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Twentieth-century Theories on Combat Motivation and Breakdown

The question of psychiatric breakdown either in battle or subsequently has received much attention in recent years, both in the historical and psychiatric literature. The latter, however, whilst plentiful, can often fail to recognize the ambiguous and complex nature of the subject.¹ In particular, there is a failure to consider the relationship between why men develop psychiatric injury as a result of military service (a well-developed narrative in psychiatric histories) and what made them fight in the first place (currently usually ignored). This article will argue that part of the contemporary confusion in psychiatric thinking, and the continued tension between the military and psychiatric perspectives on the subject, results from a failure to integrate the literature on combat motivation with the psychiatric literature on combat breakdown.

When psychiatrists write about psychiatric injury there is a tendency to place the origins of the contemporary acknowledgment of the psychological costs of war in the first world war. Many psychiatric, as opposed to historical, accounts take a Whiggish view according to which eyes were first opened to the reality of psychiatric breakdown when it became clear that no mind could withstand the stressors of the trenches. This was the beginning of the road to contemporary enlightenment, but it was only in 1980 with the entry of post-traumatic stress disorder (PTSD) into the psychiatric diagnostic bible, the *Diagnostic and Statistical Manual*, that the true cost of trauma was finally acknowledged.² At that time, soldiers with PTSD were likely to be shot; now

I would like to thank Professor Christopher Dandeker, Brigadier John Graham, Lt Commander Neil Greenberg, Colonel Richard Irons, Professor Edgar Jones, Professor Catherine Merridale and Mr Ben Shephard for their help and advice.

1 No definitive history of military psychiatry has yet been written. Ahrenfeldt provides a useful ‘official’ history of the British experiences between 1939 and 1945, whilst Anderson and Glass edited a similar volume for the USA. Ben Shephard has provided a definitive account of both world wars uniting the British and American stories, but is less compelling for the modern era, including Vietnam. David Marlowe, an anthropologist whose career was with the US military, has provided an insightful narrative that deserves to be better known. Finally, Edgar Jones and I have revisited the British experience up to the present. R.H. Ahrenfeld, *Psychiatry in the British Army in the Second World War* (London 1958); R. Anderson, *Neuropsychiatry in World War II* (Washington, DC 1966); Ben Shephard, *A War of Nerves, Soldiers and Psychiatrists 1914–1994* (London 2000); David Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment* (Santa Monica, CA 2000); Edgar Jones and Simon Wessely, *From Shell Shock to PTSD. Military Psychiatry from 1900 to the Gulf War* (London 2005).

2 Before you consider this hyperbole, attend a modern ‘traumatology’ conference. For a more

they receive counselling and all is well.³ Key figures in this narrative include Rivers, Sassoon and Owen, and key texts include *Regeneration* and *Birdsong*.⁴ Chris Brewin,⁵ a noted contemporary psychologist specializing in PTSD, labels proponents of such views as 'saviours', who argue that 'after years of neglect, the special suffering brought about by psychological trauma has at last been recognised in the form of PTSD'.⁶ Some members of the profession go further and postulate the concept of a 'universal trauma reaction', a fixed, determinate psychobiological response to trauma that they can trace back to the *Iliad*.⁷ The message is the same: the psychological consequences of trauma are an unchanging reality, but we have only belatedly come to accept this, starting with the trenches and ending with the Vietnam War.

Little could be further from the truth. As Paul Lerner's recent account of German psychiatry and the problem of trauma from the Kaiserreich via the *Kriegsneurosen* debate to the end of Weimar has shown, psychiatrists used the experiences of the first world war to conclude the opposite.⁸ At the end of the war the ascendant view was that the war-traumatized veteran was weak

scholarly account which still sees the first world war as the watershed for modern psychiatry, see Martin Stone's essay arguing that the British acceptance of Freud depended on the shell-shock experience, or Showalter's book suggesting that the acceptance of male neurosis likewise depended on the legacy of shell-shock. Martin Stone, 'Shellshock and the Psychologists' in W. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness* (London 1985), 242–71; Elaine Showalter, *The Female Malady. Women, Madness and English Culture, 1830–1980* (London 1987).

3 Give counselling to those who have just been exposed to trauma and all is not well. Single session psychological debriefing does not prevent psychiatric disorder, and probably increases it, a reminder of the dangers of medicalizing distress and medical hubris that would not have been lost on the critics of shell-shock. See Simon Wessely and Martin Deahl, 'Psychological Debriefing is a Waste of Time', *British Journal of Psychiatry*, 183 (2003), 12–14; Richard Gist and Grant Devilly, 'Post-trauma Debriefing. The Road too Frequently Travelled', *The Lancet*, 360 (2002), 741–2.

4 But as Brian Bond pointed out in his valedictory lecture, despite the success of Sebastian Faulks and Pat Barker, the most powerful image of the first world war for contemporary school-children comes from the pens of Richard Curtis and Ben Elton in the person of Captain Edmond Blackadder.

5 Chris Brewin, *Post-traumatic Stress Disorder: Malady or Myth* (Newhaven 2003) provides an accessible introduction to the subject, arguing in favour of the malady rather than the myth.

6 See Wilbur Scott, 'PTSD in DSM-III. A Case in the Politics of Diagnosis and Disease', *Social Problems*, 37 (1990), 294–310 and Allan Young, *The Harmony of Illusions. Inventing Post-traumatic Stress Disorder* (Princeton, NJ 1995) for seminal accounts of the politics surrounding the origins of PTSD.

7 Many psychiatrists have criticized the naivety of this approach. See Jerome Kroll, 'Post-traumatic Symptoms and the Complexities of Responses to Trauma', *Journal of the American Medical Association*, 290 (2003), 667–70. More polemic arguments against the entire PTSD concept are also frequently heard, but probably have more influence outside the psychiatric profession than within it: see Derek Summerfield, 'The Invention of Post-traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category', *British Medical Journal*, 322 (2001), 95–8; Sally Satel, 'The Trauma Society', *New Republic*, 19 May 2003. Frank Furedi's recent assault on therapy and victimhood takes a broader route to similar conclusions: Frank Furedi, *Therapy Culture. Cultivating Vulnerability in an Anxious Age* (London 2003).

8 Paul Lerner, *Hysterical Men. War, Psychiatry and the Politics of Trauma in Germany, 1890–1930* (Cornell, WI 2003).

and selfish — one of the reasons why Germany lost the war, and likely to bankrupt the state unless checked. It was an extension of the *Rentenkampfneurosen* triggered by Bismarck's stick-and-carrot attempts to counter the influence of socialism by introducing progressive social insurance,⁹ and resisted by the majority of doctors who saw it as a 'malingerers' charter'. For German psychiatry shell-shock was a moral matter. The nation had a duty not to encourage the labelling and recognition of psychiatric breakdown — the cost to the individual (condemned to a lifetime of psychiatric suffering and moral shame), to the army, which would be unable to deal with the manpower crisis, and to the exchequer, forced to pay the pensions bills, was unacceptable.

The official British doctrine on psychiatric breakdown in combat was enunciated by the War Office Commission of Inquiry into Shell-Shock, chaired by Lord Southborough, which reported in 1922.¹⁰ Its conclusions were not substantially different from those reached in Germany. The Southborough committee was faced with a dilemma and one that it failed fully to resolve. Of all the witnesses before them, the one who would make the most lasting impact was Charles Wilson, who had been a Medical Officer on the Western Front and would later become Lord Moran and Churchill's doctor. Later in life he wrote *The Anatomy of Courage*, based on his first world war diaries and still on the reading lists at Shrivenham and Sandhurst today. Wilson came to believe that eventually the strongest nerves would crack under the strain of trench warfare. Men had only a limited 'bank of courage', which would inevitably be expended under the conditions of the Western Front. Eventually, every man had his breaking point.¹¹

But Moran's views were not those of the Committee, nor of the majority of the witnesses it heard. The Shell-Shock Commission generally continued to reflect traditional Edwardian values of courage and moral fibre.¹² Breakdown was not inevitable, some men made better soldiers than others and some were more resilient than others. Why, for example, had the number of shell-shock cases soared in 1916 and 1917 on the Somme and at Third Ypres? Was it simply that the psychological cost of modern war had become more than the mind could bear? Or was it due to the influx of the citizen armies and finally

9 Greg Eghigian, 'The German Welfare State as a Discourse of Trauma' in Paul Lerner and Mark Micale (eds), *Traumatic Pasts. History, Psychiatry and Trauma in the Modern Age, 1860–1930* (Cambridge 2001), 92–112.

10 Anon, *Report of the War Office Committee of Enquiry into 'Shell-Shock'* (London 1922).

11 Although cited by modern commentators such as Richard Holmes as a seminal account, Moran's own views were more ambiguous. Despite his much-quoted remarks on every man having his breaking point, he also believed that shell-shock was infectious, and that it 'gives fear a respectable name'. Its victims had 'the stamp of degeneracy'. See Charles Moran, *The Anatomy of Courage* (London 1945); Carl May, 'Lord Moran's Memoir. Shell Shock and the Pathology of Fear', *Journal of the Royal Society of Medicine*, 91 (1998), 95–100.

12 See Ted Bogacz, 'War Neurosis and Cultural Change in England, 1914–1922: The Work of the War Office Committee of Enquiry into Shell-Shock', *Journal of Contemporary History*, 24, 2 (April 1989), 227–56 for the ambivalence of the Commission as it tried to reconcile the need to promote courage and deter cowardice, whilst still trying to be compassionate towards those who had broken down after 'doing their bit'.

the Derby conscripts? Members of the Commission favoured the latter view. Turning their backs on the psychologists, including Myers himself, who refused to give evidence, they preferred views such as that of the future Lord Gort, VC — that shell-shock was a ‘regrettable weakness’, ‘and never present in crack units’. The Commission concluded that the best way to prevent breakdown was to ensure that troops were properly trained, properly equipped and properly led.¹³

This conclusion was supported by numerous observations of prisoners of war (POWs) and those who had received physical wounds. The view that neither group suffered much from combat neurosis, shell-shock or its equivalents was held with conviction and endorsed by several statistical studies.¹⁴ Reflecting on his experiences, one first world war doctor later wrote: ‘We rarely saw a “shell-shocked” soldier, a neurotic soldier, who had a wound. The wounded individual did not need a neurosis, he was out of the situation by virtue of his wound.’¹⁵ Likewise, POWs did not ‘need’ a psychiatric illness, as they too were out of the war.¹⁶

Like the German medical establishment, the Southborough Committee concluded that a medical label such as ‘shell-shock’ should not be applied to breakdown in battle. Such labels medicalized a non-medical condition and gave people a way of escaping their duties. The expression was banned, just as the Germans rejected the term *Kriegsneurosen*. It is one of the paradoxes of the history of psychiatric injury that just as both doctors and the military were turning against the expression ‘shell-shock’, and removing it from official discourse and classification, it was starting to occupy the central position in literary and cultural writing that it retains today.¹⁷

Finally, there was a general conclusion across all the combatant nations that the method of treating psychiatric breakdown, which was based on the same principles as those used for the treatment of physical injuries, was a mistake.

13 This conclusion was not intrinsically flawed — these are effective methods of reducing breakdown, but they do not eliminate it.

14 See Lerner, *Hysterical Men*, op. cit., 68–9.

15 D. Thom, ‘War-Neuroses. Experiences of 1914–1918’, *Journal of Laboratory and Clinical Medicine*, 28 (1943), 499–508; see Harold Wiltshire, ‘A Contribution to the Etiology of Shell Shock’, *The Lancet*, i (1916), 207–12.

16 I have been unable to find any sources that dispute this observation, but moving to the present literature it is hard to find any authors who say anything other than the opposite. Long-term studies of Canadian prisoners after Dieppe, FEPOWs, Israelis captured during Yom Kippur or the Lebanon invasion, Americans in Vietnam, Bosnians held by the Serbs after the breakdown of Yugoslavia and so on, invariably report high rates of psychiatric disorder. Likewise, modern studies show that those who receive physical wounds are at higher, not lower, risk of psychiatric disorder. It is possible that the earlier generation of reports are all examples of the ‘denial’ of the reality of psychological distress beloved of Chris Brewin’s ‘Saviours’, but this seems an unlikely explanation for such a fundamental shift. See Robert Ursano et al., ‘The Prisoner of War’ in Robert Ursano and Ann Norwood (eds), *Emotional Aftermath of the Persian Gulf War. Veterans, Families, Communities and Nations* (Washington, DC 1996) for a contemporary review.

17 See ch. 10 of Peter Leese, *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War* (Basingstoke 2002) for a discussion of the post-1918 cultural history of shell-shock.

By the end of the war the policy of sending psychiatrically damaged servicemen down the line to a base hospital had been reversed. In came the new doctrine of ‘forward psychiatry’, according to which soldiers were treated as near to the front line as possible, in uniform and under military discipline. Soldiers were told that breakdown had a physiological basis — hence the introduction later of terms such as battle or combat fatigue to emphasize the transient nature of the problem. Treatment involved a couple of days’ rest, food, clean clothing and sleep. After that the soldier was subtly, or more often not so subtly, encouraged to resume his military role, return to his unit, and prove himself a man.¹⁸

So it is wrong to consider the first world war as the origins of our contemporary views on PTSD and combat breakdown. Instead, the conclusion was that breakdown could be avoided by better selection, training, leadership and morale. Any medical or psychiatric diagnostic label such as shell-shock provided an excuse for men to avoid their duties and was to be avoided. The real ‘watershed’¹⁹ in the conceptualization of war-induced breakdown was not reached until the second world war and the acknowledgment of the almost inescapable impact on the psyche of industrialized warfare,²⁰ and not until after Vietnam that a medical label for breakdown again found favour.

The perceived legacy of the first world war meant that the British began the second world war with policies on war breakdown that were intended to be more ruthless, and hence more effective, than those applied in the Great War. It was taken for granted that selection needed to be improved. Likewise, the so-called ‘rewards’ for mental breakdown needed to be removed, and so there would be no medical label, no discharges and no pensions payable during wartime for those suffering psychiatric breakdown.²¹

18 There is still a consensus that abandoning soldiers at rear hospitals and psychiatric institutions does little for morale, self-esteem or the prospects of recovery. Many did indeed spend lives afterwards characterized by bitterness, regret and self-loathing, as Ben Shephard’s description of Spike Milligan’s treatment in a rear hospital in Italy makes clear (Shephard, *A War of Nerves*, op. cit.). But we cannot be sure whether the opposite, keeping men in uniform near to the front line and returning them to the military environment in a few days, the doctrine of ‘forward psychiatry’, is better. This is because of the impossibility of conducting an unbiased assessment — commanders will always retain the less sick and more useful individuals, evacuating to the rear the more disturbed and less useful, who have a worse prognosis anyway. We cannot be sure whose interests are being served by ‘forward psychiatry’— is it the individual or the military? E. Jones and S. Wessely, ‘Forward Psychiatry in the Military. Its Origins and Effectiveness’, *Journal of Traumatic Stress*, 16 (2003), 411–19.

19 Marlowe, *Psychological and Psychosocial Consequences*, op. cit.; Gerald Grob, *From Asylum to Community. Mental Health Policy in Modern America* (Princeton, NJ 1991); Nathan Hale, *Freud and the Americans. The Beginnings of Psychoanalysis in the United States, 1876–1917* (New York 1971); Hans Pols, ‘Repression of War Trauma in American Psychiatry after WWII’ in R. Cooter, M. Harrison and S. Sturdy (eds), *Medicine and Modern Warfare* (Amsterdam 1999), 251–76.

20 E. Jones and S. Wessely, ‘The Impact of Total War on the Practice of Psychiatry’ in Roger Chickering and Stig Forster (eds), *Shadows of Total War, 1919–1939* (Cambridge 2001), 129–48.

21 Ben Shephard, ‘“Pitiless Psychology”. The Role of Prevention in British Military Psychiatry in the Second World War’, *History of Psychiatry*, 10 (1999), 491–524.

But as the war progressed, it proved impossible for the democracies at least to sustain these policies. The conventional wisdom held that selection played a key role in preventing breakdown; yet by 1943 the Americans had concluded that this policy was an abject failure. Despite the introduction of psychiatric screening on a massive scale the problem was not solved, but seemed worse than before.²² Selecting the 'right stuff' at induction did not prevent psychiatric casualties, but did create a serious manpower shortage. So in a vast natural experiment, many of those previously rejected for military service by the American psychiatrists were re-inducted into service, and the majority made satisfactory soldiers.²³

Removing the so-called 'rewards' did not prevent breakdown either, nor did it have popular support. As William Sargant observed after Dunkirk:

Just before the declaration of war a group of official advisory experts . . . had decided that war neuroses could best be abolished by simply pretending that they did not exist, or at least were not caused by a man's war experience but by an inherited predisposition or early childhood trauma. . . . they were entitled to no disability pension. . . . This ruling naturally caused their relatives as well as themselves great distress. . . . The pitiless World War I psychological theories that once freed from the Army these neurotics would stop 'subconsciously malingering' and recover at once proved to be arrant nonsense.²⁴

Opinion shifted away from a belief in prevention to the view that 'every man has his breaking point', and for the first time statistics appeared to support this view. Beginning with the US analysis of the setbacks in the North Africa campaign of 1942/43, these showed a robust link between the numbers of physical and psychiatric casualties.²⁵ As one increased so did the other, until

22 One contemporary source noted this double whammy — that the second world war was associated with both higher rejection rates prior to service and higher rates of breakdown. E. Strecker and K. Appel, *Psychiatry in Modern Warfare* (New York 1945). It is impossible to be certain if the true rate of psychiatric breakdown was actually higher in the second than in the first world war because of problems in the interpretation of official statistics, but the number of psychiatric war pensions paid as a proportion of the fighting force was definitely higher. Shephard, *War of Nerves*, op. cit.; Jones and Wessely, *From Shell Shock to PTSD*, op. cit.

23 See E. Ginzberg, J.W. Anderson, S. Ginsberg and J. Herma, *The Ineffective Soldiers. The Lost Divisions* (New York 1959) for an account of psychiatric screening in the USA during the second world war. E. Jones, K. Hyams and S. Wessely, 'Screening for Vulnerability to Psychological Disorders in the Military. An Historical Inquiry', *Journal of Medical Screening*, 10 (2003), 40–6, takes the story to the present, and R. Rona, K. Hyams and S. Wessely, 'Screening for Psychological Illness in Military Personnel', *Journal of the American Medical Association*, 293 (2005), 1257–60, discusses the problems posed by the reintroduction of psychiatric screening by the Americans (but not the British) as a consequence of the war in Iraq. See also the 2005 deliberations of the House of Commons Defence Committee ('Duty of Care' Inquiry) for a contemporary revisiting of the selection argument in the context of suicide prevention.

24 William Sargant, *The Unquiet Mind. The Autobiography of a Physician in Psychological Medicine* (London 1967), 94.

25 G. Beebe and M.E. DeBakey, *Battle Casualties. Incidence, Morality and Logistic Considerations* (Springfield, IL 1952); R. Anderson and A. Glass (eds), *Neuropsychiatry in World War II* (Washington, DC 1966); E. Jones and S. Wessely, 'Psychiatric Casualties of War. An Inter- and Intra-War Comparison', *British Journal of Psychiatry*, 178 (2001), 242–7.

eventually a unit was rendered combat-ineffective by psychiatric breakdowns. The Americans concluded that in the conditions of intense industrial warfare every man could indeed reach breaking point if he fought long or hard enough.²⁶

There was a second major shift as a result of the second world war, and this was in the understanding of combat motivation. Out went previous doctrines that men fought for moral reasons (patriotism, esprit de corps, pride and leadership, and so on), and in came the core role of small-group psychology. Specific motivations — those located in time and place, such as patriotism, religion and ideology — were replaced by more general explanations.

These new explanations were best articulated in three key texts that had their origins in surveys sponsored by the US War Department during the second world war. These studies, the 'Big Three' of combat motivation, profoundly altered views of combat motivation and demotivation. They are S.L.A. Marshall's study of Americans fighting in the Pacific,²⁷ the four volumes edited by Stouffer,²⁸ published as part of a larger series on Studies in Social Psychology, and finally the study of combat motivation and disintegration in the Wehrmacht, published in 1948 by Shils and Janowitz.²⁹

The key factor in combat motivation was what both Shils and Janowitz and Robin Williams called the 'primary group', a term derived from psychoanalysis.³⁰ This was defined as those with whom an individual comes into daily

26 Morris Janowitz, *The Professional Soldier. A Social and Political Portrait* (New York 1971), 46.

27 S.L.A. Marshall, *Men Against Fire. The Problem of Battle Command in Future War* (New York 1947). None of my dinner companions was aware of the later doubts cast on his methods, and in particular his famous 'ratio of fire' finding; see Roger Spiller, 'S.L.A. Marshall and the Ratio of Fire', *Royal United Services Institute Journal*, 133 (1988), 63–71.

28 Samuel Stouffer (ed.), *The American Soldier. Combat and its Aftermath* (Princeton, NJ 1949). See Robin Williams, 'The American Soldier. An Assessment, Several Wars Later', *Public Opinion Quarterly*, 53 (1989), 155–74 for a 40-year retrospective look at 'The American Soldier', and T. Schwartz and R.M. Marsh, 'The American Soldier. Studies of WWII. A 50th Anniversary Commemorative', *Journal of Political and Military Sociology*, 27 (1999), 21–37, for a 50-year assessment of its impact.

29 Edward Shils and Morris Janowitz, 'Cohesion and Disintegration in the Wehrmacht in World War II', *Public Opinion Quarterly*, 12 (1948), 280–315. Both Edward Shils and Morris Janowitz had been members of the influential Chicago School of Sociology, at the time the most prominent department of sociology in the USA, strongly influenced by Max Weber. They had been attached to both the British and American armies, then worked in the Intelligence section of the Psychological Warfare unit of SHAEF and had interrogated numerous German prisoners of war. After the war Shils returned to a distinguished career in Chicago, and subsequently founded the journal *Minerva*. He ended his career in the very distinct primary group of Peterhouse, Cambridge. Janowitz returned to the USA, and founded the journal *Armed Forces and Society*. Whilst Shils and Janowitz's article has become a seminal paper, Herbert Spiegel, an army psychiatrist, made many similar observations about US infantry four years earlier. 'Preventive Psychiatry with Combat Troops', *American Journal of Psychiatry*, 101 (1944), 310–15. 'Men fought', said Spiegel, 'for love.'

30 The influence of psychoanalytic theory on the combat motivation debate has been little noted, an exception being David Smith, 'The Freudian Trap in Combat Motivation Theory', *Journal of Strategic Studies*, 25 (2002), 191–212. Shils and Janowitz make frequent references to

contact in intimate face-to-face association and co-operation. As Marshall wrote: 'I hold it to be one of the simplest truths of war that the thing which enables an infantry soldier to keep going with his weapons is the near presence or presumed presence of a comrade.'³¹ Men fight because they belong to a group that fights. They fight for their friends, their 'buddies'. They fight because they have been trained to fight and because failure to do so endangers not just their own lives, but also those of the people immediately around them with whom they have formed powerful social bonds.

These views, and all three texts, remain standard doctrine.³² It is not hard to see why they continue to be popular with professional militaries. We live in a non-ideological age and it is hard to see how Western militaries would recruit, let alone train and sustain, a modern professional army on ideology alone. Values such as Queen and Country have not vanished from the British military, but they are not prominent.³³

Although there is little sign of a waning of influence of the 'Big Three' studies in Staff Colleges, the same is not true in the scholarly literature.³⁴ In particular, the question of what made the Wehrmacht fight for as long as it did, and in the manner that it did, has been used to support the opposite case — that ideology, not primary groups, remains a prime source of combat motivation, even if opinions differ as to exactly which ideology is involved. The contrasting views of Omar Bartov on the barbarization of warfare in the East and Andreas Hillgruber on why the Wehrmacht continued to fight in defence of the Reich when militarily the cause was hopeless, are both examples of an

psychoanalytic concepts, for example describing a soldier's reluctance to surrender as being due to 'castration anxiety', a concept that most modern readers would have difficulty in understanding. Psychoanalysis was then at the height of its influence in psychiatric and intellectual circles. Whilst it continues to have a major impact on areas such as literary criticism, nowadays it is hard to find an academic psychiatrist in the USA or UK who will admit to more than a passing flirtation with psychoanalysis.

31 S.L.A. Marshall, *op. cit.*, 42.

32 At a recent graduation dinner hosted by the Royal College of Defence Studies, I carried out an informal poll at my table, at which I was the only non-military person, the others all being senior officers representing nine different NATO nations. All were aware of Marshall, most knew 'The American Soldier' and three had read Shils and Janowitz. This was an unscientific sample, but the same three works dominate the standard works on combat motivation in use today. See also A. Kellett, 'Combat Motivation' in Greg Belenky (ed.), *Contemporary Studies in Combat Psychiatry* (New York 1987), 205–32; F. Manning, 'Morale, Cohesion and Esprit de Corps' in R. Gal and A. Mangelsdorff (eds), *Handbook of Military Psychology* (Chichester 1991), 453–70; Nora Kinzer Stewart, *Mates and Muchachos. Unit Cohesion in the Falklands/Malvinas War* (London 1991).

33 'The American Soldier' did not reject ideology as a motivation, especially when considering why men serve, as opposed to fight. It confirmed the general ideological acceptance of the social and political basis of the US armed forces, together with what they labelled as 'latent' support for the aim of the war itself. But this was less important during the actual circumstances of battle. See Williams, 'The American Soldier. An Assessment', *op. cit.*, 155–74. Patriotism and support for Queen and Country are a similar 'latent' ideology in the British armed forces.

34 Bruce Newsome, 'The Myth of Intrinsic Combat Motivation', *Journal of Strategic Studies*, 26 (2003), 24–46.

ideological view, albeit with different conclusions.³⁵ Bartov's view, to which has been added the deliberate brutalization of Wehrmacht soldiers and their exacting system of military discipline, continues to gain support.³⁶

Caution is certainly needed in interpreting Shils and Janowitz's article.³⁷ It is based partly on POW interrogations carried out during the war and it is plausible that captured soldiers would be more likely to emphasize the role of local social factors and their own military professionalism, than of National Socialist ideology. Indeed, Shils and Janowitz do accept the role ideology played amongst what they call the hard-core National Socialists, but estimate that the latter accounted for no more than 10–15 per cent of the fighting forces, mainly the junior officers.

But notwithstanding the scholarly criticisms, as far as modern military thinking is concerned there is little debate to be had. Teaching on what is called the 'moral component' of warfare at the British Staff College follows the generalist position,³⁸ rarely if ever emphasizing ideology. Albert Glass, the dominant figure in US military psychiatry in the postwar years, would conclude his career by writing that 'perhaps the most significant contribution of World War II military psychiatry was recognition of the sustained influence of the small combat group . . . "group identification", "group cohesiveness" . . . "the buddy system"'.³⁹ And over the years data has appeared on a sporadic basis which does not challenge, at least on the surface, this consensus. For example, a study of 'morale' in the Israeli army, based on interviews with 4723 participants in the Yom Kippur War, concluded that 'belief in the country, historical reasons for war, rightness of the government, and so forth, all were irrelevant'.⁴⁰ Few of the British service personnel I and my colleagues interviewed immediately after the 2003 invasion of Iraq claimed that lack of support for the war in the UK had influenced their own views of the war. Most constructed what they had done in professional terms, and, when asked to describe any negative views or experiences, chose to talk about matters such as equipment, food and kit, traditional gripes and the problem of friendly fire.⁴¹

35 Omar Bartov, 'Historians on the Eastern Front. Andreas Hillgruber and Germany's Tragedy' in Omar Bartov (ed.), *Murder in Our Midst. The Holocaust, Industrial Killing and Representation* (New York 1996), 71–88.

36 Omar Bartov, *Hitler's Army. Soldiers, Nazis, and War in the Third Reich* (Oxford 1991); Truman Anderson, 'Incident at Baranivka. German Reprisals and the Soviet Partisan Movement in Ukraine, October–December 1941', *Journal of Modern History*, 71 (1999), 585–623.

37 R. Rush, 'A Different Perspective. Cohesion, Morale, and Operational Effectiveness in the Germany Army, Fall 1944', *Armed Forces & Society*, 25 (1999), 477, is an exception, arguing that the fighting during the winter of 1944 in the West showed the Wehrmacht to be a far less effective fighting force than that depicted by Shils and Janowitz.

38 See for example the standard British army doctrine at <http://www.army.mod.uk/doctrine/resources/Publications/> or for the USA at <http://usmilitary.about.com/cs/army/a/soldiersfight.htm>

39 Albert Glass, 'Mental Health Programs in the Armed Forces' in G. Caplan (ed.), *American Handbook of Psychiatry* (2nd edn, New York 1974), 800–9.

40 Ben Shalit, *The Psychology of Conflict and Combat* (New York 1988), 158.

41 See Leonard Wong et al., *Why They Fight: Combat Motivation in the Iraq War* (Carlisle, PA 2003) for a similar US view; <http://www.carlisle.army.mil/ssi/pdf/PUB179.pdf>, although this

Likewise, the mental health of members of 16th Air Assault Brigade, admittedly élite and aggressive units, improved during their deployment in the invasion of Iraq.⁴²

The new views on combat motivation that emerged after the second world war also influenced views on combat breakdown. If soldiers fought for the primary group, then, the argument goes, soldiers ceased to fight when the primary group failed them. For Janowitz and Shils this happened when either they were never accepted by the primary group — because they were social misfits in the first place — or belonged to ‘out’ groups such as the *Volkdeutsch*, who surrendered in larger numbers because they made less identification with the primary group structures that defined the Wehrmacht. Alternatively, soldiers ceased to fight when the primary group itself permitted this, usually after some token or carefully scripted ritual of resistance to satisfy group honour before surrender. Other explanations of combat breakdown advanced during and after the second world war continued the same theme — the fundamental cause was disruption in group solidarity, either because it never formed or because of the circumstances of war. Immediately after the war, a US military psychiatrist wrote: ‘The main characteristic of the soldier with a combat-induced neurosis is that he has become a frightened, lonely helpless person whose interpersonal relationships have been disrupted . . . he had lost the feeling that he was part of a powerful group’.⁴³ Grinker and Spiegel, whose observations on combat breakdown have now been rediscovered by contemporary psychiatrists, likewise included the primary group as a core motivation: ‘The ability to identify with a group and the past history of such identification are probably the most important components of good motivation for combat’.⁴⁴

If primary groups were central to preventing breakdown in battle, preserving them was a priority for personnel policies in most of the combatant nations of the second world war, whether by accident or design. In both the Red Army and the Wehrmacht, in so much as it was possible, men continued to serve with the same unit, even when that unit had received severe casualties. Units went into the line, and were withdrawn from the line, together. Furthermore, units were in it for the duration. Service was open-ended, until death, serious injury or the end of the war. The British and Americans were different, however, in that neither recognized ‘combat neurosis’ as such. The perceived legacy of the first world war meant that the German armies officially

only pertains to the period of the initial invasion of Iraq. In the same study, interviews with Iraqi POWs suggest that they fought because of fear of the Ba’ath Party. One wonders if this information was subject to a similar bias as that gleaned by Shils and Janowitz in their interviews with German POWs, few of whom voiced pro-nazi sympathies.

42 J. Hacker Hughes et al., ‘Going to War Can be Good for You. Deployment to War in Iraq is Associated with Improved Mental Health for UK Personnel’, *British Journal of Psychiatry* 186 (2005), 536–7.

43 E. Weinstein, ‘The Function of Interpersonal Relations in the Neurosis of Combat’, *Psychiatry*, 10 (1947), 307–14.

44 Roy Grinker and John Spiegel, *Men under Stress* (London 1945). Neither Weinstein, Grinker nor Spiegel had any direct experience of combat.

did not recognize psychological breakdown. In practice it seems that at a lower level various ruses and stratagems were used to permit the treatment of breakdown, even under a harsh disciplinary code. The Red Army refused to recognize combat breakdown as a medical problem in any shape or form — only psychosis was an acceptable psychiatric label, and even then most of those who left military service under that label probably died of deprivation and/or starvation in mental hospitals. Everything else was a failure of either moral character and/or political leadership, and was treated harshly.⁴⁵

One objection to the prevailing orthodoxy on primary groups and the prevention of breakdown is that the toll of casualties during prolonged combat meant that in practice losses were reinforced piecemeal and on an individual basis, which ought to have reduced the effectiveness of the primary group in sustaining combat motivation. Numerous personal accounts of US combatants in the war in Europe include some comment about how individuals would join units, go into combat and be killed before anyone even knew who they were. However, this is less of a challenge to orthodoxy than it appears, for the intense nature of the war and combat experience meant that, as Catherine Merridale's interviews with Soviet war veterans show, it does not take long to make strong friendships in these circumstances.⁴⁶

The second world war, therefore, overturned several of the doctrines developed after the first world war. First, the view that psychiatric breakdown could be prevented by better selection was abandoned. Second, theories of combat motivation and demotivation now emphasized not patriotism or ideology, but the key role of the small group. Third, even primary groups could not prevent breakdown in conditions of modern war — there was a close relationship between physical and psychiatric casualties and eventually even the best units would become combat-ineffective. Finally, although there remained an adherence to the principle that it was poor policy to give the phenomenon of psychiatric breakdown in combat a medical or psychiatric label (preferring terms such as battle or combat fatigue), refusing to grant legitimacy to such conditions by denying their existence, and disallowing pensions and/or discharge was impossible, at least for the democracies, to sustain.

But there remained a paradox even in the doctrines developed after the second world war. Men fight in groups, but if a group is left in the field too long, it too will become combat-ineffective. Keeping people together for as long as possible maximized the influence of social ties on combat motivation, but ran the risk of physical and psychological exhaustion if carried to

45 See Merridale, 305–20; Richard Gabriel, *The Painful Field. The Psychiatric Dimension of Modern War* (New York 1988). The notorious incident in which Patton lost his command after he slapped two soldiers with 'combat fatigue' would have been inconceivable in either Germany or the Soviet Union.

46 Roger Spiller, 'Isen's Run. Human Dimensions of War in the 20th Century', *Military Review*, 68 (1988), 16–31; Merridale, op. cit.; see also J. Mouthaan, M. Euwena, J. Weerts, 'Band of Brothers' in U.N. Peacekeeping: Social Bonding Among Dutch Peacekeeping Veterans', *Military Psychology* 17 (2005), 19, 101–14.

extremes. And as the Cold War proceeded, the USA in particular became progressively more concerned about limiting casualties, and so the pendulum gradually shifted towards the latter priority — preserving the fighting strength. But this, too, was not without consequences, as the Vietnam conflict would reveal.

The Americans began the Vietnam War with a change in personnel policy. In place of serving for the duration came DEROS, Date Expected Return from Overseas, which meant that soldiers only served a year in theatre. This was introduced in response to the demonstrated links between combat exposure and physical and psychological casualties, and was intended to reduce the latter. For a time this and the other changes implemented to reduce combat fatigue seemed to work. It may come as a surprise to learn that psychiatric casualties in theatre were actually lower than those in any previous American war, so much so that during the first few years of the conflict the psychiatrists thought that they had finally ‘licked’ the problem, as they put it in numerous articles at the time.⁴⁷

But by 1968 and the Tet offensive the picture changed, not only in theatre, but even more so when the veterans came home. The reasons for this are still not fully understood.⁴⁸ Did DEROS actually create ‘short-term syndrome’? Did it impede the formation of the small-group identity and bonds that sustain service personnel through adversity, as Charles Moskos argued? Yes it did, and in consequence after Vietnam US military personnel policies changed once more. But equally, was the cause of what soon became the ‘Vietnam syndrome’ not the jungles of Vietnam, but the atmosphere of an America turning against the military in general and the war in particular? And was there really anything exceptional about the Vietnam War itself that could explain the Vietnam veteran problem?⁴⁹

The traumatized Vietnam veteran had become a political symbol used by opponents of the war. Robert Jay Lifton, Chaim Shatan and others, honourable men, opposed to the war, used the image of the disturbed veteran as a symbol of the insane war to crystallize opposition. Psychiatry was politicized, and out of it came a new stereotype of the Vietnam vet.

Another new phenomenon was the spectacle of soldiers now willingly admitting to atrocious behaviour — something new in the modern history of combat, trauma and memory. One of the reasons for the continuing debate about the conduct of the Wehrmacht on the Eastern Front is the problem of sources — there is not much direct testimony from those who took part. Few, if any, Wehrmacht soldiers would subsequently appear making tearful con-

47 Shephard, *War of Nerves*, op cit.; S. Wessely and E. Jones, ‘Psychiatry and the Lessons of Vietnam. What Were They and Are They Still Relevant?’, *War and Society*, 22 (2004), 89–103.

48 Wessely and Jones, ‘Psychiatry and the Lessons of Vietnam’, op. cit.; Charles Moskos, *The American Enlisted Man* (New York 1970); R. Fleming, ‘Post Vietnam Syndrome. Neurosis or Sociosis?’, *Psychiatry*, 48 (1985), 122–39.

49 Eric Dean, *Shook Over Hell. Post-Traumatic Stress, Vietnam, and the Civil War* (Cambridge 1997).

fessions and ritual pleas for forgiveness — amnesia, not remembrance, was the norm. But Vietnam changed that, so much so that we now have a new phenomenon, of soldiers admitting to atrocious acts which did not take place.⁵⁰

The ‘Vietnam vet’ had achieved the opposite of what the normal soldier had experienced — many had never identified themselves as part of the military, or bonded with their buddies or unit whilst they were in theatre, but only came to see themselves as ‘Vietnam vets’ and make common cause with their fellow veterans on their return: ‘In a curious reversal of soldierly tradition, Vietnam veterans may have experienced more sustained fellow feeling with their comrades after leaving the war than they ever had while they fought it’.⁵¹ However, it would be wrong to suggest that there was no primary-group cohesion in Vietnam. Instead, as war weariness developed and public support ebbed, group cohesion in theatre began to foster dissent rather than conformity with the goals of the military. Robert MacCoun used this to distinguish between group cohesion — the sense of solidarity with one’s peers, from task cohesion — a collective commitment to accomplishing the tasks of the unit. By the end of the Vietnam conflict, US forces possessed the former, but not the latter.⁵² Social cohesion may at times actively conflict with the aims of the military.

Vietnam also gave one more legacy, thanks to the inspired lobbying of Lifton and Shatan, and the change of climate in the USA. It led to a major shift in psychiatric thinking, one that remains in force today, and it gave us a new diagnosis — post-traumatic stress disorder (PTSD).

There are considerable misunderstandings about what was new about the introduction of PTSD into the official psychiatric diagnostic canon in 1980. It was not the first acceptance of the psychiatric cost of war and trauma. What PTSD changed was the interpretation of why. Until then it was assumed that if you broke down in battle, and the cause was indeed the stress of war, then your illness would be short-lived. And if it wasn’t, then the cause was not the

50 New research that compares the stories told by Vietnam veterans receiving psychiatric treatment for combat-related PTSD to the information contained in their military records reveals that perhaps 5 per cent gave entirely fictitious accounts of their military service (either never having been in the military or never having gone to Vietnam), and that another 30 per cent were unlikely to ever have seen combat. Bruce Frueh et al., ‘Documented Combat Exposure of Veterans Seeking Treatment for Combat Related Posttraumatic Stress Disorder. Review of Records from the US National Personnel Records Center’, *British Journal of Psychiatry*, 186 (2005), 467–72. Those in the group whose testimony was not supported by their military records were more likely to report having committed atrocities. To my knowledge only the anthropologist Allan Young has tackled this question in ‘The Self-traumatized Perpetrator as “Transient Mental Illness”’, *Évolution Psychiatrique*, 67 (2002), 1–21.

51 Spiller, ‘Isen’s Run’, op. cit., 16–31.

52 John Helmer, *Bringing the War Home. The American Soldier in Vietnam and After* (New York 1974); Robert MacCoun, ‘What is Known about Unit Cohesion and Performance?’ in Bernard Rostker (ed.), *Sexual Orientation and Military Personnel Policy. Options and Assessment* (Santa Monica, CA 1993). In her study of Argentinian forces during the Falklands/Malvinas war Nora Kinzer Stewart also observed how group cohesion does not always serve the interests of the military: ‘Mates and Muchachos’, op. cit.; see also Bruce Newsome, ‘The Myth of Intrinsic Combat Motivation’, *Journal of Strategic Studies*, 26 (2003), 24–46.

war, but events before you went to war. At the risk of over-simplification, the dominant school of psychiatric thinking from the latter half of the nineteenth century to the latter half of the twentieth said the reason was hereditary. It was one's constitutional inheritance, expressed either as degeneration at the beginning of the century or genetics at its end, that determined most chronic psychiatric disorders. Freud and the founders of psychoanalysis preferred to emphasize events during the first few years of life, but the conclusion was much the same. Your cards were marked long before you joined the services. So if you did break down in war, but never recovered, then the real cause was not the war, but either your genetic inheritance or your upbringing — the problem was you. The war was merely the trigger. This general view held good for the first half of the century, began to be eroded by the experiences of the second world war and the literature on concentration camp survivors, and was finally challenged by the Vietnam War.

What was new about PTSD was therefore not the claim that war caused psychiatric casualties. The manpower crisis of 1917, the pensions bill that threatened the Weimar economy, or the Veterans' Administration hospitals that filled rapidly after the first world war, proved that beyond dispute. The new orthodoxy was that long-term psychiatric casualties were no longer the fault of genes or upbringing, but the insanity of war itself. In Pat Barker's *Regeneration* trilogy the author has Rivers musing that he did not know anything that distinguished those who broke down from those who did not, with the subtext that the war itself was to blame. But this is viewing history from our post-PTSD perspective — Rivers himself said no such thing, and like most of his professional contemporaries, did not believe it. It was not until the second world war that Grinker and Spiegel would say something similar, and not until 1980 and the DSM III that this was enshrined in conventional psychiatric thinking.

With the arrival of PTSD, views on combat motivation and combat breakdown began to diverge. Military academics continued to instruct on the importance of the primary group, and military training remained centred on the creation of primary groups, often via the deliberate creation of adversity. Yet the new psychiatric concepts of breakdown in wartime now emphasized individual factors — most importantly the personal experience of battle trauma. The influence of the group, and the failure of the group, is largely ignored in contemporary psychiatric formulations of trauma-induced breakdown. PTSD is seen instead as the interaction between a person and his or her exposure to traumatic events. A recent much-cited meta-analysis of risk factors for PTSD deals entirely with individual risk factors, such as exposure to trauma, previous psychiatric history, gender, marital status and so on.⁵³ The 2005 National Institute for Clinical Excellence (NICE), a sensitive barometer of contemporary orthodoxy, says much the same in its 2005 PTSD guidelines. A recent handbook produced by Australian psychologists on combat stress

53 Chris Brewin et al., 'Meta-analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-exposed Adults', *Journal of Consulting and Clinical Psychology*, 68 (2000), 748–66.

and PTSD largely ignores group factors — the Big Three being reduced to a solitary reference amongst 277 pages.⁵⁴ Even social support, lack of which is accepted as a risk factor in PTSD, is constructed in terms of how a person's social network acts to provide emotional support to the individual exposed to trauma. The reciprocity of the military concept of the primary group with its 'network of mutual obligation'⁵⁵ (my emphasis) is largely ignored. It is tempting to see this as part of a much wider social change — from the collective values and admiration for emotional reticence that sustained the war years and beyond to the increasing importance given to individual values and emotional fulfilment that began during the 1960s.⁵⁶

The key observations that underpin most contemporary thinking on combat motivation were developed after the second world war. Men fight not because of ideology, but because of their membership of the tight-knit, self-sustaining and self-supporting unit whose creation is the principal ambition of infantry training.⁵⁷ As Western militaries continue to shrink and rely more on technology than manpower, the so-called 'Revolution in Military Affairs', the standard views have, if anything, strengthened over time. This is the legacy of the work of Shils, Janowitz, Marshall and Stouffer. This social perspective continues to be important in modern military academies because it coincides with how the military increasingly sees itself — small numbers of volunteer professionals. Ideology is frowned on in favour of professionalism, and the role of emotions downplayed. And this view is supported by considerable empirical data. However, it would be wrong to extrapolate this to other circumstances, such as the conduct of the Wehrmacht in the East, or the 'Dirty War' waged by the Argentinian professional army against the left during the 1980s (see Robben, 357–78).

But the question of why men cease to fight has continued to evolve. This question has been asked in three different ways, or at least within three different discourses, and it is not surprising that they come to different conclusions.

The most powerful discourse in military teaching and writing sees breakdown in battle as the opposite of motivation to fight. Men cease to fight when

54 G. Kearney, M. Creamer, R. Marshall and A. Goynes (eds), *Military Stress and Performance. The Australian Defence Force Experience* (Melbourne 2003).

55 F. Manning, 'Morale, Cohesion and Esprit de Corps', op. cit.

56 E. Ferri, J. Bynner and M. Wadsworth (eds), *Changing Britain, Changing Lives — Three Generations at the Turn of the Century* (London 2003); Ronald Inglehart, *Silent Revolution. Changing Values and Political Styles among Western Publics* (Princeton, NJ 1977). See David Segal and Mary Segal, 'Change in Military Organization', *Annual Review of Sociology*, 9 (1983), 151–70 for how this has influenced the US military.

57 The infantry is not the only branch of the armed forces. However, nearly all the literature is about why soldiers, as opposed to sailors or airmen, fight. At its crudest, the options available to sailors are fewer than those available to the infantry. A ship fights as a single unit, and desertion is not usually an option. Likewise, as Ben Ari points out, it is largely infantry 'who face the direct challenge of firing at other human beings' (Eyal Ben Ari, *Mastering Soldiers* [New York 1998], 5). It is not surprising that understanding combat motivation is predominantly an army preoccupation.

the primary group disintegrates or fails them and they are freed from their group obligations of service and sacrifice. Strengthening the primary group is therefore one way of preventing combat breakdown, and that indeed is one purpose of military training. But what other responses are indicated? Should it be prevented by disapproval and discipline, or managed by compassion and care? Here the military and psychiatric discourses tend to part company.

Ever since the first world war the military have recognized the reality and challenge of psychiatric breakdown, not least because of its impact on manpower. From the Shell-Shock Commission onwards, breakdown has been seen by the military as in part a moral issue. Lord Moran felt that breakdown was not a shameful dereliction of duty, but only if it was earned. Informally, most modern armies still operate something like the same code today — if breakdown was the result of courage and/or serious combat exposure, then they are understanding and supportive, but if you collapsed without a shot being fired, facing nothing more than the rigours of the training ground, then you risk receiving little in understanding or compassion.

So for some military professionals men cease to fight not only because they are lacking in professionalism, leadership or comrades (in keeping with theories of social motivation) but also because of a failure of character (the moral perspective). Open uncoded assertions of this view are not common in public pronouncements, but remain influential in the informal value systems that operate in the armed forces, and also with some sectors of the public.

But the professional military view is also pragmatic and directed towards the fundamental goals of the military — a soldier who breaks down is failing in his duty, whilst leaving his comrades to continue to face adversity and danger.⁵⁸ Likewise, virtually all commanders, past and present, accept that fear is contagious. Breakdown in battle, for whatever reason, is indeed a threat to the integrity of the group, to the sense of interdependence and mutual obligation on which 'fighting spirit' depends. Zahava Solomon, an Israeli psychologist who has extensive knowledge of combat stress reactions and PTSD in the Israeli Defence Force, as well as being extremely sympathetic to the plight of the combat soldier, could still write in 1993 that 'senior commanders are understandably loath to give any kind of legitimacy to a phenomenon that has the potential to undermine the fighting power of the whole army'.⁵⁹ Military culture, past and present, stigmatizes psychiatric disorder, but not just for reasons of prejudice.⁶⁰

58 Frederic Manning's 'Middle Parts of Fortune', one of the best fictional accounts of war, makes clear that it was not just the leadership, but the other ranks, in this case British servicemen in the first world war, who were not sympathetic to those who did break down in battle because it merely increased the danger to those remaining. The exception would be those who had, as Moran put it, 'done one's bit'. Professor Ian Palmer, who has the distinction of being both a qualified psychiatrist and a long-serving member of UK Special Forces, addresses the same point. Ian Palmer, 'The Emotion that Dare not Speak its Name?', *British Army Review*, 132 (2003), 31–7.

59 Zahava Solomon, *Combat Stress Reaction. The Enduring Toll of War* (New York 1993).

60 Anyone who has had contact with the modern military will recognize the above. As an exemplar, the following 1993 memo from the UK Assistant Chief of the Defence Staff was dis-

The third, but often the least consistent perspective, has come from the psychiatrists. It is not surprising that both psychiatric practice and theory have been subject to so much change. War has always been a stimulus to medical practice and psychiatry is no exception. Crisis care, modern community care and assertive outreach owe their existence to 'forward psychiatry', and group therapy to Bion and Rickman at Northfield and Maxwell Jones at Mill Hill during the second world war.⁶¹ But war has also changed psychiatric theory, even if the contemporary view of a progressive shift from Blimpian ignorance to therapeutic enlightenment is unsustainable. Instead, professional psychiatric responses to trauma are themselves the products of culture, doctrine and financial expediency. The ups and downs of the award of war pensions for psychiatric injury are but one example of the shifts in thinking over time.⁶²

At the moment, contemporary psychological or psychiatric literature sees adversity as having inevitable and deleterious consequences, magnified in the setting of industrialized warfare and the modern industrial state. Breakdown in battle is a predictable consequence of overwhelming fear and anxiety, which because of either psychological conditioning and/or neurobiological changes (psychiatry continuing to be split between its brainless and mindless schools of thought), may become fixed as a chronic anxiety disorder that we currently label PTSD. Those who succumb are viewed as victims and/or patients. Treatment is reflected in various institutional medical responses, be it the war clinics of Germany or the modern armies of 'trained counsellors'. More successful innovations include either drugs such as antidepressants or the skilled talking treatments such as cognitive behavioural therapy. Compensa-

closed during the conduct of the recent class action brought, unsuccessfully, by British ex-service personnel against the MOD. It was written to the then Surgeon General in response to a paper on the management of combat stress reactions and was reproduced in the Final Judgement of Mr Justice Owen (21 May 2003).

I distrust the tone of much of what is written. I think we are standing (sic) into danger if we continue along this course which attacks the social mechanisms we have developed over the centuries to control and manage fear in our fighting groups. The further we go down the line that breakdown and failure is inevitable and something requiring sensitive treatment without 'fear or prejudice' the more it shall be acceptable to fail, the more we will suffer these failures. . . . the actions of the individual, particularly in battle, will be judged in relation to the circumstances of the group as a whole. The sentence 'a sudden change in behavioural characteristics which involve a disinclination to fight and a personal imperative to leave' should be removed from the paper. The man who does this is a coward. He has 'bottled out'. In battle he is a threat to his group. He has failed his comrades and will be viewed by them as doing so, the commander must take his actions accordingly. This breakdown might be viewed quite differently if it occurs in circumstances removed from the battle, when the group can accommodate quite aberrant behaviour provided the individual is thought to be of value to the group.

61 Thomas Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments. Advancing on a Different Front* (London 2000); Shephard, *War of Nerves*, op. cit.

62 E. Jones, I. Palmer and S. Wessely, 'War Pensions (1917–1945). A Barometer of Health Beliefs and Psychological Understanding', *British Journal of Psychiatry*, 180 (2002), 374–9.

tion, either as war pensions or via personal injury litigation, is available — the latter can be generous.

The previous paragraph is a fair summary of contemporary management of psychological trauma. Many will feel comfortable with it. Few will recognize, however, that the current ascendancy of the psychological approach to trauma represents another swing of the pendulum. The Southborough committee tentatively in 1922 and the Horder Committee emphatically in 1939 would have argued that our current policies represent not progress, but the reverse. Psychiatric breakdown after battle once again has a medical name — PTSD. The principles of ‘forward psychiatry’ seem to have been forgotten. And the financial rewards for psychiatric injury run the risk of providing further perverse incentives for ill health.

It seems clear there is no ‘best’ method for both preventing and managing psychological trauma arising from military service. Indeed, prevention and management are not always compatible. Perhaps the Southborough/Horder committee approach would lead to the smallest number of psychiatric casualties, but at the cost of misery and injustice to many of those who despite everything still break down. At present the balance has shifted towards individual rather than collective approaches. There is probably a lack of support for the population approach advocated by Southborough/Horder, and a preference to emphasize the provision of care, support and compensation for each individual victim of trauma, even if it could be shown that this adds to their numbers. But at other times, when different value systems emphasized reticence and resilience rather than individual identities, goals and emotional expression, the opposite was true.

There is no universal explanation why men fight, or why they break down in battle. Historians will always be better placed to analyse the complex factors, specific to time and place, that explain the particular, such as the French defeat of 1940, Tobruk or the Fall of Singapore. And when they turn to the social sciences for assistance on understanding motivation and demotivation, they will encounter an ever-changing mixture of social, moral, pragmatic and psychological theories. Rather than being universal truths about how men fight, and cease to fight, these are themselves historical material in their own right.

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