

EDGAR JONES* *King's Centre for Military Health Research,
London*

SIMON WESSELY† *King's Centre for Military Health Research,
London*

.....

British Prisoners-of-War: From Resilience to Psychological Vulnerability: Reality or Perception

Abstract

In contemporary culture, soldiers held as prisoners-of-war (POWs) or as hostages are considered at significant risk of mental illness, in particular post-traumatic stress disorder (PTSD). This assumption contrasts with the psychiatric orthodoxy of the First World War when it was concluded in both Britain and Germany that POWs were protected against 'war neurosis'. Although 'barbed wire disease' was identified during time of captivity, post-release effects were not recognized. The repatriation of 'protected' POWs in 1943 prompted a reassessment of the psychological impact of imprisonment when servicemen of previous good character began to behave aberrantly. Rehabilitation programmes were designed to enable soldiers to re-adapt to service or civilian roles. Difficulties of adjustment were cast in social and cognitive terms, and corrective measures were occupational and educational. Psychiatric disorders found in POWs were explained in terms of a pre-conflict predisposition to, or a history of, mental illness. However, retrospective studies of veteran POWs have found a high prevalence of PTSD. A change in attitudes is explored in relation to the advance of medical terminology into the territory of emotions and the attribution of pathological processes to self-recovering mental states. The reclassification of the effects of imprisonment implies that diagnoses in military psychiatry are culturally determined and can be understood only if they are placed in a context that includes changing beliefs about mental illness, the formal development of the psychiatric profession and the immediate needs of the armed forces.

*edgar.jones@iop.kcl.ac.uk; †s.wessely@iop.kcl.ac.uk

Introduction

Retrospective studies of veterans who had been prisoners-of-war (POWs) during the Second World War established a link between captivity and mental illness, in particular post-traumatic stress disorder (PTSD). For example, an investigation conducted in 1989 found that eighteen (29 per cent) of a sample of sixty-two US veterans who had been POWs during the Second World War met the criteria for PTSD and, based on their recall of symptoms, 50 per cent would have qualified for the diagnosis in 1946, a year after their repatriation.¹ Furthermore, an investigation conducted in 1997 of 262 US veterans who had been held captive during the Second World War or the Korean conflict showed that 53 per cent had suffered from PTSD in the past, while 29 per cent still had symptoms of the disorder.² These results led the study's authors to conclude that PTSD was a 'persistent, normative and primary response' to the severe trauma of captivity.³

This modern perspective stands in marked contrast to the First World War when captivity, it was believed, protected against mental illness. Indeed, British and French servicemen taken prisoner and held in German camps were the subject of a psychiatric conference held at Munich in September 1916. The discussants overwhelmingly agreed that POWs were immune from 'war neuroses' such as shell-shock. However, the release of 'protected' British POWs in 1943 forced the authorities to reassess this orthodoxy. Aberrant behaviour in servicemen of previously good character led both doctors and commanders to question their understanding of the mentality of captives. To test the effects of captivity, the newly formed Directorate of Army Psychiatry (DAP) set up a controlled study of repatriated POWs. Military psychiatrists identified what they characterized as an adjustment disorder, a psychological form of 'caisson disease', which required a programme of 're-education' rather than formal psychological treatment. Although their findings influenced policy and management in the immediate post-war period, it was not until the 1980s and the recognition of PTSD that POWs were considered at inherent risk of psychiatric disorder.

This article explores fundamental shifts in attitudes towards the psychological effects of captivity in wartime and explores the factors that underpinned change. We also ask what these judgements about human vulnerability tell us about the validity of psychiatric diagnoses and their changing popularity.

¹ N. Speed, B. Engdahl, J. Schwartz and R. Eberly, 'Posttraumatic stress disorder as a consequence of the POW experience', *Journal of Nervous and Mental Disease*, 177 (1989), 147–53.

² B. Engdahl, T.N. Dikel, R. Eberly and A. Blank, 'Posttraumatic stress disorder in a community group of former prisoners of war: a normative response to severe trauma', *American Journal of Psychiatry*, 154 (1997), 1576–81.

³ Engdahl, 'Posttraumatic stress disorder', 1580.

Trauma and Captivity

A link between captivity and mental illness in the armed forces had been established in the late Victorian period and was reflected in the term 'doolally', a popular term for madness. In 1861, the British Army had set up a base and sanatorium at Deolali, Maharashtra, about 100 miles north-east of Mumbai. It served as a transit camp for soldiers who had finished their tours of duty ('time-expired') and were waiting for a passage to Britain. Troopships left Mumbai between November and March, so a soldier who completed his tour outside those dates often had a long wait for transport. Confined to a restricted life in camp during the hot summer months, some soldiers broke down and behaved bizarrely; they were described as having the 'doolally tap'.⁴ However, these observations were not generalized beyond India perhaps because the cause of mental illness was seen as extreme heat ('a touch of the sun') rather than enforced restrictions on movement and activity.⁵

During the First World War, POWs became the focus of an important debate about the nature and causation of 'neurosis'. In 1915, leading German psychiatrists observed a discontinuity in symptoms reported by soldiers engaged in combat and those held in captivity. Karl Bonhoeffer recalled that

the difference in behaviour between the Germans who came directly from the line of fire into the hospital station and the French prisoners was striking. Among the Germans the familiar forms of hysterical reactions could be found with great frequency, while among the French, who had come from the same front circumstances [Verdun] no trace of hysteria was to be seen.⁶

Furthermore, Fritz Mohr, based in Koblenz, claimed not to have found a single case of neurosis among 12,000 British and French POWs, while Karl Wilmanns documented only five examples among a population of 80,000 POWs.⁷ Hermann Oppenheim, a psychiatrist who believed that traumatic neurosis had an organic basis in a brain lesion, questioned the accuracy of these observations. Yet, having examined large numbers of POWs himself, Oppenheim was forced to concede that the symptoms of psychological disorder appeared to be absent.⁸

⁴ Frank Richards, *Old-Soldier Sahib* (London, 1936), 73–4.

⁵ Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove, 2005), 6.

⁶ Quoted from Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890–1930* (Ithaca, 2003), 68.

⁷ Paul Lerner, 'From traumatic neurosis to male hysteria', in Mark Micale and Paul Lerner (eds), *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age, 1870–1930* (Cambridge, 2001), 158.

⁸ Lerner, *Hysterical Men*, 69.

Similarly, British army doctors who treated captured German troops rarely found evidence of traumatic neuroses. Captain Harold Wiltshire, a physician who had served in France and Salonika,⁹ concluded that infantry soldiers welcomed a diagnosis of shell-shock because it secured a period of hospitalization away from danger. By contrast, the POW, who found himself in a place of safety, had no need of such symptoms.¹⁰ The view that a wound or captivity protected against neurosis was widely held by military doctors.¹¹ So well were these beliefs founded that they persisted into the Second World War. The 1943 edition of Henderson and Gillespie's *Text-book of Psychiatry* declared 'among prisoners of war psychoneuroses are rare'.¹² During the Normandy campaign, Brigadier E. Bulmer, consulting physician to 21 Army Group, examined large numbers of captured, wounded and sick soldiers and was 'struck with apparently few cases of psychoneurosis among German POWs'.¹³

The fact that British doctors were unable to find symptoms of neurosis in German POWs and German psychiatrists found no evidence of shell-shock in British POWs, in part, related to the conventions of war. Captured soldiers considered themselves combatants and duty bound to escape. To have admitted psychological symptoms, such as depression, anxiety, repeated fears or troubling dreams, would have been tantamount to surrender and an acknowledgement of low morale.

Yet, the conclusions drawn by psychiatrists during the First World War are contradicted by evidence from war pension files. After the Armistice, large numbers of British veterans who had been POWs were granted financial compensation and their medical records revealed the existence of psychological symptoms. Indeed, doctors examining repatriated veterans at post-war boards often diagnosed them as suffering from neurasthenia or disordered action of the heart (DAH),¹⁴ illnesses which ran counter to the hypothesis that captivity protected against neurosis. A possible explanation is that psychological symptoms recorded in war pension files arose after the 1916 Munich Conference when conditions in German camps dramatically deteriorated. The Allied naval blockade progressively cut the import of

⁹ H. Willoughby Lyle, 'Harold Waterlow Wiltshire', *Lancet*, 1 (1937), 295.

¹⁰ Harold Wiltshire, 'A contribution to the etiology of shell-shock', *Lancet*, 1 (1916), 207–12.

¹¹ T.A. Ross, *Lectures on War Neuroses* (London, 1941), 64.

¹² D.K. Henderson and R.D. Gillespie, *A Text-book of Psychiatry for Students and Practitioners* (Oxford, 1943), 531.

¹³ The National Archives: Public Record Office, Kew (hereinafter TNA: PRO), WO177/316, E. Bulmer, Quarterly report of consulting physician, 21 Army Group, 1 Jul to 30 Sep 1944.

¹⁴ E. Jones, R. Hodgins Vermaas, H. McCartney, B. Everitt, C. Beech, D. Poynter, I. Palmer, K. Hyams and S. Wessely, 'Post-combat syndromes from the Boer War to the Gulf: a cluster analysis of their nature and attribution', *British Medical Journal*, 324 (2002), 321–4.

foodstuffs to Germany. By the winter of 1917–18, growing numbers of British POWs with suffering from starvation, not to mention the influenza pandemic and other diseases.¹⁵ Official statistics recorded that 392 British officers (6.4 per cent) held in German camps and 10,856 other ranks (7 per cent) died in captivity.¹⁶ Alternatively, symptoms reported after 1918 may represent a delayed syndrome or delayed help-seeking, a phenomenon identified in relation to PTSD. Millais Culpin, writing in 1920, believed that the protection offered by a wound against psychological disorder was only temporary: ‘since we know that repressions can light up symptoms at any time, it follows that we may expect to find the latter developing when men have recovered from wounds’.¹⁷ Because medical records for POWs at the time of their capture and imprisonment rarely survive, the discrepancy between contemporary clinical judgements and historical medical files cannot be easily resolved.

Barbed Wire Disease

In the aftermath of the First World War, a syndrome specific to captivity, but distinct from shell-shock, was described. Drs R. Bing and A.L. Vischer, who had studied British POWs interned in neutral Switzerland, identified a form of ‘neurasthenia’ characterized by mental exhaustion, irritability, intellectual instability, loss of concentration and disturbance of memory.¹⁸ Adopting the term ‘barbed wire disease’, they believed it was caused by confinement and monotony, accentuated by ‘sexual deprivation’ and lack of privacy. Vischer concluded that

the treatment of prisoners (in the stalags) has but little influence on their mental condition. Brutal treatment does not produce the disease, neither does good treatment prevent it. Even a beautifully situated camp is not preventative . . . The disease is not cured by mere release from imprisonment.¹⁹

Although Bale and Vischer observed that ‘many of the interned men give the impression of a personality that has been profoundly changed’,²⁰ they conceptualized the disorder as psychoneurosis associated with mental exhaustion.

¹⁵ M. Spoerer, ‘The mortality of Allied prisoners of war and Belgian civilian deportees in Germany custody during the First World War: a reappraisal of the effects of forced labour’, *Population Studies: A Journal of Demography*, 60 (2006), 121–36.

¹⁶ War Office, *Statistics of the Military Effort of the British Empire during the Great War* (London, 1922), 329.

¹⁷ Millais Culpin, *Psychneuroses of War and Peace* (Cambridge, 1920), 37.

¹⁸ R. Bing and A.L. Vischer, ‘Some remarks on the psychology of internment, based on the observation of prisoners of war in Switzerland’, *Lancet*, 1 (1919), 696–7.

¹⁹ A.L. Vischer, *Barbed Wire Disease: A Psychological Study of the Prisoner of War* (London, 1919), 3.

²⁰ Bing and Vischer, ‘Some remarks’, 697.

Nevertheless, these clinical observations had no impact on post-war policy. UK government departments, such as the Ministries of Labour and Pensions, made no special provision for returning POWs,²¹ who were treated the same as any other veterans.²² Furthermore, the War Office declined to assume responsibility for the rehabilitation of former captives, a policy that incurred 'a good deal of criticism at the time'.²³

Repatriated 'Protected' POWs

Article three of the 1929 Geneva Convention introduced a significant change to the international regulations governing POWs. Henceforth, non-combatant troops, members of the medical corps or chaplains, together with seriously sick and wounded combatants, were eligible for exchange and repatriation. During the Second World War, evidence provided by these regulatory changes exercised a significant impact on thinking about the psychological effects of imprisonment. Although the German authorities agreed to the repatriation of 1,200 British POWs in September 1941, they cancelled the exchange when it was found that only 150 suitable German prisoners were available for return.²⁴ Not until October 1943 was a transfer of 5,000 British, Commonwealth and American repatriates arranged.²⁵ Among these were 1,200 members of medical units who became the focus of an influential study.

During the course of 1943, British military authorities had become increasingly aware of problems with repatriated officers. Although returned to duty, high rates of invalidity and disciplinary incidents in men with excellent military records suggested that imprisonment had adverse consequences.²⁶ An article published in June 1943 by Captain G.F. Collie, himself a former POW, argued that prolonged captivity often caused 'minor mental abnormality'. He called for schemes of rehabilitation in the belief that three months treatment could 'effect a complete and lasting cure' in 'even the most difficult cases'.²⁷ Furthermore, reports circulated that of ninety POWs repatriated from

²¹ TNA: PRO, LAB2/1518/DRA 203/29/1918, Eligibility of civilian prisoners of war, 1919.

²² G.C. Pether, 'The returned prisoner-of-war', *Lancet*, 1 (1945), 571–2.

²³ TNA: PRO, ADM1/18875, Sir P.J. Grigg, 'Rehabilitation of returned prisoners of war', 22 Aug 1944.

²⁴ S.P. MacKenzie, *The Colditz Myth: British and Commonwealth Prisoners of War in Nazi Germany* (Oxford, 2004), 176, 244.

²⁵ Adrian Gilbert, *POW: Allied Prisoners in Europe, 1939–1945* (London, 2006), 225.

²⁶ R.H. Ahrenfeldt, *Psychiatry in the British Army in the Second World War* (London, 1958), 227.

²⁷ G.F. Collie, 'Returned prisoners of war: a suggested scheme for rehabilitation', *The Fortnightly*, 153 (1943), 407–11.

Italy, a third had become 'sufficiently abnormal to warrant some action being taken'.²⁸ If these anecdotal accounts served as a harbinger of what might happen when the entire POW population was released, then the authorities faced a considerable problem.

In the knowledge that there were at least 98,000 British POWs in German hands and a further 45,000 held by the Japanese,²⁹ the authorities convened a meeting in September 1943 chaired by Lt General Sir Alexander Hood, Director General Army Medical Services. Significantly, they met in the London offices of the DAP, a fledgling organization seeking to justify its role. Brigadier J.R. Rees, consulting psychiatrist, argued that the ninety repatriates were a sample 'too small on which to base any valid conclusions, and that there was no literature or statistics on this problem from the last war'.³⁰ Yet he speculated that the problem might be more serious than it appeared. Because the ninety repatriates were RAMC personnel who had been employed in nursing duties during their imprisonment, soldiers from other units who had not had the benefit of purposeful activity 'might show even greater signs of abnormal reaction upon return home'. Whilst all agreed that 'a scheme of rehabilitation was required', no one could say what form it should take. Thus, an opportunity was created for the DAP to define the nature of the problem and propose remedial measures.

Crookham Rehabilitation Study

To discover more about the mentality of repatriated POWs and to test the effectiveness of rehabilitation programmes, the DAP devised a practical experiment at No. 1 RAMC Depot, Boyce Barracks, Crookham, near Aldershot. It ran between November 1943 and February 1944 and involved 1,154 recently repatriated servicemen, either RAMC personnel (61 per cent) or stretcher bearers from other units (39 per cent). Possibly because of stigma, no officers were included in the study, which comprised: 17 warrant officers (1.5 per cent), 185 NCOs (16 per cent) and 952 privates (82.5 per cent). Most subjects were experienced soldiers or volunteers: regulars (25 per cent), reservists (14 per cent) or territorials (35 per cent); only 27 per cent were conscripts. The majority

²⁸ TNA: PRO, WO32/11125, Rehabilitation of repatriated prisoners of war, meeting held at 39 Hyde Park Gate, 16 Sep 1943, 1.

²⁹ TNA: PRO, WO32/11125, Memorandum, British ex-Prisoners of War, Rehabilitation of those returning to civil life, 16 Aug 1944, 1.

³⁰ TNA: PRO, WO32/11125, Rehabilitation of repatriated prisoners of war, meeting held at 39 Hyde Park Gate, 16 Sep 1943, 2.

(85 per cent) had been imprisoned for at least three years in Germany as a result of capture in France, Greece or Crete.³¹

Questionnaires and interviews revealed what was termed a 'stalag mentality' in POWs who had been held captive for more than eighteen months: 'a very real but unfounded feeling that their physical or mental health has been somewhat damaged'. These beliefs were supported by 'depression and guilt' suffered whilst a prisoner and by 'the anxieties of re-adaptation'.³² To address these issues, a six-week residential course of education, vocational training, entertainment and games was designed. A medical officer, Captain J.C.B. Nesfield, screened the sample for physical illness, while Lt Colonel A.T.M. Wilson, a psychiatrist recruited from the Tavistock Clinic, reported on their mental state. Although 60 per cent had 'minor psychological disturbances', only sixteen (1.4 per cent) were referred for out-patient treatment and eight servicemen (0.7 per cent) were sufficiently ill to require psychiatric admission. To assess morale and general health, rates of sickness and absenteeism amongst POWs were compared with 1,311 controls (depot staff, transfers and RAMC recruits). Repatriated prisoners were found to be more likely to go absent without leave or report sick than RAMC controls.³³

These results were interpreted as a sign of low morale among the POWs. On admission, soldiers appeared 'cheerful' at having regained their freedom, though 'a reaction set in' when it dawned on them that the war was far from over and they remained eligible for active service. Colonel D.C. Scott, the Crookham depot commandant, reported that 'there is little doubt that some of the repatriated men are inclined to be difficult and appear out of their depth, but...this is not such a big problem as the psychiatrists fear it will be'.³⁴ His military opinion was supported by the medical officer who described the repatriated prisoners as a 'fit and robust group'.³⁵ Only twenty 'frankly neurotic' cases were referred to Hollymoor Military (Psychiatric) Hospital, Northfield, for further treatment.³⁶ Thus, Nesfield could conclude that 'the majority of men were perfectly normal'.

³¹ TNA: PRO, ADM1/18875, The Crookham Experimental Rehabilitation Scheme, Feb 1944.

³² TNA: PRO, WO165/129, Directorate of Army Psychiatry, Technical Memorandum No. 13, 'The Prisoner of War Comes Home', May 1944, 12.

³³ TNA: PRO, WO32/10950, A.T.M. Wilson, 'Report to the War Office', Feb 1944, graphs of sickness and absenteeism.

³⁴ TNA: PRO, WO32/10950, Colonel D.C. Scott, Report on the Repatriation of Protected Personnel ex-Germany, Oct 1943, 6.

³⁵ TNA: PRO, WO32/10950, Captain J.C.B. Nesfield, Some observations of the protected personnel recently repatriated to the country, 7 Feb 1944, 1.

³⁶ Tom Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments: Advancing on a Different Front* (London, 2000), 192.

An Adjustment Disorder

Major P.H. Newman, a surgeon and himself a former POW, likened the after-effects of captivity to a psychological form of 'caisson disease'; that is, serious physiological effects caused by insufficient time to adjust to a rapid fall in atmospheric pressure.³⁷ Problems of adaptation, Newman believed, manifested themselves in restlessness, irritability, disrespect for authority and irresponsibility. However, he considered that these symptoms would resolve themselves and confidently predicted that in the 'great majority' of cases a 'prisoner-of-war mentality' should 'pass off after six months to one year, and thus those affected should give rise to no concern'.³⁸ Lt Colonel Chapel, a medical officer who had also suffered imprisonment, argued that 'repatriates suffered from an inevitable depression after several months at home, and complete readjustment is not a short-term process'.³⁹ Time to adapt was crucial in the view of Lt Colonel Wilson who wrote that 'men who return to civil employment too soon tend to break down in three to four weeks'.⁴⁰

By the end of 1944, the problems experienced by repatriated POWs were conceptualized as an inability to cope with the changes that had taken place during their captivity.⁴¹ In the absence of husbands and fathers, and offered wider employment opportunities, women had taken on greater responsibilities. A civil liaison officer attached to a POW rehabilitation centre observed that the 'independence' shown by wives and daughters, their 'increased use of make up, smoking and drinking... came as a great shock, and, together with the fact that many women were earning more than a man's pre-war wage, were felt to constitute a threat to their manhood and aroused a fear that their place in the family was no longer necessary'.⁴² Indeed, a common trigger for breakdown among POWs was 'marital disharmony' caused by fear of, or actual, infidelity combined with feelings of guilt, inferiority and inadequacy.⁴³

Ironically, the dissonance between the POW and UK society had been accentuated by propaganda designed to reassure the families of captured servicemen. 'The general impression', wrote one repatriated

³⁷ P.H. Newman, 'The prisoner-of-war mentality: its effect after repatriation', *British Medical Journal*, 1 (1944), 8–10; see also Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists 1914–1994* (London, 2000), 316–8.

³⁸ Newman, 'The prisoner-of-war mentality', 9.

³⁹ TNA: PRO, WO32/11125, Repatriation of Canadian prisoners of war, 1 Jul 1944, 9.

⁴⁰ TNA: PRO, WO32/11125, 2, Meeting on 17 Feb 1945 to discuss certain medical aspects of the rehabilitation of repatriated prisoners of war.

⁴¹ TNA: PRO, LAB12/352, Minutes of a meeting with regional controllers Ministry of Labour and National Service, 10 May 1945.

⁴² M.G. Bavin, 'A contribution towards the understanding of the repatriated prisoner of war', *British Journal of Psychiatric Social Work*, 1 (1947), 29–35, 32.

⁴³ A. Torrie, 'The return of Odysseus, the problem of marital infidelity for the repatriate', *British Medical Journal*, 2 (1945), 192–93.

POW, 'is that the prisoners are being fairly well looked after and are in some respects lucky to be out of the war'.⁴⁴ The December 1943 edition of *The Prisoner of War*, a magazine given to next of kin, contained photographs of British POWs skiing, taking part in games and eating a hearty meal in a 'friendly atmosphere'.⁴⁵ This confirmed popular beliefs that captives were on full army rations.⁴⁶ Hence, many POWs returned home to find that their family and friends had little idea of the hardships they had endured. In time, the authorities recognized that it was 'necessary to pay as much attention to the education and preparation of the home community as it was to the returning service men'.⁴⁷

The length of time that servicemen had been imprisoned, together with the social changes created by the wartime economy, left them strangers in their own land.⁴⁸ The sense of being lost or passed by was characterized as a 'psychological disability... of a particular kind'. In addition, captivity was thought to have eroded adaptive capacities 'since all the men are expected to have suffered in some degree from the mental strain of prison camp life'.⁴⁹ Furthermore, a coping mechanism commonly adopted during imprisonment was the construction of an idyllic picture of home life to serve as 'a source of comfort and hope'.⁵⁰ Although this vision maintained morale in captivity, it served to heighten the contrast with reality when the POW returned to his family.

Policy and Operational Responses

The Crookham study did not prompt an immediate policy change. There may, perhaps, have been a suspicion that army psychiatrists were exaggerating adverse effects of captivity to increase their influence or that medical corps personnel lacked the robustness of combat soldiers. However, evidence continued to mount, suggesting that formal rehabilitation programmes were needed. At a tri-service conference held at the Ministry of Pensions on 20 June 1944, Major General J.F. Hare reported that 30 per cent of repatriated POWs in the most recent

⁴⁴ TNA: PRO, WO32/11125, 33c, Letter, unsigned, c.1944.

⁴⁵ *The Prisoner of War*, 2, 20 Dec 1943), 12.

⁴⁶ Evelyn Waugh, *Officers and Gentlemen* (London, 1955), 26–7.

⁴⁷ TNA: PRO, FO1013/177, A.T.M. Wilson, 'Some problems of repatriation and resettlement of German prisoners of war', Sep 1947, 13.

⁴⁸ T.F. Main, 'Clinical problems of repatriates', *Journal of Mental Science*, 93 (1947), 354–63.

⁴⁹ TNA: PRO, WO32/11125, Minutes of a meeting held on 13 Oct 1944 to discuss experimental rehabilitation unit for prisoners of war.

⁵⁰ Wilson, 'Some problems', 6.

exchange were 'difficult cases'.⁵¹ Despite the growing recognition that captivity 'caused a severe psychological shock',⁵² the meeting concluded that the needs of POWs were not significantly different from those of 'the general body of ex-servicemen'. Consequently, POWs continued to be managed through 'the normal machinery set up to deal with the problems of the ex-service community as a whole' and 'psychiatric rehabilitation' offered only to the small numbers of 'neurosis cases' that arose.

However, this conservative approach met official opposition. In August 1944, convinced by evidence from an experimental rehabilitation centre set up by the Ministry of Labour, the Secretary of State for War, Sir P.J. Grigg, instructed service chiefs to design a specific programme of training and resettlement for POWs. Introduced to address the gap between their pre- and post-captivity experiences, a programme of rehabilitation sought to facilitate social and cognitive readjustment through 'lectures, films discussions and so on, designed mainly to bring the ex-prisoner-of-war up to date with current affairs and problems, together with an element of physical rehabilitation by games, physical training etc'.⁵³

Further impetus for a formal policy response was provided by the return of escaped POWs, servicemen who had demonstrated resourcefulness and determination. Following the end of hostilities with Italy in September 1943, a number of POWs had been released, evading recapture for up to a year while finding their way back to British lines. A study of forty escapees who had been referred to an army 'neurosis centre' concluded that chronic anxiety and aggression inhibited re-adaptation to service life.⁵⁴ However, the trauma of captivity was considered merely a trigger of these symptoms and heredity identified as the root cause because 55 per cent of the group were found to have a family history of neurosis or severe mental illness.

In summer 1945, the government unveiled a national rehabilitation programme. Re-education and employment were the focus of the twenty 'Civil Resettlement Units' (CRUs) set up by the War Office,⁵⁵ while the Royal Air Force (RAF) opened a number of 'Resettlement Training Centres'. Brigadier H.A. Sandiford, director of army psychiatry, believed that 'resocialisation' was the aim and that 'finding a

⁵¹ TNA: PRO, AIR49/388, Record of a conference held at the Ministry of Pensions on 20 Jun 1944 to discuss the rehabilitation and resettlement of repatriated prisoners-of-war.

⁵² B. Markowski, 'Some experiences of a medical prisoner of war', *British Medical Journal*, 2 (1945), 361.

⁵³ TNA: PRO, ADM1/18875, Sir P.J. Grigg, 'Rehabilitation of returned prisoners of war', 22 Aug 1944.

⁵⁴ M. Jeffrey and E.F.G. Bradford, 'Neurosis in escaped prisoners of war', *British Journal of Medical Psychology*, 20 (1946), 422-35.

⁵⁵ Shephard, *War of Nerves*, 317.

suitable job' was both the most important therapy and outcome.⁵⁶ The CRU's function was defined as 'a primary training unit for civil life', which was to be achieved by encouraging 'a feeling of individual responsibility, which is self-supporting, by removing army discipline'.⁵⁷ CRUs opened in summer 1945 and continued to function until autumn 1946.⁵⁸ With accommodation for 250 ex-POWs, attendance was voluntary in the case of the army but, in view of smaller numbers, was compulsory in the RAF. A CRU course took a month but could be extended. It included factory visits and social activities to bring the former POW into contact with 'institutions, individuals and situations towards which he was often burdened with feelings of mistrust and suspicion'.⁵⁹ Weekend leave was designed to bridge the gap between army and home life. The intention of providing each unit with a resident psychiatrist was not met due to staff shortages. In the event 53,000 (31 per cent) former POWs held in Europe attended.⁶⁰

By contrast, the Royal Navy made no particular provision for returned POWs. Like army and air force personnel, repatriated sailors were granted immediate leave to visit their families, and after a period of not less than twenty-eight days were required to attend a medical board. Although the Royal Navy recognized that POWs were in 'a brittle frame of mind...easily irritated and disturbed',⁶¹ non-medical cases were not regarded as a special group.⁶² Repatriated sailors with psychiatric disorders were treated according to 'existing machinery' and sent to specialist units such as the Royal Navy Auxiliary Hospital, Cholmondeley Castle.⁶³ The reluctance of the navy to open rehabilitation units may have been influenced by a report from Surgeon Lt Commander P.H. Tooley, a psychiatrist attached to a boat maintenance depot. Although he recognized the value of purposeful work in reducing defaulters, Tooley argued that programmes of employment alone were not sufficient to rehabilitate POWs and suggested that specialist vocational units were needed.⁶⁴ By comparison with the army and air force, the navy had relatively few POWs and probably

⁵⁶ TNA: PRO, WO32/11125, 1, Brigadier H.A. Sandiford, Minutes of meeting, 27 Sep 1944.

⁵⁷ TNA: PRO, LAB12/352, 1, War Office, Technical policy for resettlement, 20 Feb 1946.

⁵⁸ TNA: PRO, LAB12/352, Captain G.C. Grant, Civil Resettlement HQ, Memo.

⁵⁹ A. Curle, 'Transitional communities and social re-connection, part I', *Human Relations*, 1 (1947), 42–68, 64.

⁶⁰ TNA: PRO, LAB12/352, Minutes of a conference on Civil Resettlement, 5 Oct 1945, 2.

⁶¹ TNA: PRO, ADM1/18875, H.K. Oram, Memorandum, 17 Jun 1944.

⁶² TNA: PRO, ADM1/18875, Medical Director General of the Navy, Memo, 16 Jun 1944.

⁶³ TNA: PRO, ADM1/18875, J.S. Lang, Memo to Commodores RN Barracks, 1 May 1945.

⁶⁴ TNA: PRO, ADM1/18875, Surgeon Lt Commander P.H. Tooley, Rehabilitation of prisoners of war, 6 Feb 1945, 2.

concluded that the cost of setting up dedicated centres outweighed any gain, given that they had been given the pick of recruits, that is, individuals considered at low risk of long-term psychological disorder.

Outcomes

Little attempt was made to evaluate the efficacy of CRUs. A sole study of an army CRU in Oxford by Major Adam Curle and Lt Colonel Eric Trist found that of fifty men who had attended, 26 per cent showed signs of 'unsettlement' (defined as apathy, restlessness, hostility and extreme dependency) compared with 64 per cent in the 100 cases who had not attended.⁶⁵ However, the small sample size and the fact that they had all been selected from a single location, undermine the validity of their findings. The authors themselves conceded that the social integration observed in the 'settled' cases could not be attributed solely to a CRU programme because attendance was voluntary. Former POWs with a poor prognosis were plausibly less likely to volunteer, while attendance may have acted as a screen for the least traumatized or those with better coping skills.

Follow-up studies were not conducted, in part, because the default position was one of resilience. According to psychiatric orthodoxy, servicemen were considered adaptable unless something (such as heredity, family upbringing or prolonged captivity) disrupted an inherent recovery process. Indeed, both clinicians and POWs themselves argued that the experience of captivity could promote positive psychological development. Bevin, a psychiatric social worker, observed that the prisoner of war camp was

Where many men gained an unwonted maturity of outlook... a new tolerance was developed and a surprisingly deep insight into their own and other human problems, so that potentially they are most valuable members of the community.⁶⁶

The character-building theme was explored by T.H. Hawes, himself a repatriated POW, who argued not only that adjustment was straightforward ('the process of settling into civilian life was very simple—POWs themselves were amazed that they could settle down so easily'), but also that his experience was a positive one: the POW 'is much wiser, more considerate, self-reliant, and normal than he was before being captured'.⁶⁷ Furthermore, a US Army doctor imprisoned by the

⁶⁵ A. Curle and E. Trist, 'Transitional communities and social reconnection, part II', *Human Relations*, 1 (1947), 240–88.

⁶⁶ Bavin, 'A contribution towards the understanding of the repatriated prisoner of war', 29–35, 35.

⁶⁷ T.H. Hawes, 'The returned prisoner of war', *Lancet*, 1 (1945), 643.

Japanese believed that captivity had 'changed him from a tense, ambitious individual' to one with less inhibitions and a 'more mature' outlook.⁶⁸ However, psychological survival during captivity was thought to be aided by productive work, which gave medics and chaplains an advantage as they, unlike infantry soldiers, could continue to practise their profession.

The notion that the POW experience could lead to greater maturity and personality development endured beyond the Second World War. A five-year follow up study of US servicemen who had been imprisoned during the Korean War found that 21 per cent reported having got some personal gain from their captivity.⁶⁹ In addition, a controlled study of 221 repatriated POWs from the Vietnam War identified a subgroup (32 per cent) who believed that their character had been enhanced by the experience of captivity.⁷⁰ They were correlated with those veterans who had suffered the most severe treatment, though their subjective interpretation did not equate with observed psychiatric morbidity.

Psychological Disorders in POWs

Although the majority of repatriated British POWs were not considered in need of psychiatric treatment, a minority were referred to military hospitals where their symptoms were conceptualized as a form of 'release syndrome'. Between January and May 1944, Major W.H. Whiles investigated 100 consecutive POW admissions to Hollymoor Military Psychiatric Hospital, Northfield. Common symptoms included irritability, apathy, difficulty in making social contacts, poor concentration, preoccupation and resentment.⁷¹ However, 'previous personality factors' were identified as a root cause: 50 per cent of cases had a 'neurotic family history', 60 per cent had shown 'pronounced neurotic traits in childhood' and 25 per cent had suffered an earlier breakdown. Supported by the evidence of doctors who had themselves been in captivity,⁷² this became an orthodox view in the immediate post-war period.

⁶⁸ S. Wolf and H.S. Ripley, 'Reactions among Allied prisoners of war subjected to three years of imprisonment and torture by the Japanese', *American Journal of Psychiatry*, 104 (1947), 180–93, 187.

⁶⁹ E.H. Schein, W.E. Cooley and M.T. Singer, *A Psychological follow-up of former POWs of the Chinese Communists: I. Results of Interview Study* (Boston, 1960).

⁷⁰ W.H. Sledge, J.A. Boydston and A.J. Rabe, 'Self-concept changes related to war captivity', *Archives of General Psychiatry*, 37 (1980), 430–43.

⁷¹ W.H. Whiles, 'A study of neurosis among repatriated prisoners of war', *British Medical Journal*, 2 (1945), 687–98.

⁷² A.L. Cochrane, 'Notes on the psychology of prisoners of war', *British Medical Journal*, 1 (1946), 282–4.

In May 1945, to supplement the CRUs, a 'neuroses unit' for repatriated POWs was opened at the Southern Hospital, Dartford. Over eleven months, under the direction of Maxwell Jones, a Maudsley psychiatrist, it treated 1,200 servicemen released from camps in north-west Europe.⁷³ Occupational therapy, both in hospital workshops and in local businesses, was the main activity, supplemented by community groups and social events such as dances and plays.⁷⁴ Although no systematic study of outcomes was conducted, Tanner and Jones found that POWs had greater difficulty adjusting to civilian life than other soldiers, common symptoms being fatigue, loss of energy, anxiety and poor concentration.⁷⁵

Far Eastern POWs

In June 1945, Brigadier T.F. Rodger, consultant psychiatrist to South East Asia Command, reported that 'British prisoners of war recovered from Japanese hands showed fewer psychiatric symptoms and a much more stable and satisfactory reaction to their captivity than prisoners of war from German hands'.⁷⁶ He considered this finding 'due in large measure to the contempt which British soldiers were able to feel for the Japanese and the absence of any feeling that the enemy was a man of a similar outlook and cultural background to themselves'. This surprising judgement appeared to be supported by evidence from medical boards held by the Ministry of Pensions. By 23 November 1945, 71,000 British POWs from German camps had sought financial compensation and been reviewed in contrast to only 682 from the Far East.⁷⁷ Although the number of war pensions awarded to Far Eastern prisoners-of-war (FEPOWs) rose in the post-war period, it was estimated that less than 50 per cent made an application, suggesting that those who survived imprisonment were a particularly resourceful and independent population.⁷⁸

⁷³ Maxwell Jones, *Social Psychiatry: A Study of Therapeutic Communities* (London, 1952), 16.

⁷⁴ Maxwell Jones, 'Rehabilitation of forces neurosis patients to civilian life', *British Medical Journal*, 1 (1946), 533–35.

⁷⁵ J.M. Tanner and M. Jones, 'The psychological symptoms and the psychological response of repatriated prisoners of war with neurosis', *Journal of Neurology, Neurosurgery and Psychiatry*, 11 (1948), 61–71.

⁷⁶ TNA: PRO, WO 165/129, Brigadier T.F. Rodger, 31st Meeting of Command Psychiatrists, 2 Jun 1945, 5.

⁷⁷ TNA: PRO, WO165/129, Minutes of the 34th Meeting of Command Psychiatrists, 23 Nov 1945, 4.

⁷⁸ Interview of Dr Owen Eggington, former senior medical officer, Ministry of Pensions, 29 Mar 1999.

Nevertheless, it was soon recognized that the privations suffered by FEPOWs were of a different order of magnitude to those experienced in Europe.⁷⁹ It is estimated that between 26 per cent and 32 per cent of UK servicemen captured by the Japanese died,⁸⁰ whereas deaths in German camps were significantly lower at 4 per cent. The high mortality rate among prisoners in Japanese hands was a product of forced labour, severe dietary restrictions and tropical diseases. When organizing the return of FEPOWs, government bodies showed some understanding of their physical needs but were less assured in planning for psychological contingencies. In March 1944, a committee set up by the Colonial Office decided to open reception centres close to ports to facilitate medical examinations and treatment for tropical illnesses.⁸¹ Almost as an afterthought, it was noted that a few repatriates might require referral to 'a hospital for neurosis'.

Contemporary studies by psychiatrists supported the emphasis on disease. In August 1945, 60,000 Europeans were released from POW camps under Japanese control, a high proportion being admitted to allied hospitals with illness and disease. Yet only sixty (0.1 per cent) were referred to a specialist psychiatric unit. Cases were assessed by Major Kirman, a British Army psychiatrist, who found that fifty were psychotic, six neurotic and in four cases no disorder could be identified.⁸² This remarkable statistic was explained in survival terms: 'there is no biological advantage to be gained from the development of neurotic symptoms', a reiteration of the First World War view. In other words, psychiatric disorders did not appear in captivity because they served no useful purpose. However, Kirman found that fourteen cases developed symptoms after captivity; what he termed a 'release reaction': 'a group of inadequate people who were able to overcome their inadequacy under conditions of prison life but were unwilling or unable to face the uncertainty of life in the outside world'.⁸³ By comparison, a study of thirty-five randomly selected POWs freed from camps in Luzon found that nine (26 per cent) had symptoms of psychoneurosis.⁸⁴

⁷⁹ S.P. MacKenzie, 'The treatment of prisoners-of-war in World War II', *Journal of Modern History*, 66 (1994), 487–520, 515–6.

⁸⁰ Gavan Daws, *Prisoners of the Japanese: POWs of World War II in the Pacific* (London, 1994), 360; R.P.W. Havers, *Reassessing the Japanese Prisoner of War Experience: The Changhi POW Camp, Singapore, 1942–45* (London, 2003), 3.

⁸¹ TNA: PRO, CO980/168, Record of a meeting held in the Colonial Office, 9 Mar 1944, 1.

⁸² B.H. Kirman, 'Mental disorder in released prisoners of war', *Journal of Mental Science*, 92 (1946), 808–13.

⁸³ Kirman, 'Mental disorder', 813.

⁸⁴ Wolf and Ripley, 'Reactions among Allied prisoners of war', 180–93.

Although no follow-up studies have been undertaken of British veterans who had been prisoners of the Japanese, anecdotal accounts suggest that psychological morbidity may have been masked in the immediate aftermath of the war. Aidan MacCarthy, a RAF doctor captured in Java and transferred to Japan, described a sense of shock and unreality after release: 'it was like being in a void... This state of dazed trance could not continue and we gradually became aware of the existence of another world outside the void'.⁸⁵ In addition, he argued that the intense privation and mortality of the camps were such that 'no one could go through such experiences without losing some of his sanity. There were some, of course, who never recovered it'.⁸⁶ MacCarthy believed that the pamphlet issued by the DAP in 1944 to prepare families to receive their repatriated relatives was counter-productive,⁸⁷ it created an impression that ex-POWs 'were slightly unbalanced' and caused 'my relations to view me with a kind of compassionate apprehension'.⁸⁸

Reframing the Psychology of Captivity

The psychological model of captivity developed during the Second World War witnessed no fundamental change during the Korean conflict and it was not until the later stages of the Vietnam War that US psychiatrists proposed a different perspective. In part, they were motivated to show that the effects of war endured well beyond the battlefield itself, impairing the ability of ex-servicemen to function in civilian life.⁸⁹ Studies of Vietnam veterans prompted a re-evaluation of earlier conflicts. A landmark investigation conducted in 1975 by Gilbert W. Beebe transformed thinking about the psychological effects of imprisonment.⁹⁰ He conducted a follow-up study of a representative sample of US Army veterans who had been POWs in the Pacific (1,020) and in Europe (508) during the Second World War, together with 1,528 servicemen captured during the Korean conflict. Using hospital records, Beebe found that POWs compared with controls had significantly higher psychiatric morbidity across all three groups. He concluded that the somatic effects of captivity were generally short term but

⁸⁵ Aidan MacCarthy, *A Doctor's War* (London, 1979), 139.

⁸⁶ MacCarthy, *Doctor's War*, 101.

⁸⁷ TNA: PRO, WO165/129, Directorate of Army Psychiatry, Technical Memorandum No. 13, 'The Prisoner of War Comes Home', May 1944.

⁸⁸ MacCarthy, *Doctor's War*, 156.

⁸⁹ R.J. Ursano and D.M. Benedek, 'Prisoners of war: long-term health outcomes', *Lancet*, 362 (2003), s22-3.

⁹⁰ G.W. Beebe, 'Follow-up studies of World War II and Korean War prisoners. II. Morbidity, disability and maladjustments', *American Journal of Epidemiology*, 101 (1975), 400-22.

'psychologic injury' was 'essentially permanent'.⁹¹ No evidence was found to support an organic brain syndrome, a form of cerebral atrophy that some researchers had proposed following investigations of concentration camp survivors. Interestingly, Beebe discovered that most former POWs had adjusted well to post-war life in terms of employment and marital relationships, though had encountered difficulties with social and recreational activities. Based on medical records, rather than retrospective self-report, Beebe's findings carried weight and had an impact on policy, such that today the Department of Veterans Affairs offer POWs special priority in health-care enrolment.

With the formal recognition of PTSD by the American Psychiatric Association in 1980, a number of US psychiatrists sought to re-evaluate the long-term psychological effects of captivity on Second World War and Korean War veterans. For example, an investigation conducted in 1986 of 188 former POWs living in Minneapolis who had been imprisoned during the Second World War found that 67 per cent had a lifetime prevalence of PTSD.⁹² However, the sample had not been randomly selected and reports were not checked against military and medical records. Engdahl *et al.* (1997) studied 262 US veterans who had been imprisoned during the Second World War and Korean conflict.⁹³ More than half (53 per cent) met criteria for lifetime PTSD, and 29 per cent currently had PTSD. Of the fifty-six POWs held in Japanese camps, 84 per cent had a lifetime prevalence of PTSD and a current rate of 59 per cent. By contrast, the 191 Second World War veterans held in Europe had a lifetime rate of 44 per cent and current rate of 19 per cent. Yet, this was an investigation based on self-report and was not a random sample: 334 potential subjects had been contacted and 262 (78 per cent) agreed to participate. A follow-up study of former US POWs of the Second World War and the Korean conflict, which involved a structured clinical interview, identified amplified rates of PTSD, depression and generalized anxiety; indeed depressive symptoms were three to five times higher than in the general population and greatest in young POWs who had suffered the harshest conditions.⁹⁴

US studies encouraged UK researchers to re-evaluate the long-term effects of imprisonment on British veterans. From a broad survey of European veterans of the Second World War, Ørner found that there was sufficient evidence to suggest a higher level of psychiatric

⁹¹ Beebe, 'Follow-up studies', 418.

⁹² J.C. Kluznik, N. Speed, C. Van Walkenburg and R. Magraw, 'Forty-year follow-up of United States prisoners of war', *American Journal of Psychiatry*, 143 (1986), 1443–6.

⁹³ Engdahl *et al.*, 'Posttraumatic stress disorder'.

⁹⁴ W.F. Page, *The Health of Former Prisoners of War* (Washington DC, 1992).

morbidity than in comparable civilian controls.⁹⁵ Hughes and Neil, psychiatrists in the RAF, found that nine (30 per cent) in a group of thirty British veterans who had been prisoners of the Japanese met the criteria of PTSD.⁹⁶ However, this was not a random sample, being drawn from ex-service personnel attending a screen for tropical diseases, and no controls were studied.⁹⁷ Thus, most retrospective studies, from whatever nation, relied on subjective memory for symptoms experienced on release from captivity. With the exception of Beebe's research, none of the Second World War or Korean investigations had access to servicemen's medical records to collaborate personal recollections.

How then can we explain the current high rates of PTSD found in elderly former POWs and the comparative rarity of psychiatric disorders detected in servicemen released from captivity in 1945? In part this may reflect reporting bias introduced by contemporary culture. In the immediate post-war period, reference to traumatic experience was discouraged in an effort to accelerate a return to peacetime functioning. Dwelling on past difficulties was viewed as counterproductive. Indeed, a study by Lee *et al.* showed that many Second World War servicemen who had experienced intense combat during the conflict were able to establish successful careers as civilians despite continuing to experience a range of psychological symptoms.⁹⁸ By the 1990s, most former POWs had retired. With time to reflect on their lives, anecdotal accounts suggest that they re-experienced these traumatic events. Combat and capture were plausibly the most intense experiences of their adult lives and it is not surprising that wartime memories dominated the thoughts of elderly veterans.

Conclusion

During both world wars, psychiatric orthodoxy taught that a traumatic experience, whether as a combatant or prisoner, was a trigger rather than an essential cause of mental illness. 'It is not the event itself that matters', wrote Henderson and Gillespie in 1943, 'but what the subject

⁹⁵ R.J. Ørner, 'Post-traumatic stress disorders and European war veterans', *British Journal of Clinical Psychology*, 31 (1992), 387–403.

⁹⁶ J.C. Hughes and L.A. Neal, 'Former prisoners who show symptoms', *British Medical Journal*, 309 (1994), 873.

⁹⁷ L.A. Neal, N. Hill, J. Hughes, A. Middleton and W. Busuttill, 'Convergent validity of measures of PTSD in an elderly population of former prisoners of war', *International Journal of Geriatric Psychiatry*, 10 (1994), 617–22.

⁹⁸ K. Lee, G. Vaillant, W. Torrey and G. Elder, 'A 50-year prospective study of the psychological sequelae of World War II combat', *American Journal of Psychiatry*, 152 (1995), 516–22.

feels about it.⁹⁹ Whether or not an individual succumbed to a psychological disorder was determined by their predisposition, family history or repressed childhood conflict.¹⁰⁰ Civilians were characterized as essentially resilient,¹⁰¹ while military training was designed to 'harden' them for the rigours of combat. A stress reaction sustained by a healthy person as a result of a life-threatening event was expected to recover naturally with rest, akin to a self-healing wound.

In part, the attention given to POWs in the Second World War was a reflection of the development that had taken place in psychological medicine during the inter-war period. In the UK, departments of academic psychiatry had been set up in medical schools and the specialty gradually worked its way into the undergraduate curriculum. Psychology had become a university discipline, albeit one of applied research into aptitude and capacity, rather than clinical treatment.¹⁰² The war itself created opportunities for psychologists to demonstrate that their techniques could serve as tools of management and selection. Indeed, in December 1943, Brigadier H.A. Sandiford, director of army psychiatry, wrote, 'the time has arrived, in my opinion, when I can no longer afford to be without the aid and advice of a consulting psychologist'.¹⁰³ In the event, Dr William Stevenson, an Oxford lecturer attached to the Directorate of Biological Research, was appointed consulting psychologist to the British Army with the rank of brigadier. The creation of the DAP in April 1942 and its spread into areas of morale, training, discipline, education and welfare could not have happened without the professionalization of psychology in the inter-war period. By the end of 1943, the British Army had 227 specialist or graded psychiatrists deployed to hospitals, training establishments and units in the field.¹⁰⁴

However, new ideas about the psychology of imprisonment were not simply a product of numbers and the development of clinical services. Germany, during the First World War, had a network of high-status psychiatric departments which served as assessment centres for psychological battle casualties.¹⁰⁵ Their judgement that captivity conferred immunity from mental illness was driven by a model of pathology

⁹⁹ Henderson and Gillespie, *Text-book of Psychiatry*, 67.

¹⁰⁰ E. Jones and S. Wessely, 'A paradigm shift in the conceptualization of psychological trauma in the twentieth century', *Journal of Anxiety Disorders*, 21 (2007), 164–75.

¹⁰¹ E. Jones, R. Woolven, B. Durodié and S. Wessely, 'Civilian morale during World War Two: responses to air-raids re-examined', *Social History of Medicine*, 17 (2004), 463–79.

¹⁰² Mathew Thomson, 'The psychological body', in R. Cooter and J. Pickstone (eds), *Companion to Medicine in the Twentieth Century* (London, 2000), 291–306.

¹⁰³ TNA: PRO, WO165/129, H.A. Sandiford, Memo to the Director General of Army Medical Services, 6 Dec 1943.

¹⁰⁴ F.A.E. Crew, *The Army Medical Services: Volume II—Administration* (London, 1955), 469–70.

¹⁰⁵ Lerner, *Hysterical Men*, 135–37.

which emphasized heredity and notions of 'secondary gain'. Developed from Freud's concept of 'epinosic' gain, the latter described any advantage that a patient might secure from his symptoms, the primary gain being a reduction in anxiety following the so-called 'flight into illness'.¹⁰⁶ At first, the gain was conceived as largely monetary (reflected in concepts of railway spine and pension neurosis where the injured party received compensation), though in time it was elaborated to include suppressed wishes for sympathy, attention or revenge. Symptoms had to be the product of an unconscious process because if they were reported as part of a carefully conceived plan, then the patient was considered a malingerer.¹⁰⁷ Ganser syndrome, first described in 1898 among prisoners awaiting trial, was characterized by approximate answers, clouding of consciousness and functional somatic symptoms.¹⁰⁸ The secondary gain for such individuals, it was hypothesized, included a reduced sentence or stay of execution.

The recognition of PTSD rendered the concept of secondary gain obsolete. By making the event rather than the person paramount, any gains that followed became an understandable and appropriate consequence of what was conceived as an invisible psychological wound. However, this interpretation is controversial, not least because it fails to explain the different patterns of psychological response observed in the First and Second World Wars. PTSD, according to Young, is not a universal stress reaction but a culturally driven response to stress. 'The disorder is not timeless', he argued, 'rather it is glued together by the practices, technologies and narratives with which it is diagnosed, studied, treated and represented.'¹⁰⁹

This article has traced a pendulum swing in the way that the psychological effects of imprisonment have been conceptualized. From offering protection against mental illness during the First World War to a cause of adjustment problems in the Second World War, today the POW experience is closely tied to formal psychiatric disorder, chiefly PTSD. A paradigm of resilience has given way to a paradigm of vulnerability. If biases operate in both directions, this implies that the psychological trauma experienced by POWs during the First and Second World Wars may have been understated, while the resilience and resourcefulness of those imprisoned today may also be underappreciated.

¹⁰⁶ Sigmund Freud, 'Some general remarks on hysterical attacks', *On psychopathology*, *Pelican Freud library*, Volume 10 (Harmondsworth, 1909), 99–100.

¹⁰⁷ M.R. Trimble, *Post-Traumatic Neurosis: From Railway Spine to the Whiplash* (Chichester, 1981).

¹⁰⁸ M.D. Enoch and W.H. Trethowan, *Uncommon Psychiatric Syndromes* (Bristol, 1979), 50–62.

¹⁰⁹ Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton, 1995), 5.