neuroses, by reconceptualising them as *“caused by the secondary psychological mechanisms, i.e. the wish to escape danger and the desire to receive financial compensation, not by the trauma itself ...”*. It was stated at the time that the mass of hysterical paraplegics, stammerers and shakers disappeared, almost overnight.

In 1920, the Government sponsored an Enquiry into shellshock, it reported in 1922 and concluded shellshock was not cowardice and every man had his limits. It recommended that efforts should be directed at prevention through selection as issues of predisposition to breakdown and inherited deficiencies were noted in research and by informed opinion. In WW II the Americans went to great lengths to reject those with low IQ and neurotic traits before service, in an endeavour to prevent combat breakdown. However, despite such selection, their medical discharge rate for mental illness was greater than that in WWI. Furthermore, when those rejected on neurotic grounds

were re-examined, many were sent into combat and roughly three quarters of them performed well.

In 1939, as war loomed, a committee was convened to consider ways in which a future pension bill could be minimised. Its recommendations aimed to remove the ‘attraction’ [gain] of a pension and found that *“no man is to be medically discharged from any service in consequence of developing a neurosis, and not ordinarily to receive a pension. No possible advantage should be gained from the illness. The pension and its attainment may become a preoccupation and lessen the natural tendency to recover”*. This directive was later rescinded by Parliament.

World War-Again

Unfortunately, the psychological lessons of WWI were largely forgotten by 1939 and had to be re-learned, repeatedly, in various theatres of operation. The phenomena of mental breakdown under stress became better understood being seen more often in raw recruits and those with personality difficulties, previous psychiatric and drink problems. It was noted to be related to the intensity of battle, of losing, being ill prepared, ill informed, poorly fed and poorly led. On some Normandy beaches, before the breakout, almost a third of all casualties were psychological, afterwards rates fell to one in twenty.

Forward management employed the 7Rs. Rearward management focused on abreaction induced by suggestion, hypnosis or drugs such as sodium pentothal or ether. Physical treatments in rear areas aimed to provide drug induced sleep for between 3 to 10 days, so called narco-therapy. Hypnosis was still used, even in groups of up to 20, and was considered successful.

The infrequent mental breakdown seen in German troops early in the war was attributed to zero or low tolerance of such ‘behaviour’. It is reported, however, that as the war went on, the number of breakdowns increased and between 15 and 30,000 soldiers were summarily executed on various battlefields.

On demobilisation, Society assumed, in much the same way as Freud in 1919, that if soldiers could adjust to the horrors of warfare, once released from the constraints of military service and back with their family they would easily readjust to family and civilian life. Most probably did. However, I recollect as a child in the 60’s my family knew at least one or two individuals who were *“not the same since the war”*.

Returning prisoners of war had particular problems in readjusting to life at home. During WWI it was believed they did not suffer mental illness whilst incarcerated, as ‘their war was over’. On repatriation many could not readjust and the Government had to set up voluntary rehabilitation centres

focusing on re-socialising and return to work. Apparently, they were successful despite the delay in their implementation.

As a group, Far Eastern Prisoners of War [FEPOWS] had the worst experience of captivity. On their return home, they had cursory medical examinations and the Government only responded to their needs following public pressure. As their psychological problems were initially attributed to the malnutrition, vitamin deficiencies, chronic disease and ill health that they suffered, little or no psychological help was offered. Sadly, their mental health had, in many cases, been shattered and their difficulties went unrecognised and untreated for years.

In WWII, stigmatising psychiatric labels were again replaced by concepts understood and more acceptable to soldiers. 'Exhaustion' and 'fatigue' spoke of superhuman effort and testing the limits of human endurance and endeavour; not of mental illness. Some individuals would however never make good soldiers, and those who, by dint of upbringing or genetic makeup, could not "*cut the mustard*" were marginalised and said to swell the ranks of the so-called malingerers.

Unlike WWI, WWII drew attention to the pre-eminence and importance of the Group and Group Dynamics. Individuals subordinated themselves to the group effort required to defeat the Nazis, reflecting a social need and a societal effort. The protective nature of groups were created by training, shared adversity, trust and mutual interdependence and forged in battle. Without time for this process individuals would be more psychologically vulnerable. At demobilisation, such shared group experiences and supportive dynamics were lost, few families could have understood what the returnee had been through; divorces reached 60,000 in 1947, ten times the pre-war rate.

Given the paucity of mental health professionals and the large numbers of patients, groups became the basis of many treatments. Group therapy in the UK is often associated with the first and second Northfield experiments in Birmingham involving Bion, Ffoulkes, Main and Bridger. Out of their work, group analysis and therapy developed, as did the therapeutic community.

Social work, occupational therapy and work therapy were considered fundamental for the societal reintegration of damaged veterans, and the war did much to raise the stock of these specialities. It was said that 'no-hopers' who could not cope with military life ended up in the hands of the psychiatrist. Society could not, however, marginalise those sent to Northfield and similar hospitals; they were often heroes, if medals are a measure of this. In one group of

21 officers, 6 had Military Crosses and one a VC.

Following WWII psychological disorder in veterans was conceptualised [classified] in terms of anxiety, depressive or schizophrenic reactions. It would appear that although military service and combat was acknowledged as important, it was generally not thought to have been as aetiologically significant as it is now characterised. One American psychiatrist, Kardiner did make this link in 1941 but his work was largely forgotten until the PTSD debates in the 1970s.

Korea

Only five years after the end of WWII, the Korean War started. Whilst psychiatric support was mobilised early, it was not initially effective as the main problems came from soldiers recalled to service. High levels of disgruntlement were common and only settled when their tours ended and they were replaced by troops who had not fought in WWII. There were few combat psychiatric casualties in the campaign but the Americans had an 'epidemic' of frostbite which came to be seen as deliberate acts of self-harm or neglect, i.e. psychological not physical accidents or misfortune.

Psychologically however, the Western media focused on torture and brainwashing at the hands of dastardly Communists. This interest permeated popular culture through books and films reinforcing the role of the subconscious mind in psychological and societal discourse on mental illness.

Empire for the British was crumbling and skirmishes were only minor in comparison to the two world wars. As Pax Britanica waned, Pax Americana waxed and the Americans became embroiled in Vietnam.

Vietnam

Vietnam was a military psychiatric success as there were few psychiatric casualties at the time. For many and varied, valid and invalid reasons all that later changed.

WWI initiated a debate about mental collapse during combat. Vietnam initiated the debate on psychological sequelae of combat. Since 1918, all of these debates have had political, financial, philosophical, spiritual and cultural dimensions which often, in my opinion, have the ability to obfuscate as much as to clarify the issues for veterans and clinicians alike.

Soldiers, Culture, Combat and Soldier's Dilemmas

It is a poor doctor who does not understand how culture interacts with the presentation and experience of mental illness and disorder. It behoves all involved in the care of serving soldiers and veterans with psychological difficulties to acquaint

themselves with the military culture and community.

On a battlefield, a soldier has a moral dilemma from the outset; there is little in the human condition that provides such a dramatic conflict. Without escape [deserting, surrendering, malingering, disease, injury], he exposes himself to the possibility of death, wounding or capture. Should he save himself and live with the shame and guilt or should he risk his life and remain with his comrades to fight?

Combat is the most ambivalent of human experiences and I believe that denial and suppression, at all levels, are a prerequisite for the efficient functioning of an Army in combat. Furthermore, denial at a societal level must also exist if too early expression or acceptance of the loss and pain which war brings is not to undermine the National will. Some have even suggested that combat is the ‘ultimate’ male experience, a *rite de passage* in much the same way that childbirth has been described as the ‘ultimate’ female experience.

We know that man-made disasters produce more psychopathology than natural disasters and war is the most human of all disasters. Yet young men, and women, continue to enlist, why? I believe that this ‘group experience’ is key to soldier’s experiences. The feeling of belonging, being part of something bigger than one’s self, duty, honour and the like are human needs, sadly seldom seen in civilian life; where life seems increasingly risk averse.

The mutual interdependence of combat often engenders a closeness and camaraderie never subsequently experienced. Combat can lead to acts of altruism and self-sacrifice that becomes the stuff of myth and fable. Under threat, in the close company of trusted comrades an individual can transcend himself in actions that may later become folklore or, not infrequently, never spoken of. The threat of imminent death can accentuate the sweetness of life.

Loss and grief are the connecting threads of the psychological costs of combat. Combat involves exposure to sudden and violent death. A battlefield is not the place to breakdown; denial and suppression are required for survival in such a physically and emotionally hostile environment. For example, the initial relief, even euphoria, at having escaped death often leads to guilt, shame and anger at surviving when others, friends, have died. If the losses occur during combat, a period of overwhelming psychological arousal, they may become state dependent emotional experiences, which may make them unavailable for subsequent grief work. Losses include loss of innocence [of having to kill or be killed]; of the sense of invulnerability [omnipotence]; of humanity; of dignity and group support through death or injury.

Grief may be masked and bereavement disturbed; close therapeutic rapport is required before psychotherapeutic work can be commenced.

Group Dynamics

On enlistment, individuals ‘lose’ some basic human rights, which are counterbalanced by membership of a society without the usual strictures of secrecy. No Army can function in great danger without trust and mutual interdependence, situations seldom knowingly encountered in civilian life. Many who leave the Army miss the closeness, the shared goals and achievements it is possible to experience during service.

Whilst individuality is diminished at one level, on another it is enhanced through altruism and the mobilisation of personal resources for the benefit of the group. Soldiers clearly know their rights, responsibilities and place in a hierarchy with clear boundaries and where there is always a superior responsible for them. It can lead to what has been termed ‘a facultative regression’ in which separation from biological family is replaced by a new (Army) family. In this new family rules, structures and boundaries are clear and obvious which, coupled with hard training, encourage the forging of close peer group relationships, so-called horizontal relationships. In combat, survival is dependent on these relationships and their corporate responsibility of reciprocity. Combat is the proving ground of the relationships formed in training and as such, they may rival, or exceed, familial bonds in intensity and importance. Superior figures such as officers and senior NCOs become very important, almost parental, figures whose significance may, in war at least, be of life or death providing as they do food, clothing, shelter and information.

Reliance on these figures is required, so-called vertical bonding. This may vary from the realistic to idealistic. When stress is extreme, the tendency to regress is exacerbated and individuals will look for leadership in such circumstances. Pathological idealisation or idolisation of superiors may predispose soldiers to demoralisation and disillusionment if reality doesn’t turn out as they expected; this may in turn lead to mental distress and possibly projection of blame which will be damaging to all concerned.

The support of comrades in the group is vital for survival. Regard for comrades, respect for leaders and urge to contribute are the major elements of resilience in combat. Thus, well-trained soldiers arrive in combat with a military psychosocial mind-set that is both their strength and resiliency under battle but harbours within it a vulnerability to bereavement from the loss of the close bonds forged in training and under the stress of battle.