

The Hard School: Physical Treatments for War Neurosis in Britain during the Second World War

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Summary. While accounts of the practice of military psychiatry during the Second World War have tended to emphasise the development of psychodynamic innovations such as therapeutic communities and group therapy in treating patients with war neurosis, this article explores the parallel use of 'physical treatments' by British practitioners during the conflict. Focusing on the work of William Sargant and his collaborators at the Sutton Emergency Hospital, it argues for the importance of these treatments not only for understanding the tenor of wartime psychiatry, but for demonstrating the attractions of physical treatments for managing large patient cohorts during wartime and in the post-war decades.

Keywords: Second World War; physical treatments; William Sargant; psychiatry; war neurosis

In February 1945, the British medical journal *The Lancet* published a review of *The Anatomy of Courage*, Lord Moran's meditation on courage and fear in wartime, based on his time as Medical Officer with a battalion of Royal Fusiliers on the Western Front. While *The Lancet* praised the book for its 'artistry and insight' in recalling the devastated landscapes and painful atmosphere of the front-line, it was less enamoured of Moran's pronouncements on the mental suffering that accompanied trench warfare. Moran held that in war men wore out 'like clothes', and that once soldiers broke down they were beyond help and could only be sent far behind the lines, joining the ranks of broken men trudging towards the Army shell shock hospitals. *The Lancet* regarded this as 'unjustifiably hopeless in a therapeutic sense' and noted that in the present war, such a man 'would retire to a Corps exhaustion centre little further away than the transport lines of the old war, and would have a very good chance of returning to his work in a fortnight'.¹

The Lancet had an interest in promoting this narrative of enlightened progress. Since the early months of the war the journal had advocated an energetic and 'scientific' approach to the diagnosis and care of psychiatric casualties that took full account of the 'lessons' of the First World War. Yet the implication in February 1945 that the problem had been solved was misleading on two counts. In the first instance, the 'very good chance' of a soldier returning to duty was wildly overstated: figures from various theatres suggest that at most only a third of all service personnel (if that) returned to full combat duty after receiving psychiatric treatment, even if this was administered near

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¹'Courage', *The Lancet*, 24 February 1945, 249.

the front-line.² Indeed, by 1943 it was estimated that one-third of the men invalided out of the Army were discharged for psychiatric reasons; by the end of the war, the estimate was closer 40 per cent.³ In addition, psychiatric conditions accounted for up to 10 per cent of all pensions awarded to service personnel.⁴

The second elision concerned the kind of treatment these neurotic service personnel received. The treatment model referred to by *The Lancet*—close to the battlefield, with an emphasis on rehabilitating the ‘exhausted’ soldier with sound sleep and a nourishing diet; the so-called ‘PIE’ system of forward psychiatry—applied only to combatants treated immediately after their symptoms appeared.⁵ Instead, service personnel with persistent conditions were likely to find themselves transferred into the network of military hospitals or hospitals commandeered under the Emergency Medical Service (EMS) scheme. In these institutions so-called ‘physical treatments’ formed a key therapeutic response to the symptomatology of war neurosis. As such, they are crucial to the way we characterise the psychiatry practised in the Second World War.

These physical treatments are significant in several respects. There has been a tendency to emphasise the advent of ‘therapeutic communities’ and particularly the storied Northfield experiments as the most significant treatment innovation arising from the Second World War—a ‘radical change in attitude towards mental illness and the status of patients’ that was ‘perhaps the most significant psychiatric effect of the war’, according to Edgar Jones, albeit one with ‘limited’ impact during the war itself.⁶ There can be no doubt that these experiments in group therapy were crucial in reinforcing the status of psychotherapy in the National Health Service and the visibility of psychodynamic understandings of neurotic distress in the post-war era. Yet like the encounter between Siegfried Sassoon and the psychotherapist W. H. R. Rivers during the First World War, such a focus also risks obscuring a broader reality—in this case, what close examination of the medical press suggests was the widespread use of drug therapies, insulin comas, convulsive therapies and even leucotomies to allay the symptoms not only of ‘psychopathic’ or ‘schizophrenic’ service personnel but of ‘neurotic’ military patients as well.⁷ A key proponent of this transposition of physical treatments from the asylum to private practice and then into wartime therapeutics was the self-promoting psychiatrist William

²There is no encompassing return-to-duty rate for the entire war, and the figures that do exist vary between theatres. In the case of British forces in Normandy in 1944, for example, the rate of return to full combat duties was 36 per cent: Edgar Jones and Stephen Ironside, ‘Battle Exhaustion: The Dilemma of Psychiatric Casualties in Normandy, June–August 1944’, *The Historical Journal*, 2010, 53, 109–28. By contrast, return-to-duty rates in Italy were as low as 3 per cent during the fighting at Casino in May 1944: Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove and New York: Psychology Press, 2005), 80–2. One American post-war study suggested that only about 30 per cent of patients could be reasonably expected to return to full combat duties: *ibid.*, 88.

³J. R. Rees, ‘Three Years of Military Psychiatry in the United Kingdom’, *British Medical Journal*, 2 January

1943, 2 and Mark Harrison, *Medicine and Victory: British Military Medicine in the Second World War* (Oxford: Oxford University Press, 2008), 279.

⁴Jones and Wessely, *Shell Shock to PTSD*, 160–1.

⁵On the principles of ‘PIE’, see *ibid.*, 78–80.

⁶Edgar Jones, ‘War and the Practice of Psychotherapy: The UK Experience 1939–1960’, *Medical History*, 2004, 48, 500; Jones and Wessely, *Shell Shock to PTSD*, 95.

⁷On the role of psychotherapy post-war, and in particular the attractions of group therapy and therapeutic communities for the NHS, see Jones, ‘War and the Practice of Psychotherapy’, 509–10. On the distorting effect of the Sassoon–Rivers encounter see Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, MA: Harvard University Press, 2001), 89–90.

Walters Sargant, whose work on the two great waves of psychiatric casualties after Dunkirk and Normandy reinforced his convictions about the efficacy of these methods, and provided important material for his evangelism in the medical press. His wartime advocacy as well as his career more broadly is thus a useful object of analysis for understanding wartime psychiatric practice in Britain.⁸

The prevalence of physical treatments for war neurosis is important in three additional ways. First, by bringing therapeutics to the fore, an examination of these physical treatments complicates the relationship between theory and practice—or, more precisely, between aetiology and treatment.⁹ As I shall argue, while psychiatric discourse framed war neurosis in largely psychodynamic terms, the treatment of this condition did not necessarily proceed on conventional psychotherapeutic lines—a dissonance that reflects not only the eclecticism of wartime therapeutics but an emerging consensus on the benefits of managing neurotic symptomatology with physical interventions. A second, related effect goes to the periodization of the history of psychiatry in the twentieth century. The wartime use of physical treatments for neurotic symptoms modifies the conventional chronology, most usually associated with Edward Shorter, that there was a ‘re-biologisation’ of psychiatry after a ‘psychoanalytic hiatus’, and that this was a result of the development of chlorpromazine (often referred to by its trade name, Largactil) and other antipsychotic medications in the 1950s—a precursor to the full blown psychopharmacological revolution that developed in subsequent decades.¹⁰ Instead, the wartime use of physical treatments suggests a broader continuity in the use of bodily interventions (such as drugs) for neurotic conditions that existed alongside—rather than in spite of—psychodynamic precepts. In that regard, the growth of psychopharmacology beyond the antipsychotics of the 1950s can be seen not only as a consequence of their efficacy but also as a reflection of a wider receptivity to the use of physical interventions in alleviating all kinds of psychiatric distress.

The third way in which these physical treatments are significant relate to the way we characterise the trajectory and practices of psychiatry in the twentieth century, and in particular the period after 1945. It was during these decades that psychiatry became, in Greg Eghigian’s words, a ‘technoscience’, practised in multiple sites beyond the asylum, and implicated in broad social aims and programmes, ‘such as promoting healthy and harmonious families or enhancing productivity’.¹¹ The perceived efficiency of physical treatments in a wartime context, where ‘neurotic’ patients came into contact with psychiatrists in large numbers, and where treating large groups of patients swiftly was regarded as a strategic edict, provides a useful demonstration of the attractions of a certain kind of therapeutics when allied to state imperatives and collective ends. This in turn suggests that the rise of subsequent therapeutic interventions—primarily pharmaceuticals,

⁸For an overview of Sargant’s career, see John A. S. Beard, ‘Dr William Sargant (1907–88) and the Emergence of Physical Treatments in British Psychiatry’, *Journal of Medical Biography*, 2009, 17, 23–9.

⁹On the importance of therapeutics and their neglect in the literature, see Andrew Scull, ‘Somatic

Treatments and the Historiography of Psychiatry’, *History of Psychiatry*, 1994, 5, 1–12.

¹⁰Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997).

¹¹Greg Eghigian, ‘Deinstitutionalizing the History of Contemporary Psychiatry’, *History of Psychiatry*, 2011, 22, 203–4.

but also arguably cognitive behaviour therapy, the enthusiasts of which espouse its efficacy, limited treatment period and focus on symptom mitigation—were not unprecedented in their claims of social utility.

Psychiatry in the Era of Mass Warfare

The First and the Second World Wars presented the medical profession with extraordinary opportunities to observe, diagnose and treat the injuries and illnesses of hundreds of thousands of service personnel who passed through the armed forces over the course of both conflicts. Just as the exigencies of wartime prompted rapid technological and industrial development, maintaining fighting strength required significant investment in medical research to treat the conditions that rendered service personnel—and in particular fighting men—unfit for duty. Yet if wartime shaped the practice of medicine, it also influenced the theoretical and discursive elements of practitioners' work. Access to the bodies and minds of large numbers of service personnel allowed doctors to observe, describe, catalogue and aggregate medical conditions across large cohorts of patients. In this sense, the military replicated the factory, the prison and other state institutions as a site of medical appraisal and experimentation—a relationship that exemplified the Weberian 'rationalisation' of the modern state and its functions.¹² This was particularly true for the psychiatric symptoms affecting service personnel: save for the asylum, which, as the latter half of the nineteenth century progressed, housed an increasing number of pauper insane, and the few private mental hospitals that catered to the moneyed unwell, it was comparatively rare for so many psychiatric cases to be concentrated in one location.¹³ Amongst the damaged citizen-soldiers of these mass armies, doctors with an interest in theorising the causes and characteristics of wartime psychiatric illnesses had an unparalleled opportunity to interpret symptoms, scrutinise case histories and experiment with treatment regimes.

These extraordinary circumstances mean that it is particularly tempting to posit the 'shell shock' of the First World War as a watershed event in the history of psychiatry—one that incontrovertibly moved understanding of mental disorder away from models of moral and physical causality towards a psychogenic paradigm, with all the psychotherapeutic remedies that implied. Yet recent scholarship suggests that the effects of the First World War on psychiatric theory and practice were more complex. Of course, as Thomson has noted, this conflict *did* break down certain preconceptions about the susceptibility of a broader cohort of the population to mental disorder. The very scale of the problem required recognition of the vulnerability of many 'ordinary' men when put under sufficient strain.¹⁴ But it did not cause a wholesale break with older organicist explanations for the origins of psychiatric symptoms—instead, 'psychology, physiology, and biology were all inseparably blended' in many accounts.¹⁵ As we will see, this persistence of

¹²Mark Harrison, 'Medicine and the Management of Modern Warfare: An Introduction', in Roger Cooter, Mark Harrison and Steve Sturdy, eds, *Medicine and Modern Warfare* (Amsterdam: Rodopi, 1999), 1–2.

¹³For a useful discussion on the state of psychiatric care in Britain prior to the world wars, see Hugh Freeman, 'Psychiatry in Britain, c.1900', *History of Psychiatry*, 2010, 21, 312–24. See also Edgar Miller,

'Variations in the Official Prevalence and Disposal of the Insane in England under the Poor Law, 1850–1900', *History of Psychiatry*, 2007, 18, 25–37.

¹⁴Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth Century Britain* (Oxford: Oxford University Press, 2006), 185.

¹⁵Tracey Loughran, 'Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its

physiology and biology manifested again in the Second World War as a theory of predisposition—the notion that men who broke down in combat were constitutionally ‘predisposed’ to do so.¹⁶

The legacy of the First World War is equally indistinct in terms of therapeutics. As Peter Barham has argued, not only did working class soldiers run the risk of being labelled as ‘psychotic’ (rather than ‘neurasthenic’—the diagnosis for officers), they were also more likely to be subject to various physical interventions, the severity of which varied according to hospital and practitioner.¹⁷ Similarly, as Leese has suggested, these ‘workaday clinical realities’ meant that ‘the most common definition of cure remained the cessation of visible symptoms’ and that ‘mass treatment of psychological casualties employed low-cost treatments that required a minimum of qualified personnel’.¹⁸ Moreover, the principles and practices of military psychiatry—which, after all, evolved in response to a particular set of circumstances within a broader context of battlefield urgency—did not necessarily ensure an efficient segue into peace time civilian practice. There was also a moral and physical distancing between damaged soldiers and the civilian insane, and this may have tempered the flow of psychogenic explanations of shell shock into broader psychiatric understanding, as well as undermining the impact of therapeutic insights.¹⁹ Indeed, the psychotherapy that did emerge from the war was mediated by a pragmatism born of battlefield experience, with prominent practitioners such as Charles Myers, William McDougall and W. H. R. Rivers substituting fear mechanisms for libidinal energies to account for the production of neurotic symptoms.²⁰

Nevertheless, the experience of shell shock in the First World War predictably shaped the administrative framing of psychiatry in the Second World War, even if its interwar consequences are difficult to isolate. British authorities were particularly concerned to maintain fighting strength while also restricting access to pensions—a delicate exercise in balancing fiscal prudence with public sympathy.²¹ On these grounds, official policy pilloried a psychotherapeutic approach for its waste and inefficiency, as demonstrated by the experience of psychiatrists John Bowlby and Kenneth Soddy at the Fazakerley hospital in Liverpool early in the war, after the first Dunkirk casualties arrived on the wards. Being psychoanalytically orientated, both wanted, they said, to have ‘one clear hour each

Histories’, *Journal of the History of Medicine and Allied Sciences*, 2012, 67, 112. Edgar Jones has set out the competing causal explanations (psychodynamic versus ‘physicalist’) in ‘Shell Shock at Maghull and the Maudsley: Models of Psychological Medicine in the UK’, *Journal of the History of Medicine and Allied Sciences*, 2010, 65, 368–95.

¹⁶On the significance of ‘predisposition’, see Harrison, *Medicine and Victory*, 60–1 and Ben Shephard, ‘Risk Factors and PTSD: A Historian’s Perspective’, in Gerald Rosen, ed., *Posttraumatic Stress Disorder: Issues and Controversies* (Chichester: John Wiley, 2004), 39–61.

¹⁷Peter Barham, *Forgotten Lunatics of the Great War* (New Haven: Yale University Press, 2004), 4–5.

¹⁸Peter Leese, “‘Why Are They Not Cured?’ British Shellshock Treatment During the Great War”, in Mark S. Micale and Paul Lerner, eds, *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age, 1870–1930* (Cambridge: Cambridge University Press), 205–6, 208 and 219.

¹⁹See Thomson, *Psychological Subjects*, 185–6 and Barnham, *Forgotten Lunatics*, 43–6.

²⁰See Suzanne Rait, ‘Early British Psychoanalysis and the Medico-Psychological Clinic’, *History Workshop Journal*, 2004, 58, 63–85, particularly 69–71.

²¹See discussions on pensions in Shephard, *War of Nerves*, 165–7 and Jones and Wessely, *Shell Shock to PTSD*, 156–61.

week' for psychotherapy with select patients suffering from 'considerable emotional disturbance'.²²

Their superior, the neurologist William Johnson, did not agree, and his fondness for the term 'scrimshanker' tended to put his view of the affected soldiers beyond doubt.²³ In the increasingly terse correspondence between Bowlby and Soddy and the EMS Consultant Neurologist Gordon Holmes, two rival views of appropriate treatment emerged, demonstrating the ambiguous legacy of the First World War. Holmes, himself a veteran of the First World War, held that 'direct and simple' interventions were best.²⁴ But Bowlby and Soddy had drawn different lessons: primarily, that certain soldiers with chronic 'emotional disturbances' and 'amnesia of shocking events' needed psychotherapy.²⁵ They pointed to the work of Rivers and Millais Culpin as inspiration, with the latter quickly becoming exercised on their behalf. 'Get your facts ready as if for a court of law', Culpin advised Bowlby; '... remember these chaps will wriggle like the devil when you stand up to them'.²⁶ Bowlby and Soddy soon resigned in protest and went to work for the RAMC under the more sympathetic J. R. Rees, former Director of the Tavistock clinic, who had been a confidant during the conflict.²⁷ As they explained in an angry letter intended for the *Lancet* but never published, 'we wished to be free to work in a service where psychotherapy is not discouraged and with colleagues who do not condemn our patients as cowards'.²⁸

If two divergent views on treatment emerged from the First World War, then accounts of the aetiology of the war neurosis of the Second World War adhered to a broadly coherent framework. This schema was ostensibly psychodynamic, proposing that the conditions of wartime produced unconscious conflicts between instinctual urges or irreconcilable emotional imperatives. In combat this might take the form of the conflict between the murderous rage felt for the enemy and the guilt associated with this blood lust, or the conflict between self-preservation and loyalty to the group.²⁹ Traumatic memories of horrific events—near-misses, witnessing friends killed—could also wreak havoc.³⁰ For servicemen who had never seen action, neuroses might be produced by the emotional conflicts attending separation from the family (guilt about deserting a widowed mother was seen as particularly significant) or suppressed concerns about the fidelity of a spouse.³¹ Symptoms ranged from those demonstrating anxious affect

²²'War Neurosis Centre, Royal Southern Hospital, Liverpool, 9', PP/BOW/C.5/1, Wellcome Library (hereafter 'Bowlby Papers').

²³John Bowlby and Kenneth Soddy, 'Treatment of War Neuroses', Letters to the Editor, *The Lancet*, 14 September 1940, 343. Note that Shephard also has a brief account of this episode: *War of Nerves*, 171–2.

²⁴Gordon Holmes to John Bowlby, 22 July 1940, Bowlby Papers.

²⁵John Bowlby and Kenneth Soddy to Gordon Holmes, 24 July 1940, Bowlby Papers.

²⁶Millais Culpin to John Bowlby, 16 August 1940, Bowlby Papers.

²⁷Rees more or less offered these positions to Bowlby and Soddy as a means of escaping their predicament: see J. R. Rees to John Bowlby, 1 August 1940, Bowlby Papers.

²⁸'Dear Sir', unsigned letter, no date, Bowlby Papers.

²⁹A paper co-authored by William Sargant argued that war provided 'a stimulus to aggressive and sadistic impulses', resulting in 'guilt and its associated depressive affect': Gilbert Debenham, Denis Hill, William Sargant and Eliot Slater, 'Treatment of War Neuroses', *The Lancet*, 25 January 1941, 108. As discussed later, Sargant soon retreated from this kind of Freudian language.

³⁰See for example Alfred Torrie, 'Psychosomatic Casualties in the Middle East', *The Lancet*, 29 January 1944, 139–40.

³¹See for example J. A. Hadfield, 'War Neurosis: A Year in a Neuropathic Hospital'—Part I', *British Medical Journal*, 28 February 1942, 285 and Emmanuel Miller, 'Psychiatric Casualties among Officers and Men from

(palpitations, breathlessness, tremors, uncontrollable crying) to full-blown conversion hysteria ('functional' paralysis of limbs, for example, or hysterical blindness and aphasia). Some practitioners proposed a relationship between combat and conversion symptoms, which more closely mirrored the symptom pattern of the First World War but the relationship was not always clear-cut.³² Moreover, the majority of war neuroses were not attributed to combat. Louis Minski, who as Physician Superintendent of the Sutton Emergency Hospital (and therefore William Sargant's boss during the war) had seen many of the Dunkirk wounded, argued that the number of men who broke down from the 'acute stress of war' was small compared to individuals who were 'chronic neurotics' in civilian life and found that the 'trivial stresses' of military life exacerbated their symptoms.³³ Similarly, the army psychiatrist J. A. Hadfield's classification of 332 patients indicated that 60 per cent of cases 'had little or nothing to do with active service'.³⁴

These numbers tended to lend credence to the idea that war neurosis came about not only because of external circumstances, but because these external circumstances interacted with a constitution that was already predisposed to neurotic breakdown. Such reasoning demonstrates the operation of resilient biological imperatives in psychiatric discourse, with theories of predisposition positioning individual 'weaknesses' above the severity of traumatic experience. Indeed, in this regard an experience need not have been objectively traumatic to provoke a neurotic response, just as an horrific event need not be traumatic to a differently-constituted individual. The determinant, instead, was the vulnerability of the individual—residing in the deep structures of personality or existing as a vaguely construed 'constitutional' weakness. This resulted in two important caveats to the psychodynamic framing of war neurosis. The first is the subtle shading of physical, organic or 'constitutional' factors into the genesis of neurotic symptoms. While there were few purely physiological explanations for war neurosis in the medical literature, the notion of a neurotic body and its compromised physiology persisted, and this may go some way to explaining the willingness of some practitioners to seek cure via physical interventions.³⁵ The second, related factor is the extent to which the causative power of an objectively 'traumatic' event—so central to contemporary understandings of Post Traumatic Stress Disorder—therefore had an ambivalent place in these British accounts of war neurosis in the Second World War.³⁶ If trauma only exposed constitutional weaknesses rather than created them, then harrowing combat experiences did not confer a special kind of victimhood or survivorship. Even the most sympathetic of observers might founder on this score, because how else to explain why one man broke down and another did not?

Normandy: Distribution of Aetiological Factors', *The Lancet*, 24 March 1945, 366.

³²Jones and Wessely, *Shell Shock to PTSD*, 194–6.

³³Louis Minski, 'Exclusion of Neurotics from the Forces', *The Lancet*, 27 September 1941, 382.

³⁴Hadfield, 'War Neurosis: A Year in a Neuropathic Hospital', 283.

³⁵On physiological explanations see, for example, C. P Symonds, 'The Neurological Approach to Mental Disorder', *The Lancet*, 15 March 1941, 337–41, where he suggests that there is no such thing as 'un-

conscious experience', only 'unconscious activity' of a 'physiological nature' (337).

³⁶For a discussion of the importance of the 'event' and its connotations, see Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995), 124–8 and Didier Fassin and Richard Rechtman, *The Empire of Trauma: An Inquiry into the Condition of Victimhood* (Princeton: Princeton University Press, 2009), 84–7.

William Sargant and Wartime Therapeutics

All these considerations framed the approach of William Sargant to the treatment of the psychiatric casualties of Dunkirk at the Sutton Emergency Hospital where he began to elaborate a wartime therapeutics based on physical interventions. In part this reflected his predilection for 'heroic' cures, inculcated by the experimental ethos of certain sections of psychological medicine in the interwar period, and fostered by his own substantial ambitions (realised in later years by his popular writings on 'brainwashing').³⁷ Yet he also claimed to have been prompted by a genuine desire to help chronically suffering patients in the back wards of asylums, for whom psychotherapy was pointless, and for whom some physical interventions were helpful in alleviating their distress. The only aim of the psychiatrist (or, as Sargant referred to himself with deliberate care, a 'physician' who practised 'psychological medicine'³⁸) was the amelioration of symptoms—not the pursuit of some higher integration or insight, and certainly not the realm of metaphysics or philosophy.

Sargant had begun forming this view early in his medical training, when the suffering of psychiatric patients and the fatalism of doctors soon became clear. As a locum at the Hanwell Mental Hospital he used to walk the grounds and 'brood on the terrible sights the hospital had witnessed and was still witnessing', dreading his daily circuit 'round those dreadful wards . . . with my bunch of keys'.³⁹ But it was not just the suffering of asylum patients that drew his attention: working for a time alongside his brother-in-law, a GP, he began to appreciate the worth of tranquilisers in helping distressed people carry on with their working lives. 'To change one's environment, or to get the prolonged intensive treatment demanded by psychotherapists for a supposed radical cure, once must be both rich and leisured', he concluded.⁴⁰ Here was the rationale for applying physical treatments to a range of patients: why engage in hours of 'so much useless talk' when a swift physical intervention could do the therapeutic work just as well?⁴¹ As emerged during the war, Sargant was increasingly unconcerned about the conceptual boundary between the disordered and sedated schizophrenic who had spent years in hospital back wards, and the recently admitted neurotic patient incapacitated by persistent anxiety or depression. For Sargant the boundary was in fact immaterial: if a physical intervention could alleviate suffering, it ought to be applied.

The strictures of wartime made this supreme pragmatism particularly tenable. Indeed, the Second World War was pivotal for Sargant's career insofar as it crystallised these opinions and gave him the opportunity to pursue physical treatments on a large number of service patients. In the medical press he became an important if blinkered proponent of the value of physical therapeutics, and his career and professional identity became enmeshed with their advancement and the anti-Freudian stance they implied. This distaste for what he regarded as the dogmas of psychoanalysis developed during his year as a Rockefeller Fellow in 1938–1939. Visiting the Massachusetts General Hospital he had

³⁷Dominic Streatfield, *Brainwash: The Secret History of Mind Control* (London: Hodder & Stoughton, 2007), 17–20.

³⁹*Ibid.*, 6 and 13.

⁴⁰*Ibid.*, 32.

⁴¹*Ibid.*, 97.

³⁸William Sargant, *The Unquiet Mind: The Autobiography of a Physician in Psychological Medicine* (London: Heinemann, 1967).

been appalled by the reluctance of the psychoanalytically-inclined staff to prescribe sedatives for patients whose agitation and sleeplessness only added to their anguish, as well as bemused by the paranoid atmosphere of transference and counter-transference amongst colleagues who were also each other's analysts and analysands.⁴² He also simply doubted psychoanalysis' efficacy for serious mental disorders. As he later wrote, 'despite the continued and yearly more extensive use of the Freudian technique, it has never shown to have helped greatly, let alone cured, the really mentally ill'.⁴³

Sargant's worldview was also formed by the atmosphere at the Maudsley Hospital, which he joined in 1935 and which during the war was split between two sites—the Belmont Hospital at Sutton (known during the war as the Sutton Emergency Hospital) and Mill Hill. Under Edward Mapother, the culture and practice of the Maudsley had been more sceptical of the psychotherapeutic claims of institutions such as the Tavistock, and instead pursued a research agenda on organicist premises, though Sargant noted in his autobiography that 'Freudian, Adlerian and Jungians dogmas' were still 'taken seriously'.⁴⁴ Indeed, Mapother was more pragmatist than zealot, and believed in the necessity of empiricism for establishing psychiatry's respectability, notwithstanding the impediments in gathering reliable clinical data.⁴⁵ The impressive publication rate of Maudsley doctors during the 1930s is a testament to this imperative.⁴⁶ This focus on research goes some way to explaining the culture of wartime experimentation at Sutton which appears to have encouraged both pure research and the development of therapeutics with little insistence on divining the broader 'meaning' of patients' symptoms. Indeed, Sargant wrote that Mapother sought out staff capable of turning 'accidental discoveries' into viable treatments.⁴⁷ This focus on practical therapeutics suited Sargant's sympathies and purpose; it also was in keeping with the pragmatism of wartime. In the introduction to their 1944 textbook on physical treatments, Sargant and his collaborator, Eliot Slater, wrote that they had learned from Mapother 'a balanced view in which the genetic, the somatic and psychopathological aspects all met their due appraisalment', and that wartime had 'tested the principles we have absorbed, in the hard school of work under pressure and on the largest scale'.⁴⁸

This 'hard school' of physical treatments, born of the volume of urgent cases, also reflected Sargant's perception of a divergence in the philosophy of Mill Hill and Sutton. At Sutton, he claimed, Louis Minski 'gave us as much clinical liberty as possible in often difficult circumstances', in contrast to the 'irksome restrictions' he believed were imposed by Aubrey Lewis at Mill Hill.⁴⁹ Here he was referring primarily to the availability of physical treatments for patients. This was, in turn, reflected in institutional ethos: the staff at Sutton, according to Sargant, were the 'practical "doers"' and those at Mill Hill

⁴²*Ibid.*, 59–60.

⁴³*Ibid.*, 51.

⁴⁴Edgar Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley', in K. Angel, E. Jones and M. Neve (eds), *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s*, Supplement 22 to *Medical History* (London: Wellcome Trust Centre for the History of Medicine at UCL, 2003), 3–38. Sargant wrote that some of his colleagues interpreted the

hot flushes of menopause as the consequence of 'repressed aggression', for example: *Unquiet Mind*, 50.

⁴⁵Jones, 'Maudsley', 12–13.

⁴⁶*Ibid.*, 21.

⁴⁷Sargant, *Unquiet Mind*, 49.

⁴⁸William Sargant and Eliot Slater, 'Preface to the First Edition', *An Introduction to Physical Methods of Treatment in Psychiatry* (New York: Science House, 1972), xi.

⁴⁹Sargant, *Unquiet Mind*, 78.

'conservative and philosophical'. How much of this estrangement was a product of Sargant's own resentments—linked to his self-perception as an energetic 'doer' thwarted by hidebound conservatism—is open to question. Certainly Lewis appears to have been wary of invasive or irreversible physical interventions.⁵⁰ Sargant's brother, who at the time had some dealings with the London County Council (LCC), 'was shocked at the description that Mill Hill colleagues seemed to have given of me. I was said to be often cruel and irresponsible . . . [s]omething of a menace who refused to listen to my seniors' advice and insisted on pushing ahead with ill-balanced views . . .'⁵¹ Here, perhaps, was the beginnings of the 'whiff of sulphur' that contemporaries remembered wafting around Sargant—a product of his towering self-belief and a fondness for extreme therapeutic measures, not to mention the whispers about his alleged involvement with British intelligence post-war.⁵²

Yet the split between Sutton and Mill Hill was not necessarily as thoroughgoing as Sargant, with his tendency to see things in stark binaries, asserted. The practices at both institutions disclosed a degree of interwoven interest in both the physical indicia of neurosis and the potential for physical treatments, though Sargant's enthusiasm for the latter meant that the practices at Sutton were more extensive. Both institutions used convulsion therapies and insulin comas, for example, though at Mill Hill these comas were of the modified variety and leucotomies were not practised at all.

In addition, practitioners at both hospitals conducted extensive clinical research that involved physical interventions—giving EEGs to 'psychopathic' military patients; injecting others with adrenalin to measure the effects on pulse rate and blood pressure; attempting to exercise 'effort syndrome' patients to exhaustion in order to measure 'blood lactic acid and pH changes'; even forcing a group of patients to sit out a night bombing raid in an upstairs clinic while being questioned about their 'feelings'.⁵³ That Maxwell Jones, perhaps best known as a pioneer of group therapy while at Mill Hill, was a co-author in these last two studies demonstrates the degree to which psychodynamic ideas and physical interventions might coexist.⁵⁴ Indeed, the divergence between the two hospitals was perhaps one of presentation as much as practice, with the instructional film *Neuro Psychiatry*, shot at Mill Hill in 1943 to showcase the British approach to psychiatric casualties, focusing more on 'psychological, social, and occupational initiatives' than the physical interventions also in use.⁵⁵

Even the Northfield Military Hospital, an institution whose practices might present the best counterpoint to Sutton given its Tavistock influences and its famous radical experiments in therapeutic communities, does not present as a perfect antagonist. Here

⁵⁰Edgar Jones, 'Neuro Psychiatry 1943: The Role of Documentary Film in the Dissemination of Medical Knowledge and Promotion of the U.K. Psychiatric Profession', *Journal of the History of Medicine and Allied Sciences*, 2012, 69, 309.

⁵¹*Ibid.*, 121.

⁵²Streatfield, *Brainwash*, 245 and generally 242–56.

⁵³Denis Hill and Donald Watterson, 'Electro-Encephalographic Studies of Psychopathic Personalities', *Journal of Neurology and Psychiatry*, 1942, 5, 47–55; A. S. Thorley, 'The Action of

Adrenalin in Neurotics', *Journal of Neurology and Psychiatry*, 1942, 5, 14–21; Maxwell Shaw Jones and Ronald Scarisbrick, 'Effect of Exercise on Soldiers with Effort Intolerance', *The Lancet*, 11 September 1943, 331–2; Maxwell Jones and Aubrey Lewis, 'Effort Syndrome', *The Lancet*, 28 June 1941, 813–18.

⁵⁴Jones, 'Practice of Psychotherapy', 500–1.

⁵⁵Jones, 'Neuro Psychiatry 1943', 300 and 314. This film 'stung Sargant into competitive response', and he produced his own film in 1944 (319–20).

physical treatments—modified insulin comas, continuous narcosis, electro-shock therapy—were still in use, though their effects were often understood in a Freudian light. Patients undergoing continuous narcosis, for example, were regarded as returning to an infantile state, and efforts were made to keep a nursery-like atmosphere on the ward, with some patients even being fed from nursing bottles.⁵⁶ In this regard, it is worth reiterating the extent to which Sutton and Northfield were directed towards the same ends, despite the very real differences in therapeutic technique—efficient treatments that maintained fighting strength. In a military setting, therapeutic communities sought to corral, mould and harness the unconscious and ultimately to ‘persuade the patients to go back to fulfilling their social-military roles’ by emphasising the primacy of the collective and its needs.⁵⁷ Both of the short-lived Northfield experiments sought to create a therapeutic environment that circumvented the need for individual therapy and adapted the soldier to life in the services or a return to civilian status by exposure to group environments and the championing of personal responsibility and initiative within that milieu.⁵⁸ Here was one answer to Bowlby and Soddy’s problem of how to practise psychotherapy in wartime, when scarce resources and administrative scepticism made it impossible to sustain a conventional therapeutic relationship. This also goes to the broader point that proponents of therapeutic communities were not necessarily the radical forefathers of the anti-psychiatry movement, insofar as they sought to serve social ends and often relied on antipsychotics and other ‘biological’ treatments to enable their communities to function.⁵⁹

Physical Treatments in Wartime

If the proponents of physical treatments and the psychiatrists of Northfield were acting towards the same ends, the physical interventions used on service patients nevertheless contained a degree of risk and permanency that talking therapies did not. These physical treatments assumed a variety of forms, running a spectrum from commonplace interventions—such as the use of sedatives—to leucotomies. The simpler measures advocated for civilians and troops were often uncontroversial replications of peacetime practice. At the beginning of the war, for example, *The Lancet* urged the use of ‘a dose of bromide’, morphine injections or the administration of barbituates such as phenobarbitone to assist in the treatment of ‘confusion, excitement, loss of memory or disorientation’, and to forestall chronicity in victims of air-raids.⁶⁰ There was also a species of sedation in the field, with alcohol recommended for steadying the nerves of combat

⁵⁶Tom Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments: Advancing on a Different Front* (London and Philadelphia: Jessica Kingsley Publishers, 2009), 139.

⁵⁷Nafiska Thalassis, ‘Soldiers in Psychiatric Therapy: The Case of Northfield Military Hospital 1942–1946’, *Social History of Medicine*, 2007, 20, 352.

⁵⁸For a detailed account, see Harrison, *Northfield Experiments*, throughout and Thalassis, ‘Northfield Military Hospital’, 351–68. For summaries, see Jones, ‘Practice of Psychotherapy’, 496–500 and Shephard, *War of Nerves*, 257–71. The key article describing the approach of the first experiment is W. R. Bion

and John Rickman, ‘Intra-Group Tensions in Therapy: Their Study as the Task of the Group’, *The Lancet*, 27 November 1943, 678–82, and for the second experiment S. H. Foulkes, ‘Group Analysis in a Military Neurosis Centre’, *The Lancet*, 2 March 1946, 303–6.

⁵⁹Catherine Fussinger, ‘“Therapeutic Community”, Psychiatry’s Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry after World War II’, *History of Psychiatry*, 2011, 22, 146–63.

⁶⁰‘Neuroses in War-Time’, *The Lancet*, 16 December 1939, 1279.

troops.⁶¹ Undisturbed sleep was regarded as particularly important, and sedatives were a common recourse to this end. An 'incapacity to sleep restfully' was often a sign of imminent neurosis, warned an editorial in *The Lancet* at the end of 1942. 'Preconceptions about the "drugging of the troops" should not be allowed to interfere with the treatment of this symptom, which may itself start the vicious circle of exhaustion and avoidable neurosis', it argued.⁶² When a bomb fell on the Sutton, killing 16 patients and leaving Sargant and his colleagues severely shaken, they also had recourse to sedatives to treat the same 'short-lived functional amnesia for which we were treating so many of our soldiers'.⁶³

More significant for demonstrating the extent of physical treatments in wartime Britain is the use of two broad categories of treatment developed in Europe in the 1920s and 1930s and, at least initially, aimed at treating chronic schizophrenia, psychosis, depression or other recalcitrant conditions: coma therapies and convulsion therapies. Both approaches worked on the assumption that disrupting a chronically disordered mind by extraneous means might restore a measure of tranquility to afflicted patients. Coma therapies were essentially a form of continuous sedation achieved most often via barbituates or insulin; convulsion therapies relied on either Cardiazol, a cardiac stimulant, or electricity.⁶⁴ Both therapies had reached Britain just before the war, and Sargant was an enthusiastic proponent of each. He pressed for permission to use insulin comas at the Maudsley, for example, soon after reports began appearing in the medical press. Mapother, however, was wary of accidentally killing the Maudsley's voluntary patients and made him wait until 1938, when a Swiss doctor came to supervise the procedure.⁶⁵ Sargant also resorted to subterfuge to try Cardiazol on a severely depressed Maudsley patient, getting an Australian doctor to perform the procedure while Mapother was absent. Sargant was willing, he said, to use 'every device or trick' to subvert the 'heartless medical authoritarianism' of his superiors.⁶⁶

Sargant's enthusiasm reflects, I think, a broader wartime adoption of these physical techniques for the treatment of war neurosis—an instance of 'therapy creep' similar to that effected post-war by psychopharmaceuticals, where treatments for schizophrenia and other forms of psychosis segued into the treatment of neurotic conditions. Of course, the boundary between neurosis and psychosis was always porous—McCrae, for

⁶¹Rum 'may be recommended prior to or after severe psychological strain': Brigadier E. W. Wade, 'First Army Medical Standing Orders', 23, 22, in 'MS/8030/3, Captain A. M. Steward Papers, Wellcome Library. Sargant also noted the temporary fortifying effects of alcohol, such as brandy during the Dunkirk retreat: William Sargant, 'Physical Treatment for Acute War Neuroses: Some Clinical Observations', *British Medical Journal*, 14 November 1942, 575.

⁶²'Neurotic Casualties in the Field', *The Lancet*, 19 December 1942, 729.

⁶³Sargant, *Unquiet Mind*, 101.

⁶⁴For a general overview of the development of both techniques, see Shorter, *History of Psychiatry*, 207–24. For an overview of the use of Cardiazol, see Niall McCrae, "'A violent thunderstorm": Cardiazol

Treatment in British Mental Hospitals', *History of Psychiatry*, 2006, 17, 67–90. For a valuable account of these treatments as carried out in Californian state hospitals, see Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley and Los Angeles: The University of California Press, 1997), particularly 95–124 on electro-convulsive therapy. On the impetus for 'active therapy' and somatic treatments, including psychosurgery, see Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 2002), 147–93.

⁶⁵Sargant, *Unquiet Mind*, 52–3.

⁶⁶*Ibid.*, 54.

example, suggests that in the interwar period 'schizophrenia' was a broad category, and that anyone exhibiting catatonic symptoms might fall into this group, such as patients with severe depression. Such elasticity tempers any notion that the wartime use of comas and convulsions for neurotic patients was wholly unprecedented.⁶⁷ It also highlights the likelihood that the perceived severity of the 'neurosis' (itself a commodious and contested category) was an essential factor in recommending physical interventions. Nevertheless, the imperatives of wartime in shaping therapeutic decisions cannot be discounted. The need to maintain manpower, or at least return men to civilian life with some degree of functioning, plus the acute and comparatively mild nature of military patients' illnesses, may have paradoxically impelled more rigorous treatment, because a 'cure'—or at least some measure of therapeutic success—appeared not only desirable but achievable. In this respect, the effects of the 1930 Mental Treatment Act appear to provide a useful precedent, insofar as a greater number of voluntary patients, presenting with 'more minor, neurotic illnesses', were 'subject to a more active therapeutic regime than their certified peers', including lengthy sedation and convulsions.⁶⁸ Similar reasoning was to guide Sargant's advocacy of leucotomies for patients with neurotic conditions.

Coma therapies and prolonged sedation were Sargant's initial recourse as the first casualties from Dunkirk began arriving at Sutton. Writing in *The Lancet* in July 1940, Sargant and his colleague Eliot Slater argued that these longer periods of 'continuous narcosis' were crucial for treating service patients who had been through particularly harrowing experiences or presented with extreme "conversion" or distressing symptoms. '[T]he longer the symptoms are allowed to last', they wrote, '... the more deeply they will be ingrained, and the more likely they will be to recur as future behaviour patterns'. Practitioners also needed to be mindful of the importance of assuring quality of sleep—without delirium, hallucinations or other disturbances.⁶⁹ Under such a regime, a patient might be made to sleep for 20 hours a day, for up to ten days—a substantial feat of nursing, and a foretaste of Sargant's later and far more extreme practice of 'deep narcosis', where patients were hospitalised for treatment for up to three months.⁷⁰

Continuous narcosis and insulin comas were resource intense and risky, with patients requiring constant monitoring and lengthy hospitalisations. Wartime stringencies prompted some expediences: 'modified' insulin comas that kept patients in a twilight state by balancing insulin injections against doses of sugared tea administered via a nasal or stomach tube. When wartime shortages meant that sugar became scarce, small doses of insulin were alternated with large servings of potatoes.⁷¹ As Sargant came to realise, a corollary of this modified version was that the accompanying heavy diets replicated an older notion, popularised by S. Weir Mitchell during the American Civil War, of feeding thin and distressed patients back to health.⁷² Sargant became particularly enthusiastic on this point, writing that 'it is open to doubt whether a stable psychological recovery can be obtained without restoration of normal physique' and, later, that 'psychological

⁶⁷ McCrae, "'Violent thunderstorm'", 76–7.

⁶⁸ David Pearce, 'Evacuation and Deprivation: The Wartime Experience of the Devon and Exeter City Mental Hospitals', *History of Psychiatry*, 2011, 22, 333 and 342 (note 1).

⁶⁹ William Sargant and Eliot Slater, 'Acute War Neuroses', *The Lancet*, 6 July 1940, 1.

⁷⁰ Sargant, 'Physical Treatments', 575; Streatfield, *Brainwash*, 246–56.

⁷¹ Sargant, *Unquiet Mind*, 90–2.

⁷² *Ibid.*, 92–3.

improvement is rarely permanent if the patient's physique has much deteriorated'.⁷³ While the published data on these modified comas pointed to an average treatment cycle of around four weeks, there were efficiencies nonetheless.⁷⁴ As patients never lapsed into a full coma they required less specialty nursing. It also held a lower mortality risk than a protracted and fully comatose state—the risks of which were substantial, as Mapother's hesitancy demonstrates. When H. A. Palmer reported on findings comparing the efficacy of insulin comas against convulsion therapies in a group of 100 military patients, his data showed two of the 30 coma patients falling into dangerous 'irreversible comas' (meaning that the patient could not be brought out of the coma by the administration of glucose alone). As was characteristic of the champions of these physical treatments and their application in wartime, however, he optimistically reported that the depth of the coma 'reached the limit of safety in most cases'.⁷⁵

The dangers and inefficiencies of coma therapies made convulsion therapies attractive in ways that their later malign reputation discounts. Inducing fits with Cardiazol or electricity also made logistical and fiscal sense in wartime: large numbers of patients could be processed comparatively quickly, and while there were some concerns about the potential for amnesia and impaired mental functioning (some practitioners recommending against the use of convulsions for patients engaged in intellectual work), it did not pose the same risk of death as coma therapies.⁷⁶ This is not to say that convulsion therapies were pleasant for patients. Cardiazol was particularly problematic, producing dramatic seizures and hairline spinal fractures in some patients.⁷⁷ The seconds before the convulsions began were also terrifying, with the imminent seizure manifesting as acute and objectless dread—meaning that some patients resisted subsequent injections and were tormented by memories of previous ones.⁷⁸ Administering Cardiazol could therefore have a disciplinary effect. The psychiatrist John D. Sutherland reported using 'one or two' Cardiazol convulsions on 'a few uncooperative or unresponsive' men admitted to an EMS hospital with conversion hysteria. Since he concluded that the great majority of men who broke down on the front-lines—including those who had survived ships being bombed, who had seen friends die beside them or witnessed women and children being machine-gunned—had compromised personalities prior to breakdown, he theorised that any treatments could only effect superficial and temporary changes, and one senses he persisted with Cardiazol for its punitive potential as much as therapeutic effect.⁷⁹ The unpleasantness of Cardiazol explains the attractions of electricity as a convulsive agent, rendering the patient immediately unconscious and producing less violent seizures.⁸⁰ It could be given as an out-patient procedure: William Sargent administered it to

⁷³William Sargent and Nellie Craske, 'Modified Insulin Therapy in War Neuroses', *The Lancet*, 23 August 1941, 212; Sargent, 'Physical Treatment', 574.

⁷⁴Sargent and Craske's data includes treatment cycles of as little as two days and as many as 69. See Table II, *ibid.*, 213.

⁷⁵H. A. Palmer, 'An Experimental Approach to the Determination of Comparative Efficiency of Insulin and Convulsion Therapy', *Journal of Neurology and Psychiatry*, 1942, 5, 10–13. Shorter puts the mortality risk at one in 100: *History of Psychiatry*, 212. McCrae

cites figures from 1938 suggesting 0.3 per cent death risk for convulsions versus 1.3 per cent for comas: "'Violent thunderstorm'", 77.

⁷⁶*Ibid.*, 78.

⁷⁷*Ibid.*, 77.

⁷⁸*Ibid.*, 78–80.

⁷⁹John D. Sutherland, 'A Survey of One Hundred Cases of War Neuroses', *British Medical Journal*, 13 September 1941, 368.

⁸⁰McCrae, "'Violent thunderstorm'", 83.

out-patients at his clinic at the West End Hospital for Nervous Diseases during the war.⁸¹ At Sutton, where permission to treat out-patients was withheld, Sargant went to some lengths to obtain a 'shock box' against the objections of the London County Council's medical advisers, who refused to use public funds to pay for a machine. Sargant approached a private charity instead.⁸²

If comas and convulsions proposed an extraneous intervention to disrupt the disordered mind, then the psychic mechanisms implicated in so-called 'narco-therapy' or 'narco-analysis' were more complex. This drug-abetted form of psychotherapy aimed at achieving 'abreaction' or 'catharsis' by restoring—or was it erasing?—the repressed traumatic memories of service patients and thereby relieving the patients' neurotic symptoms. Here drugs took the place of hypnosis—used by practitioners like William Brown during the First World War but difficult to achieve in some patients—in freeing tongues and memories.⁸³ It therefore represents an intriguing hybrid of a physical intervention explicitly premised on psychodynamic theorising. '[T]he man is forced to re-live the frightening experience which precipitated breakdown', the *British Medical Journal* explained, and 'recovery of lost memories, disappearance of panic states, and abolition of battle dreams may be obtained with little demand on the doctor's time.'⁸⁴ Like the infantile regression Freudians were wont to see in patients undergoing prolonged sedation at Northfield, or the psychotherapeutic opportunities some doctors saw in the terrors and stupors of comas and convulsions, 'narco-therapy' is a good example of the way physical interventions and Freudian interpretations might co-exist.⁸⁵

That sodium amytal came to be the drug of choice for narco-therapy appears to be down to convenience and coincidence. It had previously been used at the Maudsley in combination with Benzedrine and other barbituates for anxious patients.⁸⁶ When Sargant began administering it to casualties of the Dunkirk evacuation, he found that it not only relieved muscle tension but also made patients talkative. The drug, he said, offered the 'quickest and most convenient method' for eliciting painful or significant memories, far preferable to 'taking the man over the same ground again and again' in talking therapies, which would likely cause the man considerable emotional pain.⁸⁷ Sargant's famous exemplar—a case he later said 'greatly disturbed him'—was a BEF soldier who arrived at Sutton with a paralysed right hand and under sodium amytal recounted finding his brother, also a BEF soldier, lying mortally wounded by the side of the road. His brother begged to be killed rather than left to suffer, and so the soldier had dragged him into an adjacent field and shot him. Having recounted this story to Sargant, the soldier's paralysis lifted. Even Sargant could not resist the Freudian inference, concluding that the soldiers' paralysis—in his right hand, his trigger hand—was not only a classic 'conversion'

⁸¹Sargant, *Unquiet Mind*, 97.

⁸²*Ibid.*, 81.

⁸³See Ruth Leys, *Trauma: A Genealogy* (Chicago: The University of Chicago Press, 2000), 84–5.

⁸⁴'Progress in the Psychiatry of War', *British Medical Journal*, 30 June 1945, 914.

⁸⁵On the 'psychotherapeutic openings' of comas and convulsions, see McCrae, "'Violent thunderstorm'", 80–82.

⁸⁶Sargant, *Unquiet Mind*, 46.

⁸⁷Sargant and Slater, 'Acute War Neuroses', 2.

symptom, but also a symbolic representation of the guilt and horror of having to shoot one's brother.⁸⁸

Yet this satisfyingly neat story was not representative of all experiences of narco-therapy, nor a precursor of universal adoption and esteem. Other men recounted more dream-like and fanciful experiences, prompting debates in the medical literature about the cathartic value of these 'memories', and whether they needed to be 'true' to effect a cure. J. F. Wilde could not say that all the stories told under narco-analysis were truthful; indeed, 'the hidden fears of the neurotic may be sheer fantasy and the wildest confabulations imagination'—yet these could still be 'terrifying' and therefore the material with which the therapist must grapple.⁸⁹ Similarly, Sargant and Slater emphasised that not all recollections were 'trustworthy'.⁹⁰ Nor were the subjects always willing. Indeed, a degree of persuasion was sometimes required to get men to submit to this procedure. '[W]ild rumours' would circulate in the wards, with soldiers speculating that the injection would overthrow their willpower, cause them to reveal their deepest secrets, and that every utterance 'would be taken down by a stenographer and afterwards used in evidence against them'.⁹¹ And some soldiers *did* confess to intimate troubles—domestic unhappiness and love affairs—that confirmed psychiatrists' suspicions that the stress of combat was not the only cause of neurotic symptoms.⁹² Indeed, the perception that sodium amytal was a 'truth drug' was not far wrong, as it appears Sargant's work piqued the interest of the British government and its intelligence agencies from the time he began publishing his findings on sodium amytal early in the war, though it has proved impossible to substantiate how thoroughgoing this relationship was.⁹³

Always keen to experiment, sodium amytal was not the only drug Sargant used. When he and Slater were temporarily moved to Graylingwell Hospital in Chichester to receive casualties from Normandy, they followed Harold Palmer's example of using ether on patients to relive war experiences, concluding that this drug elicited 'the intenseness of emotion' that did the therapeutic work, rather than a 'recovery of the experience itself'.⁹⁴ In fact, in contrast to his earlier quasi-Freudian explanations of narco-therapy via sodium amytal in 1940, Sargant had come to regard narco-therapy as a remedy for a Pavlovian mechanism of conditioned response.⁹⁵ It was not the content of the recovered 'memory' that was important but the bringing of the patient to an emotional crisis and collapse, which would then 'reset' or at least turn off his acquired neurotic behaviours.⁹⁶ This interpretation was far more consistent with Sargant's professed antipathies, for it suggested that neurosis was a culmination of physiological mechanisms and that its relief was a physical proposition. To this end he and Slater would suggest fictitious but terrifyingly plausible scenarios to patients under drugs—to a tank crewman that he was

⁸⁸Sargant, *Unquiet Mind*, 88. Sargant wrote that he was sorry for the sensationalist press coverage this case generated (88–9).

⁸⁹J. F. Wilde, 'Narco-Analysis in the Treatment of War Neuroses', *British Medical Journal*, 4 July 1942, 6.

⁹⁰William Sargant and Eliot Slater, 'Acute War Neuroses', *The Lancet*, 6 July 1940, 1.

⁹¹Wilde, 'Narco-Analysis', 4.

⁹²See the tables of results in Wilde's article, which are peppered with comments like 'domestic worries',

'unrequited love affairs' and 'personal experiences'. As Wilde concluded, 'the trauma experienced in fighting [was] only the precipitating factor in predisposed subjects': 'Narco-Analysis', 5 and 7.

⁹³Streatfield, *Brainwash*, 34–6.

⁹⁴Sargant, *Unquiet Mind*, 107–8.

⁹⁵For Sargant's interpretation of Pavlov, see *ibid.*, 110–19.

⁹⁶Leys, *Trauma*, 208–11.

trapped in a burning tank, for example—to precipitate emotional collapse and exhaustion.⁹⁷

This move towards a Pavlovian explanation is representative of Sargant's changing thinking on the value of abreactive techniques—and the confusion surrounding the area in general. As Ruth Leys has pointed out, it was rarely clear, in the accounts of Sargant and others, whether the point was to remove memories or revive them, and whether the patient was a full and knowing participant in the procedure, or a passive recipient of psychological 'surgery'.⁹⁸ There was also disagreement about the ultimate utility of narcotherapy, and the ends to which it was directed. Was it a last resort when an 'impasse' was reached (as J. F. Wilde argued⁹⁹), or a supplement to other therapies, or the first port of call for practitioners overwhelmed by a flood of psychiatric casualties requiring quick and effective treatment? The psychiatrist J. A. Hadfield—working in a 'neuropathic' military hospital, where treatment was 'mainly analytic in the broad sense, and essentially abreactive'—regarded its status as merely 'adjuvant', and requiring additional work with free association to consolidate any recovered memories. This goes to the broader question of what wartime psychiatry was actually trying to achieve—a proposition that discloses the strong vein of 'therapeutic nihilism' from British practitioners. Psychotherapy alone could never 'reconstitute the make-up of the personality', argued Sargant and his co-authors in a 1941 paper, because 'the neurotic cannot be freed of his neurotic tendencies'.¹⁰⁰ Narco-therapy might remove symptoms, but it did not address the fundamental conflicts driving patients' neuroses. For Sargant and like-minded colleagues, pragmatic wartime psychiatry should aim to treat symptoms alone. Drug-assisted abreaction appeared to be quick and effective, and was able to be used by practitioners 'unversed in hypnotic and analytic techniques'; in any case, most of these men would not be returning to the Army.¹⁰¹ Sargant's autobiography makes clear that the point was to discharge men back to civilian life with some degree of functioning, because—using one of several rugby metaphors the former first XV player liked to employ—'[y]ou don't insist on keeping your broken-down footballers in the first football team if you want to win the championship'.¹⁰²

If narco-therapy was a kind of surgery for the psyche, then prefrontal leucotomy was its somatic and far more literal equivalent. While the crude mechanics of the procedure have lent its early advocates an air of ridicule and outrage, the fact of its widespread adoption underscores the kind of pragmatism that might impel extreme physical interventions in straightened institutional settings. As Jack Pressman has argued, the perception of medical success is not necessarily dependent on the 'actual physiological status of the ailment', but rather the 'perception that the problem has been resolved' and this was

⁹⁷Sargant, *Unquiet Mind*, 112–13.

⁹⁸See Leys, *Trauma*, 190–228 and particularly 215 on Sargant's changing interpretation of post-abreactive forgetting / remembering: 'he wavered between imagining that drug-induced remembering was constitutive of the cure and the view that forgetting was equally effective'.

⁹⁹Wilde, 'Narco-Analysis', 4.

¹⁰⁰Debenham et al., 'Treatment of War Neurosis', *The Lancet*, 25 January 1941, 107. Nafsika Thalassis has

argued that psychiatrists were less concerned about returning *all* soldiers to duty but rather used discharge as a mechanism to dispense with men of 'low intelligence' or 'inadequate personality': 'Useless Soldiers: The Dilemma of Discharging Mentally Unfit Soldiers during the Second World War', *Social History of Medicine*, 2010, 23, 98–115.

¹⁰¹Debenham et al., 'Treatment of War Neurosis', 107.

¹⁰²Sargant, *Unquiet Mind*, 93.

attractive in an era of institutional pressures—the main reason for the popularity of the procedure in overcrowded state hospitals in the USA, for example.¹⁰³ Like coma and convulsion therapies, in Britain the spread of this radical surgical intervention appears to have been accelerated by the war—or at least its widespread adoption happened in parallel with the conflict. Pearce notes that the first leucotomy at the Devon Mental Hospital was carried out in 1943, and by 1944 there were 1000 cases available for review across the country.¹⁰⁴ Nevertheless, it is difficult to know just how widely this operation was performed on service patients.¹⁰⁵ William Sargent was of course an enthusiastic adopter, having sought out the procedure's American populariser Walter Freeman and interviewed three of his patients during his study year in the USA.¹⁰⁶ In his autobiography, Sargent claimed to have engineered, with characteristic subterfuge, the cautious adoption of the procedure at Sutton: by prevailing on colleagues at the Burden Neurological Institute to begin cutting the brains of its patients early in the war, he created a precedent to cite in order to do the same at Sutton from 1942.¹⁰⁷ The pace of official procedures, with each operation requiring permission from the LCC, was slow but steady, amounting to 27 by the end of August 1947.¹⁰⁸ But other operations were performed more clandestinely, with Sargent discharging patients not approved by the LCC to St George's Hospital where Eliot Slater was temporarily clinical director and which, as a teaching hospital, was not bound by LCC regulations. Here the neurosurgeon Wylie McKissock performed the operations, and the patients were discharged or sent to other hospitals to convalesce.¹⁰⁹ Sargent later claimed to have operated on 'quite a large number of L.C.C. and *E.M.S* [my emphasis] patients and avoid general personality deterioration by constantly trying out new modified forms of leucotomy'.¹¹⁰ At the very least we know Sargent oversaw a minimum of 30 leucotomy patients at Sutton, though the case notes for these patients are now closed.¹¹¹

Sargent and his colleague C. M. Stewart published a lengthy account of one war neurosis patient treated with the procedure in the *British Medical Journal* in 1947. This article is worth considering in detail, given the small but telling differences between the draft, held in Sargent's papers, and the printed version, both of which went to some trouble to emphasise that the technique had been tried on civilians in the years prior—'[s]ince 1941 ... the possibilities of leucotomy in helping various types of chronic civilian neuroses have been carefully studied'.¹¹² Sargent and Stewart claimed that the service patient showed a

¹⁰³Pressman, *Last Resort*, 15. Braslow's work on Californian state hospitals also emphasises the role of family and the individual doctor–patient relationship in informing a decision to leucotomise: *Mental Ills and Bodily Cures*, 125–51.

¹⁰⁴See Pearce, 'Evacuation and Deprivation', 337 and Board of Control (England and Wales), 'Pre-Frontal Leucotomy in 1,000 Cases', (London: His Majesty's Stationery Office, 1947).

¹⁰⁵The case is slightly clearer in America, insofar as it appears that Veterans Administration hospitals adopted the procedure with alacrity: Pressman, *Last Resort*, 394–7.

¹⁰⁶Sargent, *Unquiet Mind*, 65–6.

¹⁰⁷*Ibid.*, 84–5.

¹⁰⁸Sutton Emergency Hospital—Report of Medical Superintendent, 1st September, 1946–31st August, 1947', LCC/MIN/01248, London Metropolitan Archives (hereafter 'Report of Medical Superintendent').

¹⁰⁹Sargent, *Unquiet Mind*, 84–5.

¹¹⁰*Ibid.*, 85.

¹¹¹'Leucotomy Results', PP/WWS/F/7/1, Wellcome Library. The catalogue entry for this file describes it as '[p]atient notes and associated correspondence for over 30 cases, mainly from the Sutton Emergency Hospital'.

¹¹²William Sargent and C. M. Stewart, 'Chronic Battle Neurosis Treated with Leucotomy', *British Medical Journal*, 29 November 1947, 867.

'great improvement' after the operation, which had been successful in reducing 'self-perpetuating tension within the nervous system'.¹¹³ This patient had broken down after months of harrowing fighting in an armoured unit as part of the D-Day invasion. 'Many of his friends were gradually either killed or burnt to death in their tanks', they wrote, 'and the patient increasingly expected each day's fighting to be his last.' Searching for particular events that might have produced his symptoms, 'so many of them were found in his fighting experiences that they proved impossible to evaluate or disentangle'. He survived two direct hits on his tank, but his injuries after the second blast required hospitalisation in England, and here his nervous symptoms began to manifest. Resuming work as a printer after discharge from the Army he suffered with 'pains in the legs, lethargy, headaches, irritability, and poor sleep'; after he was admitted to Sutton he was judged to be 'afraid of himself' and 'often expressed the opinion that it would have been luckier for him to have died in battle with his friends than to live on as he was'.¹¹⁴ Leucotomy was proposed after nine months of 'very intensive treatment', including narco-therapy, insulin comas, barbiturates and electro-convulsive therapy. Asked for an 'independent psychiatric opinion', Louis Minski, who had reservations about the procedure, concluded that the patient was an 'hysteric'—'not really depressed' but rather 'self-centred and shallow'. Nevertheless, he agreed that 'psychological and ordinary physical methods of treatment' were not likely to help, 'but I don't know what effect leucotomy will have on him'.¹¹⁵

McKissock operated on the patient in the middle of 1947. Afterwards '[h]is whole attitude had changed to one of pleasant co-operation, friendliness, and sociability with other patients and the doctors'. Though he lacked some of his previous energy and his concentration was poor (he was 'rather inclined to switch his interest of the moment too quickly'), he was relaxed and eager to return to work. 'The improvement of this patient', Sargant and Stewart concluded, 'has been among the most gratifying in the several thousand cases of war neurosis treated at Sutton in the past seven years'. This case, they implied, also demonstrated that concerns about the procedure were unfounded. The patient's wife had initially become 'very alarmed' when the operation was first proposed, influenced by her general practitioner's 'fears' about the operation 'which could have been derived from the correspondence column of the *British Medical Journal*', chided Sargant and Stewart. 'It is hoped . . . that others who might benefit from this operation in the future will not lose their chance of being helped solely because of misinformed opinion or theoretical prejudice'.¹¹⁶

Sargant and Stewart were careful in their exposition in the published version, reigning in their enthusiasm and acknowledging fears about the extent of the damage to the brain and possible effects on personality and behaviour. Whereas the draft argues for leucotomy's 'high probability of success', the published version cites a 'reasonable probability of success'. The draft suggests that success ought to be high when 'cases are skillfully chosen for the operation amongst chronically suffering and severely incapacitated

¹¹³*Ibid.*, 866.

¹¹⁴*Ibid.*, 867.

¹¹⁵*Ibid.* Earlier that year Minski had argued that leucotomies should not be 'indiscriminately undertaken' in

neurotic patients: 'Report of Medical Superintendent'.

¹¹⁶Sargant and Stewart, 'Chronic Battle Neuroses', 868–9.

patients'; the published version argues that success is high when 'cases are skilfully chosen for the operation amongst chronically suffering and severely incapacitated patients *and operative interference is not too extensive* [my italics]'.¹¹⁷ The selection of the patient was also important. For Sargant and Stewart, however, this did not mean schizophrenics but rather patients suffering from neurotic disorders—albeit intractably. The stronger the basic personality, the better the outcome; paradoxically, 'the more loath one has been in the past to carry out the operation because of a continued preservation of general personality the better the quality of the eventual result'. The neurotically anxious and the unwaveringly depressed fared better than the 'chronic schizophrenics', who after surgery tended to disintegrate further.¹¹⁸ This is suggestive, perhaps, of a British trend to leucotomise neurotics as well as schizophrenics—another indication of the importance of regional differences in understanding the history of this procedure.¹¹⁹ This is borne out by the (very) small sample of leucotomy patients at Sutton: of the 27 patients, only six were schizophrenic—the rest were suffering from 'obsessional states' (11), 'chronic depersonalisation' (7) and 'anxiety states' (3).¹²⁰ A study from the early 1950s on the results of procedure in Wylie McKissock's patients reportedly found that the majority of patients studied—about 75 per cent—suffered from psychoneurosis or depression and that 'slight' personality changes occurred in 95 per cent of these 240 cases.¹²¹ On the other hand, the Board of Control report on the thousand leucotomies performed to 1944 showed a marked preference for schizophrenia (599 cases) and 'manic depressive insanity' (250 cases), with 'neurosis' only accounting for 34 cases.¹²² A simple explanation for this discrepancy would be that the prevalence of leucotomy for neurosis increased as the procedure gained popularity, moving from a means to relieve institutional pressures to part of a broader therapeutic regime for serious neurotic distress.

The use of leucotomies for neurotic disorders invites speculation on how practitioners assessed and quantified therapeutic results and side-effects. How much damage might be done to those patients with 'better personalities' that might go unremarked in the chronic schizophrenic? For if the operation did tend to quell agitation, it also ran the risk of making patients socially disinhibited and inappropriate. Part of the reluctance to adopt the procedure at Sutton was due to the unease of Louis Minski, whose reports to the hospital's sub-committee demonstrated a degree of disquiet about the 'anti-social' traits that might develop in neurotic patients after this operation.¹²³ This, however, was not Sargant's concern: his enthusiasm was premised on the conviction that amelioration of symptoms was the only real therapeutic outcome for long-term or severely distressed

¹¹⁷'Chronic battle neurosis treated with leucotomy c.1947', PP/VVWS/F.7/9, Wellcome Library. See also the account in Shephard, *War of Nerves*, 335–8. It appears Shephard had access to this patient's case notes before they were closed to researchers.

¹¹⁸Sargant and Stewart, 'Chronic Battle Neuroses', 868.

¹¹⁹Brianne M. Collins and Henderikus J. Stam have emphasised the need to view leucotomy as practised by 'a global community of physicians and health care professionals', rather than focusing only on Portugal and America: see 'A Transnational

Perspective on Psychosurgery: Beyond Portugal and the United States', *Journal of the History of the Neurosciences*, 2014, 23, 336 and 335–54 generally. Table 1 lists 40 countries in which leucotomy was practised between 1935 and 1965 (341).

¹²⁰Report of Medical Superintendent'.

¹²¹J. S. Pippard, 'Leucotomy: a qualified defence of "then"', *Quarterly Journal of Medicine*, 2001, 94, 451.

¹²²Board of Control, 'Pre-Frontal Leucotomy', 8–9.

¹²³Report of Medical Superintendent'.

patients. Up to the 1960s, Sargant claimed that it could 'usually' be promised that 'barring such accidents as a hemorrhage of the brain, or a misplaced cut, the beneficial effects of leucotomy can be obtained in all suitable patients', especially given the new modified form of the original operation.¹²⁴ In Sargant's papers there is a type-written fragment that appears to detail statistics on leucotomy patients' progress—how many still in hospital, how many returned home, how many in employment. 'Translate these cold statistics into the relief of human misery at its worst', Sargant has written by hand, 'and theoretical philosophy loses [sic] much of its importance in this matter'.¹²⁵

Conclusion

As I have suggested in this article, the use of physical treatments for war neurosis in Britain during the Second World War has several ramifications for our understanding of wartime psychiatry and the history of psychiatry in the twentieth century more broadly. Most obviously, it suggests that a focus on psychotherapeutic modes of treatment—primarily, the experiments in therapeutic communities and group therapy at Northfield Hospital—risks minimising the role played by physical interventions in managing the symptoms of war neurotic patients. More conceptually, however, it also demonstrates the dangers of assuming a 'clean' or consistent relationship between aetiology and treatment. Indeed, even if we accept that the more intensive physical treatments were applied to only a small group of intractable neurotics (though it seems to me that the proportion is likely to be far wider), it nevertheless demonstrates an important shift in the application of these therapies from an asylum population—and, as Andrew Scull has pointed out, 'the mad' have always been subject to intrusive, dangerous and degrading 'therapies'—to a broader cohort of patients.¹²⁶ There is a clear analogy here with the reorientation of anti-psychotic medication and psychopharmacology more generally from a small group of chronic schizophrenics to a much larger patient population by the 1970s.¹²⁷

In this regard, an examination of physical treatments for war neurosis also holds implications for the way historians periodise and characterise the history of psychiatry in the twentieth century. Not only does the use of physical interventions for neurotic conditions prefigure the rise of psychopharmacology in the subsequent decades, but it also suggests a larger shift in psychiatric theory and practice. Wartime therapeutic decisions intersected with psychiatry's expanding influence as it came into contact with large numbers of patients in a political environment that emphasised the importance of collective ends and the social import of the post-war settlement. Certainly by the end of the war British policy

¹²⁴Sargant, *Unquiet Mind*, 85.

¹²⁵'Leucotomy', PP/WWSD/1/8/1, Wellcome Library. Sargant was characteristically optimistic about how patients fared after discharge. However, Vicky Long suggests that the post-war psychiatric social workers who followed-up leucotomy patients and recipients of other physical treatments saw the social consequences of these purported cures, which often saw long-term hospitalised patients returned to a radically altered social environment, with unhappy consequences: "'Often there is a Good Deal to be

Done, But Socially Rather than Medically": The Psychiatric Social Worker as Social Therapist, 1945–70', *Medical History*, 2011, 55, 228.

¹²⁶Scull, 'Somatic Treatments', 5.

¹²⁷See accounts in Shorter, *History of Psychiatry*, 246–72 and Andrew Scull, 'The Mental Health Sector and the Social Sciences in Post-World War II USA Part 2: The Impact of Federal Research Funding and the Drugs Revolution', *History of Psychiatry*, 2011, 22, 268–84, particularly 269–70.

makers were making this connection between the lessons of military psychiatry and post-war reconstruction—in particular, the disposition of the new national health scheme. ‘Public opinion’, noted Sir Laurence Brock, former Chair of the Board of Control, in the *Lancet* in March 1946, ‘is becoming more alive to the value of psychiatry not merely as a method of treatment but also a practical aid in everyday life’; indeed, there ‘never was a time when the public was so psychologically minded’.¹²⁸ In this way, the use of physical treatments for war neurosis has implications for the present day, insofar as we can understand wartime psychiatry as foreshadowing a marked change in psychiatric practice in post-war decades that has ended with its entrenchment in general medicine. William Sargant was prescient on this point at least, if characteristically optimistic about the ultimate outcome. Writing in his autobiography in 1967, he said that he felt ‘safe in predicting that in the course of the next twenty-five years nearly all psychiatric patients will be readily cured with simple drugs mostly prescribed by general physicians’.¹²⁹

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¹²⁸Sir Laurence Brock, ‘Psychiatry and the Public Health Service’, *The Lancet* 9 March 1946, 337.

¹²⁹Sargant, *Unquiet Mind*, 161–2.