ENCYCLOPÉDIE D'HISTOIRE NUMÉRIQUE DE L'EUROPE

CONTROL AND DISCIPLINE

Military Psychiatry in Europe: 19th-20th Centuries

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ABSTRACT

Although the impact of battle on soldier's psyches had been described since Antiquity, for many years, the role of psychiatry in European military health services was far from being a given. A lack of awareness, or even a denial of the reality of mental disorders in the army can be partially explained by the slow structuration of psychiatric medicine in Europe. In societies dominated by the virile-military model, it can also be ascribed to the fear and scorn they inspire. On the eve of the Great War, countries where the practical organization of psychiatric military assistance was ensured were rare. Granted, progress was made between 1914 and 1918, but the experience acquired on the ground seems to have been forgotten quickly, and the same difficulties resurfaced in 1939 in armies that were ill-prepared to care for "psychological wounds." After World War II, military psychiatry, which had long been marginalized, obtained greater recognition, but its attributions within health services and with military command are still subject to constant negotiation.

Photo of Emmanuel Régis (1855-1918), father of military psychiatry in France, surrounded by his students. It was published in 1956 in *L'information psychiatrique*, a medical journal.

The Experience of World War I and the Recognition of Military Psychiatry in Europe

The American Civil War (1861-1865), the Boer Wars (1880-1881; 1899-1902) and the Russo-Japanese War (1904-1905) were watershed moments in Europe for the appearance of psychiatric research devoted specifically to the military. Numerous articles in the medical press report on cases of mental disorders observed in soldiers and emphasize the need to train specialists both to select recruits better and to provide adequate care on the battlefield. Those recommendations had little actual effect, however, and, in 1914, military health services were poorly prepared for the afflux of the "psychologically wounded." They had to mobilize civilian doctors and psychiatrists as well as neurologists, psychologists and psychoanalysts, at a time when the dividing lines between those various specialties were still fairly hazy. Like the French Army, which began to generalize psychiatric services at the front lines in 1915, first the Italian and then the British Army also installed psychiatric units near combat zones. Great Britain nonetheless continued to bring most affected soldiers home, as did Germany and Austria-Hungary.

While some psychiatrists believe that soldiers didn't suffer from new disorders, others referred to various war neuroses. In Great Britain, the term *shell shock* came into use but was not unanimously accepted. First used in 1915 by the psychologist Charles Myers, a consultant to the British Army, it was considered too imprecise and likely both to convince patients of their own incurability and to give rise to demands on their part. The term was so widely decried that its use was banned in 1917. Treatment methods used by the various warring nations showed a great many similarities. Far from being summed up by electro-shock therapy, which led to scandals in France, Germany and Austria, methods included traditional practices like baths, tonics and sedatives, which were not specific to care for soldiers. Although there is documentation attesting to the use of other methods, like hypnosis, in some countries, they were not found in others. Both the German and the Austrian armies did send representatives to the 5th International Congress on Psychoanalysis, which was held in Budapest in 1918.

Nonetheless, psychoanalytic practices remained fairly marginal in most European countries, and doctors treating soldiers with psychological disorders tended to rely on either the theory of predisposition – which stated that those men would have become mentally ill eventually anyway, war having simply acted as a catalyst, revealing their mental flaws – or the idea that their sickness was due to a desire to escape combat.

A Slow, Halting Institutionalization

After the war was over, research devoted to military psychiatry did not come entirely to an end. Psychiatrists' role did, however, soon seem to be limited to identifying the veterans who deserved a pension and attempting to develop selection criteria. In Great Britain, it wasn't until 1943 that the principle of rapid provision of treatment near the frontlines was adopted once again. France's defeat interrupted the deployment of dedicated structures, and the army that was rebuilt from 1942 tended to be averse to acknowledging combat-related psychological suffering. In Russia, implementing the assistance measures that had been drawn up by psychiatrists in the period between the two world wars was not a priority for the Red Army, which had been disorganized by purges and was already confronted with numerous strategic, tactical and logistic issues.

So it wasn't until after the end of World War II that the institutionalization of military psychiatry was confirmed. Italy's air force experimented with a system of prevention that consisted in requiring flight crews to take mandatory rest periods in hotels selected for their comfort. The Netherlands set up a recovery center for soldiers

needing psychiatric care. And finally, as in civil psychiatry, the evolution of treatments applied in a military context led to the introduction of both biological and psychotherapeutic methods. Particularly in Great Britain, at the military-psychiatry ward of Royal Victoria Hospital, attempts were made to care for soldiers in the context of a "therapeutic community."

To support the organization effort, health services in most European armies gradually began to hire specialized personnel. In this way, psychiatry acquired an official position as an advisor to command. That intensified doctors' "conflicting roles." How can you defend both the patient's interests and military command's? Should psychiatrists have access to combat units or intervene in military hospitals only? Should care be provided within or outside of the military context? In an ambivalent position, military psychiatry was torn between opposing theories: although the effects of exposure to combat began to gain greater recognition – the terms *combat fatigue, battle fatigue* and *battle neuroses* came into use – the assumption of a predisposition remained central, and soldiers who were mentally unwell were still suspected of trying, whether consciously or not, to avoid doing their duty.

The Appearance of PTSD and "Disaster Psychiatry"

That era of suspicion came to an end with the introduction of a new diagnosis that was influenced by an influx of American veterans of the Vietnam War: Post-Traumatic Stress Disorder (PTSD). In 1980, the disorder was introduced into the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the American Psychiatric Association's manual of mental disorders. That inclusion was seen as a sign of official recognition of the mental trauma caused by war. Introduced into European manuals in 1991, its adoption by psychiatrists sparked great debate. Some, particularly in France (where the disorder is called *trouble de stress post-traumatique,* or TSPT), criticized the diagnosis for leading to confusion between stress and trauma and for erasing the patient behind an overly simplistic clinical description. Others believe that the label, which is widely used in the media and can grant eligibility for an array of benefits, forces psychiatrists to renounce their expertise, reducing them to little more than forensic agents, screening for false PTSD claims.

Nowadays, military psychiatry is closer to civilian psychiatry, and the term "disaster psychiatry" is sometimes used to refer to a new specialty on the cusp between the two worlds. Nonetheless, the obstacles that long slowed the development of psychiatry in a military context have not disappeared. Insufficient care measures still make it difficult to do prevention, or provide short-term, or above all, follow-up care for mental issues, which sometimes have delayed onset. Most importantly, the disorders are still stigmatized. In France, up until just a few years ago, psychiatrists were still reporting receiving veterans from the Algerian War of Independence (1954-1962) for first consultations. Although they had been suffering from psychological issues for decades, they had never dared consult a specialist before then.

BIBLIOGRAPHY

CROCQ, Louis, *Les traumatismes psychiques de guerre* (Paris: Odile Jacob, 1999).

FASSIN, Didier, RECHTMAN, Richard, *L'empire du traumatisme. Enquête sur la condition de victime* (Paris:

Flammarion, 2007).

HOFER, Hans-Georg, *Nervenschwäche und Krieg. Modernitätskritik und Krisenbewältigung in der österreichischen Psychiatrie (1880-1920)*, (Vienne, Böhlau, 2004).

LERNER, Paul, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890-1930* (New York: Cornell University Press, 2003).

SHEPHARD, Ben, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2001).

THOMAS, Gregory M., *Treating the Trauma of the Great War: Soldiers, Civilians, and Psychiatry in France, 1914-1940* (Baton Rouge: Louisiana State University Press, 2009).

WANKE, Paul, *Russian/Soviet Military Psychiatry, 1904-1945* (Londres: Frank Cass, 2005).

WITHUIS, Jolande, MOOIJ, Annet, *PTSD before PTSD. The Politics of War Trauma: The Aftermath of World War II in Eleven European Countries* (Amsterdam: Aksant, 2010).
