

## **HELP OR HARM: BATTLE EXHAUSTION AND THE RCAMC DURING THE SECOND WORLD WAR**

***Ryan Flavelle, University of Calgary***

“Stark naked, he was striding through the cordite stench with his head held high and his arms swinging. His body shone white in the brilliant light of the flare... He was singing ‘Home on the Range’ at the top of his lungs. The Worm That Never Dies had taken him.”<sup>1</sup> In his book And No Birds Sang, Farley Mowat, one of Canada’s most widely read and respected authors, records some of his own experiences facing psychological breakdown during warfare. As it was known at the time, “battle exhaustion” was an inseparable part of warfare on all fronts. As such, the Canadian army didn’t find itself immune to the effects of psychiatric losses, suffering casualties even before active campaigning had commenced. In 1940 Dr. William Baillie, who would go on to serve with the No. 1 Canadian Neurological Hospital in England, submitted a paper to the Academy of Medicine in Toronto. In it he outlined 200 cases of Canadian army service personal that were admitted to Christie St. Hospital in Toronto.<sup>2</sup> Casualties would become far more numerous once active campaigning began, and during the Italian campaign alone 5020 “Neuropsychiatric casualties” were reported, 16.9 percent of total battle casualties.<sup>3</sup> This was not a phenomenon that went unnoticed both within the army and abroad. Even Mathew Halton, a foreign correspondent for the CBC in Germany, reported on the state of a stretcher-bearer

---

<sup>1</sup> Farley Mowat, And No Birds Sang (Toronto: McLelland and Stewart Ltd., 1979), 229.

<sup>2</sup> William Baillie, “A Summary of 200 Neurological and Psychiatric Admissions from the Canadian Army Service Forces,” The American Journal of Psychiatry, 97:4 (January 1941).

<sup>3</sup> Terry Copp and Bill McAndrew, Battle Exhaustion, (Montreal: McGill-Queen’s University Press, 1990), 187.

named Johnny who had succumbed to battle exhaustion. In the words of the MO he interviewed, "Each time a man goes through an ordeal, though he overcomes fear and does his job the memory or the effect of the ordeal is pushed into his subconscious and the gate is barred and guarded by will. But the day comes when there too many ordeals; the will breaks and the gates fly open and fear and torment come swirling through."<sup>4</sup>

As this was such an ubiquitous phenomenon, the torrent of first hand accounts of battle exhaustion available from the Canadian Army are as moving as they are numerous. However, there are still a number of questions left unanswered. What exactly is battle exhaustion, and how does it affect the body and the mind? How did the Royal Canadian Army Medical Corps (RCAMC) understand battle exhaustion, when judged against our current perceptions of it? Were the measures that they took sufficient, or did they do more harm than good? Battle exhaustion is an easy condition to be sympathetic too, but a much more difficult one to understand. Most histories that have arisen dealing with battle exhaustion in the Canadian army have tended to focus on the organizational structure of the neuropsychiatric establishments within the RCAMC or the roles of various individuals within that establishment. Although such discussions are important, they fail to address the fundamental question of how battle exhaustion affected the Canadian Army. They also don't speak to the effectiveness of those services in treating soldiers who succumbed to battle exhaustion. New research has revolutionized the way that the medical community looks at battle exhaustion and

---

<sup>4</sup> Mathew Halton, "Losing Your Nerve", CBC archives, Dec 4<sup>th</sup> 1944, <http://archives.cbc.ca/400d.asp?id=1-71-636-3451> (March 25 2006).

combat stress (or immediate Post Traumatic Stress Disorder)<sup>5</sup>. It is worthwhile to examine what we now know about the bio-psychosocial model of battle exhaustion and its treatment before returning to the discussion of battle exhaustion in the Canadian Army during the Second World War. Keeping the current model in mind, the RCAMC's record in dealing with battle exhaustion is mixed at best. Doctrinal and administrative problems plagued psychiatric patient care from the moment the RCAMC arrived in England. Moreover, debates about the proper psychiatric constitution of the soldier hampered legitimate attempts at diagnoses and treatment. Despite this however, Army psychiatrists were unrelenting in their attempts to care for battle exhausted patients. When encountering those who required care, they would do their utmost to safeguard the mental well being of all psychiatric casualties, including those who had succumbed to battle exhaustion. When dealing with such a complex issue, so deeply embedded in the human psyche, no cursory examination is sufficient. However, given what we know of battle exhaustion today, the RCAMC can accurately be judged both by its theoretical foundations, and the physical care given to those in need.

With the myriad of terms used both in past and present studies of psychological casualties of war, it is important to define exactly what battle exhaustion is in the context of this paper. When a large number of psychological casualties were encountered during the First World War, it was initially believed that they were caused by the concussion of shells. Thus "shell shock" was originally thought to be caused primarily

---

<sup>5</sup> Franklin Jones, "Chronic Post Traumatic Stress Disorder," in *The Textbooks of Military Medicine*, (Washington: The Office of the Surgeon General of the United States, 1995), available at ([http://www.bordeninstitute.army.mil/WarPsych/default\\_index.htm](http://www.bordeninstitute.army.mil/WarPsych/default_index.htm)), 416.

by a physical reaction to shelling.<sup>6</sup> However, as psychiatrists studied the numerous cases that arose, they began to believe that the shell shock was not a purely physical malady, and that it may in fact be psychological in origin. John T MacCurdy MD, a British psychiatrist who worked extensively with psychiatric casualties during WWI, wrote in 1918; “The role of concussion in the production of anxiety states has been emphasized by the more organically minded neurologists with probably too great an emphasis... In less than a fourth of the cases I have seen could concussion be determined as a preponderating factor.”<sup>7</sup> By the Second World War, the pendulum had swung almost entirely in the other direction, and most believed that “war neuroses” were caused almost exclusively by psychogenic conditions. As The Lancet, an influential British medical journal, put it, “The advances made in the mechanical arts of warfare since 1914 have been paralleled by advances in man’s knowledge of himself. Where the last war brought a recognition of the importance of psychogenesis in the production of neurosis, the present war has already confirmed evidence long accumulating of the importance of constitution.”<sup>8</sup> The Lancet was read widely by Canadian Army psychiatrists and reflected the prevailing beliefs about neuropsychiatry at the time.

As the war progressed however, it became clear that even men of the finest constitution were still prone to psychological breakdown. What resulted is a definition of this type of psychiatric casualty as a state of mental exhaustion. At the outset of the War this condition was grouped in with the larger maladies, psychosis, or psychoneuroses.<sup>9</sup> More alarmingly, it was also referred to as “Not Yet Diagnosed

---

<sup>6</sup> Richard Gabriel, *A History of Military Medicine*, 2 Vols (New York: Greenwood Press, 1992), 2:236.

<sup>7</sup> John MacCurdy, *The War Neuroses*, (Toronto: The Cambridge University Press, 1918), 63.

<sup>8</sup> “Neurotics in the Forces,” The Lancet, September 7 1940, 299.

<sup>9</sup> Baillie, “A Summary of 200 Cases”, 754-756.

(Nervous)” NYD (N)<sup>10</sup> and psychopathic personality (unsuitable).<sup>11</sup> Eventually however, this condition began to be referred to as “exhaustion”, “battle exhaustion” and also “combat fatigue” (primarily by the American army)<sup>12</sup>. It was, and remains, a complex psychological problem dealt with in combat.

Battle exhaustion is a term that deals with a very specific type of psychological casualty. One of the challenges facing historians studying it, are the constantly changing terms used to describe it. However, with modern research, we are not only able to categorize battle exhaustion, but make meaningful statements about its etiology, and treatment. Following high incidents of exhausted casualties during the Vietnam and 1982 Lebanon-Israeli Wars, studies of this condition again came into vogue. Today, thanks to new techniques, a wholly different model of battle exhaustion is accepted. Dr. Franklin Jones, a retired US army psychiatrist postulates the following theory. In studies done with animals, it has become clear that battle exhaustion is a form of Post Traumatic Stress Disorder (PTSD). PTSD can take on numerous forms including, immediate, acute and chronic and delayed, of which battle exhaustion falls into the immediate category. As he puts it, “In each case the etio-pathogenic element is combat stress. The distinctions are based on certain intrinsic (personality, prior adjustment) and extrinsic (degree and quality of trauma, presence of ameliorating influences) factors.”<sup>13</sup> But what exactly is the physiological cause of battle exhaustion? Research has shown that the stress of battle directly affects the noradrenergic and locus cereleus areas of the brain. These are the areas that control the body’s response to alarm or trauma, and

---

<sup>10</sup> Copp and McAndrew, *Battle Exhaustion*, 48-55.

<sup>11</sup> George Boyer, “The Psychoneuroses Of War,” *The Canadian Medical Association Journal*, 42:6, (July 1940), 56.

<sup>12</sup> Copp and McAndrew, *Battle Exhaustion*, 43.

<sup>13</sup> Jones, “Chronic Post Traumatic Stress Disorder,” 416.

initiate the fight or flight response.<sup>14</sup> When under combat stress, these regions of the brain become fundamentally, and possibly permanently altered through structural rearrangement and a change in gene expression.<sup>15</sup> This can result in a state where the body is hypersensitive to stimuli that mimic the original stressors. The subject also goes through changes in the production and regulation of certain hormones such as epinephrine and cortisol.<sup>16</sup> With physical changes such as these, it was not an overstatement when Richard Holmes wrote in his book Acts of War; “These men are not merely extremely frightened... and capable of being helped... They are ill: ill in the same sense that they would be if they had influenza or malaria.”<sup>17</sup>

Biological factors are not alone in causing battle exhaustion. Social and psychological factors also play an important part. There is evidence that certain people are predisposed to breaking down in a combat environment, either due to genetic or behavioral causes. It is important to keep in mind however that battle exhaustion can affect almost anyone at almost any time when exposed to combat stress. The Canadian Army’s current doctrine on stress shows that, when encountering stress, every person has a malleable breaking point. This breakdown generally occurs either immediately following the first incidence of Combat Stress, or after a cumulative period.<sup>18</sup> As such, where the onset of this condition is based initially on a biological defense mechanism, these changes are ameliorated by psychological and social

---

<sup>14</sup> Ibid., 415

<sup>15</sup> Ibid., 415-416

<sup>16</sup> Ibid.

<sup>17</sup> Richard Holmes, Acts of War – The Behaviour of Men in Battle, (New York: Simon and Shuster, 1985), 254.

<sup>18</sup> “Management of Critical Incidence Stress in the Canadian Forces”, Canadian Forces Administrative Order 34-55, (11 March 1994) available at, [http://www.admfincs.forces.gc.ca/admfincs/subjects/cfao/034-55\\_e.asp](http://www.admfincs.forces.gc.ca/admfincs/subjects/cfao/034-55_e.asp).

factors. Based on current research, psychological factors fall into three categories.<sup>19</sup> Individual factors, such as personality and nonmilitary stresses, condition the response of the individual to combat stress. Battlefield factors such as the type of battle, enemy action, and uncertainty, colour the experience of the soldier, making him more or less likely to breakdown under the strain. Unit factors, such as cohesion and morale, training, leadership and commitment, foster the environment with which the individual will face stress, and thus his responses to it.<sup>20</sup> Closely tied to unit factors, social factors also have an impact on the incidence of battle exhaustion. Fighting units are composed of individuals, all of whom have different personalities, hopes, and fears. Thus, at the individual level, interaction with other unit members does much to either insulate or hasten the onset of battle exhaustion. Almost every memoir available that deals with firsthand accounts of combat fatigue stresses the role of other members of the individual's tight knit social group. For example, L/Cpl C., a dedicated and typical example of a Canadian infantryman, who fought at the Moro River in Italy, records that, "I'm out of it and I don't want to go back because I just never could be responsible in a tight place again and I know it."<sup>21</sup> His lengthy and detailed account of the experiences that led to his becoming a psychiatric casualty, and his personal history, show social factors as primary in the onset of battle exhaustion. He had acquitted himself well in almost eight months of continuous fighting, but could no longer handle the stress associated with leading a section into battle.

---

<sup>19</sup> Reuven Gal and Franklin Jones, "A Psychological Model of Combat Stress", in *The Textbooks of Military Medicine*, (Washington: The Office of the Surgeon General of the United States, 1995), available at ([http://www.bordeninstitute.army.mil/WarPsych/default\\_index.htm](http://www.bordeninstitute.army.mil/WarPsych/default_index.htm)), 135.

<sup>20</sup> Ibid.

<sup>21</sup> WJ McAndrew, "Recording the War: Uncommon Canadian Perspectives of the Italian Campaign," *Canadian Defence Quarterly* 18:3 (Winter 1988), 48.

L/Cpl C.'s case is by no means uncommon. Some psychologists, such as Major Gundry of the RCAMC, realized that some patients didn't respond well to treatment because of social factors. "Often there would be circumstances that had placed an extra burden on the men who broke down. Frequently they would be men who for some reason hadn't developed a sense of belonging to a unit."<sup>22</sup> The most important point to note here is the interplay between the biological realities that affect the brain during combat stress, and the psychological and social factors that affect the impact of those biological changes on the individual.

There is a constant conflict within the individual between the social and psychological factors influencing him to stay and fight, and those biological factors imploring him to run. This conflict is well illustrated in one World War Two memoir of Fred Cederberg, a Canadian Sergeant fighting in Italy. During a battle, one of Cederberg's buddies was losing his nerve when he visited the regimental aid station for another Company. "It's better here than over in that Baker Company casa. It's filled with wounded, guys losin' their minds... I knew an' you knew, I was losin' my nerve. ... But not after I got in that friggin' casa. When I found out how many guys were really havin' troubles, I realized I didn't have any."<sup>23</sup> The body and mind look for an honourable way out of the stressful environment, and battle exhaustion can be viewed as the body's way of forcing its way out of that conflict. It is thus essential that treatment of battle exhausted soldiers doesn't reinforce the condition as a way out of conflict. Such cases must be treated in the forward areas, while still in at least nominal danger of the enemy. The soldier must be returned to his unit as soon as practicable,

---

<sup>22</sup>C.H. Gundry, "Classification and Reallocation of 'Exhaustion' Casualties in a Theatre of War," *American Journal of Psychiatry*, 51:5 (May 1946), 823.

<sup>23</sup> Fred Cederburg, *The Long Road Home* (Toronto: Stoddart, 1985), 208-209.



and evacuation to rear areas should be avoided at all costs.<sup>24</sup> According to one study, when this model of treatment was followed, 41% of battle exhausted casualties returned to full duty, and the remainder recovered sufficiently to remain employed in the army.<sup>25</sup> This is what modern psychological studies of this problem have taught us. This is also the lens through which we should view the Canadian Army's methodology and treatment of soldiers afflicted with battle exhaustion.

Battle exhaustion was by no means an under appreciated problem in the Canadian Army during this time. In the months following the outbreak of war, a veritable flurry of articles and documents from leading Canadian neurologists, psychologists, and neurosurgeons were published. Taken together, this body of work is illustrative of two things; firstly, the RCAMC understood the threat that psychological breakdown posed to the army during the upcoming war. Secondly, they greatly under appreciated the role of physiology in the onset of battle exhaustion, and over appreciated the role of "moral fibre" and personal history in its onset. One such article, "The Nature of the War Neuroses" by Lt-Col Colin Russel, a consulting neuron-psychiatrist to the RCAMC, illustrates this point well. Stressing the importance of "negative self feeling" in the onset of "suggestability," and consequent "conversion hysteria", Dr Russel believes, "One sees that the only common factor which can be the cause of the increased suggestibility is negative self-feeling, so that if a man with the symptoms and signs of a conversion hysteria appears to be aggressive and self assertive he obviously has not the negative self-feeling that is his only legitimate

---

<sup>24</sup> Jones "Chronic Post Traumatic Stress Disorder, 430.

<sup>25</sup> Copp and McAndrew, Battle Exhaustion, 178.

excuse.”<sup>26</sup> Modern research has shown that such a comment is not only medically unsound, but also potentially dangerous to the patient who may very well be suffering from “conversion hysteria”, despite his self-assertiveness and aggressiveness.

Another example is as indicative. After a lengthy, and surprisingly lucid discussion of the causes of combat stress reaction and battle exhaustion, Dr. George Boyer goes on to say, “The most frequent state of neurological casualty in war occurs in shorter or longer periods of time to susceptibles on service. In intellectual inferiority (or moral inferiority), as in the mental defective, the symptoms as a rule assert themselves soon after stressful conditions supervene.”<sup>27</sup> This comment is alarming for a number of reasons. It essentially argues that only those with intellectual or moral inferiority succumb to combat stress. This is obviously not the case, and Canadian psychiatrists should have understood such a basic principle. Given the insanity of War, some view battle exhaustion as the only “rational” response. As Copp and McAndrew point out in their book, Battle Exhaustion, “Rational behaviour is not necessarily militarily effective. It was hardly rational for an individual to expose himself willingly to severe mutilation or death in order to achieve some objective of which he was probably only dimly aware.”<sup>28</sup> Although this is fundamentally a philosophical or motivational point, it serves to illustrate the problem at the core of military psychology. It also illustrates the almost callous approach adopted towards battle exhaustion at the beginning of the war. In almost every article written by a prominent Canadian psychiatrist in the early years of the Second World War, moral and constitutional qualities are cited as the leading cause of the psychoneuroses, and there is little to no empathy given to the patients themselves

---

<sup>26</sup> Colin Russel, “The Nature of the War Neuroses,” Canadian Medical Association Journal 41:6, (Dec 1939), 550.

<sup>27</sup> Boyer, “The Psychoneuroses of War,” 54.

<sup>28</sup> Copp and McAndrew, Battle Exhaustion, 151.

and the stress they would be forced to overcome. William Sargant, a prominent and pioneering British psychiatrist, believed “It was obvious that personality deviations, constitutional instability, and lack of stamina played the preponderant role in these cases. This could easily be established from their past history.”<sup>29</sup> A belief, so strongly held by so prominent a psychiatrist, exemplifies the problems that soldiers and psychiatrists would face throughout the war. It also typifies the vast ideological and structural hurdles that the Canadian Army would have to overcome before it could give meaningful and sympathetic care to its patients.

Despite these problems, by September 1939, the Canadian medical community stood ready to do its part in the coming struggle. Motivated by a multitude of factors including memories of the last war, and the very real threat that the Axis posed to Canadian and British society, medical practitioners of every colour, including psychiatrists, stood ready to do their part. As the October 1939 editorial of the Canadian Medical Association Journal (CMAJ) stated, “The die is cast. We are at war. The Canadian Medical Association has not been remiss in its duty... (it) has at all times manifested its readiness to do its bit... It is a relief to know that we are better prepared. The lessons of the last war have been well learned. There will be no attempts to fit square pegs into round holes.”<sup>30</sup> This statement is true in many ways. The Canadian Medical Association was ready to “do its bit” and many lessons of the Great War had been learned, and learned well. This coupled with advances in medical science meant that Canadian doctors would be well able to help the armed forces at home and abroad. However, in the area of neuropsychiatry, contemporary research, performed in the

---

<sup>29</sup> Sargant, “Acute War Neuroses” *The Lancet*, July 6<sup>th</sup> 1940, 6097.

<sup>30</sup> TC Routley, “Editorial” *Canadian Medical Association Journal*, 41:6 (October 1939), 390.

absence of substantial data, had led to divergent and misleading conclusions. As has been mentioned, there were doctrinal misunderstandings of the psychobiology of battle exhaustion. This misunderstanding quickly translated into derision of the moral and psychological makeup of patients, which inevitably led to misdiagnoses and poor treatment. As one Canadian psychologist recorded, "Individual examples are constantly quoted of neurotic ex-patients distinguishing themselves in actual fighting, and if all neurotic and potentially neurotic men were excluded from the Army it would no doubt lose some valuable soldiers; but it would be rid of some thousands of indifferent ones and more thousands of men who are no use to it at all."<sup>31</sup> The proper treatment of neurotic patients is not mass exclusion, but rather inclusion into the group dynamic that has the power to sustain the soldier.

Unfortunately, this was only part of the doctrinal and physical problems facing Canadian army psychiatry. Another problem was the arrogant, condescending attitudes adopted by many psychiatrists, examples of which can be found in many of the available documents. Although one cannot condemn a system by the tone it takes in medical journals, that tone was often translated into mistreatment of the patient who was often looked down upon. For example, in Russel's, "The Nature of the War Neuroses," he concludes with the following statement, "The cure of a psycho-neuropath really consists of a mental contest resulting in the victory of the physician. This, in conclusion, is the secret of psychotherapy."<sup>32</sup> Although there is certainly a mental contest involved in psychotherapy, in the case of battle exhaustion, the importance of proper patient care is integral to a successful return to service, and sanity. "Mental

---

<sup>31</sup> "Neurotics in the Forces," *The Lancet*, 299.

<sup>32</sup> Russel "The Nature of the War Neuroses," 533.

contests” have little to do with this treatment. The patient is not simply malingering, and is not trying to outwit the psychiatrist; he is suffering from a perfectly justifiable psychopathic disorder. He should be treated as a wounded man who requires aid. In the case of battle exhaustion, a psychiatrist engaging in a mental contest with his patient could do as much harm as a surgeon engaging in a physical contest with his.

Despite these problems however, the psychiatrists who would accompany the Canadian Army overseas, were to a man dedicated to their profession and their patients. The first organized neurological unit that departed overseas was No. 1 Neurological and Neurosurgical Hospital, also known as Basingstoke (after the road on which it was situated), or “No. 1 Nuts”.<sup>33</sup> Originally intended as a mobile hospital that would accompany the Canadian Army to France, the disastrous early months of the war would drastically change its role.<sup>34</sup> It is proverbial that no plan survives first contact with the enemy, and this adage was certainly true for Basingstoke. After the evacuation at Dunkirk, the hospital found itself treating assuming an altogether unfamiliar role. Instead of embarking overseas, the hospital found itself treating psychiatric casualties from the evacuation at Dunkirk, the London Blitz, and the various training exercises undertaken by the Canadians. These patients served only to reinforce the doctrinal viewpoints of many of the psychiatrists at Basingstoke. For example, in an article in The Lancet, published shortly after the Dunkirk evacuation, the author had this to say, “(For) the men who developed acute anxiety neuroses after the evacuation of Dunkirk, a weak spot in the personality must have played a predisposing role.”<sup>35</sup> The cases that were handled at No. 1 Neurological Hospital did seem to substantiate the closely held

---

<sup>33</sup> Copp and McAndrew, Battle Exhaustion, 16-17.

<sup>34</sup> Ibid., 18-19

<sup>35</sup> “Neurotics in the Forces,” The Lancet, 299.

beliefs of many regarding psychiatric and physical predisposition.<sup>36</sup> Indeed, it does stand to reason that those who were diagnosed with psychiatric breakdowns at this point of the War were predisposed to them. This led inexorably to an undue emphasis being placed on a desirable prehistory and psychiatric makeup of all potential recruits. This trend would continue until the end of the War as medical practitioners tried to come to grips with the realities of battle exhaustion, which frequently defied established medical beliefs.

An article coauthored by the O.C. of No. 1 Canadian Exhaustion Unit, published in the last month of the War, illustrates the doctrinal deficiencies of this policy. "With the test of battle a considerable number of men broke down and were evacuated as exhaustion cases. A large proportion of these were considered 'predictable' casualties because of the neurotic predispositions and psychopathic traits which were admitted in their histories."<sup>37</sup> The symptoms displayed by the soldiers studied for this article are textbook examples of battle exhaustion. Patients who were originally brave felt their courage erode after, "(a) few days of heavy shelling and loss of comrades brought home the grim reality of battle, and in many cases brought on shakiness under fire."<sup>38</sup> Indeed the symptoms that Dancey and McNeel cite are predictable reactions to battle stress. The conclusions they reach however are far removed from the realities of battle exhaustion. The paper concludes, "the (battle exhausted) soldiers showed excessively high rate of neuron-pathic traits both in family and early personal history."<sup>39</sup> It is true that any study of battle exhaustion must deal with predisposition as a factor influencing

---

<sup>36</sup> Copp and McAndrew, *Battle Exhaustion*, 19-20.

<sup>37</sup> T.E. Dancey and B.H. McNeel, "The Personality of the Successful Soldier," *American Journal of Psychiatry*, 11:5 (Nov 1945), 337.

<sup>38</sup> *Ibid.*, 341.

<sup>39</sup> *Ibid.*, 342

the onset of psychological breakdown. However, this article shows that even at the end of the War, high ranking and well respected experts who closely studied this phenomenon still believed predisposition was preeminent in the onset of all psychoneuroses including exhaustion. It is disheartening to realize that both research into the matter during the First World War, and research conducted after the War comes to vastly different conclusions, despite the similarities in symptoms examined. The current Canadian doctrine dealing with stress breakdowns defines them thus, “during the *Exhaustive Phase*, the person’s internal resources are so depleted that the ability to resist stress fails... Without attending to the unit and individual variables, stress resistance decays, resulting in an increased psychological casualty rate”<sup>40</sup> Such a model of stress seemed clear to some medical practitioners during World War II, such as Mathew Halton’s sympathetic Medical Officer. He realized that, “the day comes when there too many ordeals; the will breaks and the gates fly open and fear and torment come swirling through.”<sup>41</sup> However, amongst some of those charged with the care of battle exhausted patients, this conclusion was never reached.

The history of neuropsychiatry in the RCAMC is not wholly a negative one. It is important to keep in mind that every doctor and psychiatrist in the Canadian Army held the patient’s welfare as paramount in their treatment. For example, Major C.E.G. Gould, neuropsychiatry in the RCAMC, displayed the paramountcy of patient care in his operational Italian practice. “It is the policy of the RCAMC, to give to the Canadian troops the best possible type of medical practice. Therefore any new method... that

---

<sup>40</sup> CFAO 34-55.

<sup>41</sup> Halton, “A Soldier at the Breaking Point.”

might involve haphazard medical practice, or guesswork, would not be feasible.”<sup>42</sup> The argument that untried methods should not be tested on Canadian soldiers was in no way unanimous. For example, when a British psychiatrist named William Sargant proposed a new type of treatment for the exhausted, many Canadians wholeheartedly supported its use for Canadian troops, despite the possibility of detrimental effects.<sup>43</sup> There were still those who demurred, such as Clifford Allen, a Canadian Psychiatrist in England. In responding to Sargant and Slater’s article, Allen stated, “I disagree with Drs. Sargant and Slater in so far as the cases I have seen (some twenty) have shown a normal family history... a good personality... the differential diagnosis of a fear-residue from an anxiety state is that the causal material is completely conscious and the patient willing to speak of it, whereas in the anxiety state it has to be extracted piecemeal.”<sup>44</sup> Although this may seem like a purely academic argument, Sargant and Slater’s article specifically outlined the treatment of fear residue, and anxiety states.<sup>45</sup> Allen’s disagreement illustrates the importance of debate, and the unwillingness of most Canadians to employ untested treatments on their patients.

Even the term Combat Exhaustion was derived out of fear of harming patients by branding them psychoneurotic. In A.J. Glass’ study of the war neuroses published in 1973, he noted that, “Psychoneurosis implied unresolved intra-psychic conflict with unconsciously derived symptoms. The linkage between the symptoms and the conditions of combat was lost... Exhaustion was selected because it best described the appearance of most psychiatric casualties... Exhaustion was readily accepted by the

---

<sup>42</sup> Copp and McAndrew, *Battle Exhaustion*, 183.

<sup>43</sup> Copp and McAndrew, *Battle Exhaustion*, 22-23.

<sup>44</sup> Clifford Allen, “Acute War Neuroses,” *The Lancet*, July 13<sup>th</sup> 1940, 53.

<sup>45</sup> William Sargant and Eliot Slater, “Acute War Neuroses” *The Lancet*, July 6<sup>th</sup> 1940, 2. And Nellie Craske and William Sargant, “Modified Insulin Therapy in War Neuroses” *The Lancet* Aug 23 1941, 212.



casualty and his combat reference group.”<sup>46</sup> Canadian Medical practitioners were quick to adopt this change, realizing the therapeutic effect it could have on soldiers. In 1942, Brigadier G.W.B. James, the chief Canadian psychiatrist in the Mediterranean theatre, formally insisted on the use of the term “physical exhaustion”, or simply “exhaustion” to describe some types of psychiatric patients.<sup>47</sup> Many, such as George Boyer, felt that this type of breakdown was a perfectly understandable reaction to the stresses of warfare. Concerning those patients who have succumbed to battle exhaustion, Boyer has this to say; “His ideal is high, but his capacity has its limitations and he has usually exhausted it... He is worthy of the best his officers and physicians can give.”<sup>48</sup> Despite this however, there were still those who viewed this type of reaction as unnatural. Major Van Nostrand, a district psychiatrist with the RCAMC believed that most exhaustion cases were beyond sophisticated help. “I am not convinced that the incidence of functional nervous disease in the (Canadian Overseas Army) will be materially reduced by all the special measures that have been introduced.”<sup>49</sup> Van Nostrand seemed to view battle exhaustion as akin to malingering. “It is hoped that restricting the return to Canada (of exhausted patients) will remove from the mind of the unwilling soldier the idea that nervous disease offers an easy and honourable escape from his distasteful environment.”<sup>50</sup> This statement has some merit to it, as subconsciously the mind may see battle exhaustion as a relatively honourable way out of fighting. But the tone of the article makes it seem as if these patients are faking their injuries in the hope of

---

<sup>46</sup> A.J. Glass, “Lessons Learned,” in Neuropsychiatry in World War II, 2 Vols, ed A.J. Glass, (Washington, DC: Office of The Surgeon General, US Army; 1973), 998.

<sup>47</sup> Copp and McAndrew, Battle Exhaustion, 43.

<sup>48</sup> Boyer, “The Psychoneuroses of War,” 55.

<sup>49</sup> Van Nostrand, “Three Years of Neuropsychiatry in The Canadian Army”, Canadian Medical Association Journal, 10:49 (October 1943), 371.

<sup>50</sup> Ibid.

“escaping their distasteful environment.” This is clearly not so in most cases of battle exhaustion. Some RCAMC psychiatrists even went so far as to question whether or not battle exhaustion is truly an illness. In his paper on the matter, Major D.G. McKerracher refers to exhaustion patients only as “clinical entities”, going on to describe battle exhaustion as “that condition of emotional instability which we speak of as neurosis... The etiology is found in the immaturity of the individual which is manifested in his inability to cope with his environment.”<sup>51</sup> Psychiatrists like this were luckily in the minority, and by the end of the War, it had become clear that battle exhaustion was not glorified malingering, and could, in many cases, be treated. In his reminiscences about war psychiatry, Major Gundry of the RCAMC recalls, “Thirty-seven percent of exhaustion cases were being returned to their units from advanced medical units... I think that the better success of treatment within the fighting unit as compared to treatment in the rear was due to the fact that men received so much support from their feeling of belonging to a unit.”<sup>52</sup>

In terms of numbers, the RCAMC would have some success during the Second World War. Despite the above mentioned doctrinal deficiencies, the RCAMC still managed to return some 36% of battle exhaustion patients to full duty in the Italian front between 1943 and 1945.<sup>53</sup> Only 7% had to be evacuated to Canada or a psychiatric hospital.<sup>54</sup> The reasons for this success rate stem from the forward aid posts and the very serious thought given to the problem of battle exhaustion prior to the outbreak of War. During the First World War, little to no provision had been made for the treatment

---

<sup>51</sup> D.G. McKerracher, “Psychiatric Problems in the Army,” *The Canadian Medical Association Journal*, 5:49 (May 1943), 400-402.

<sup>52</sup> Gundry, “Classification and Reallocation of ‘Exhaustion’ Casualties in a Theatre of War,” 822-823.

<sup>53</sup> Copp and McAndrew, *Battle Exhaustion*, 187.

<sup>54</sup> *Ibid.*

of psychiatric casualties.<sup>55</sup> During the Second World War, the war neuroses were by no means an under appreciated problem; this led originally to the establishment of the Canadian Neuro-psychiatric Hospital at Basingstoke, and later to forward “Exhaustion Units” and roaming psychiatrists who treated their patients at Regimental Aid Posts. With resources like this, Canadian soldiers at least had an administrative apparatus to fall into if they became a psychiatric casualty.

It would be unfair to condemn the psychiatrists of the RCAMC based on the current model of battle exhaustion. That model is based primarily on data and methods unavailable to those during the Second World War. However, it is worthwhile to look back on Canadian Army psychiatric practitioners with a view to what we know now. Modern research has told us that the three factors that make up the body’s response to combat stress are biological, psychological and social. It is the interplay of those factors that can either lead someone towards becoming a casualty, or insulate them against it. Obviously, expecting a World War Two psychiatrist to understand this would be unreasonable. The RCAMC did the best that they could to treat those patients who responded to combat stress in an adverse way. However, there were still grave doctrinal errors in the way that Canadian psychological analysts thought about battle exhaustion. Far too great an emphasis was placed on the constitution of the ideal soldier. This was not a phenomenon conspicuous to pre-modern psychiatry; those in the First World War had believed biology was the preponderant factor in battle exhaustion. However, as the discipline of psychiatry grew, so to did its belief that the mind consciously or unconsciously mitigated all of its responses. As the War progressed, there should have been a realization that it was not a deficiency in the

---

<sup>55</sup> Ibid., 150.

soldier that caused battle exhaustion, but rather a rational response to the insanity of war. Unfortunately, Canadians never properly understood this. This being the case, good work was still done by those psychiatrists determined to help their patients. Like so many Second World War services, the RCAMC neuron-psychiatric branch was an entity bogged down by prewar doctrines and beliefs. It proved itself intransigent in those beliefs. This is probably because battle exhaustion is such a difficult to understand condition, and early experiences in the war, especially at Basingstoke, reaffirmed closely held beliefs on the nature of the war neuroses. RCAMC psychiatrists did the best they could with the doctrinal tools available, but didn't do enough to allow themselves to be malleable in the face of changing data that should have changed their perceptions. Despite this, they did more good than harm, and many a soldier's mind was saved through their efforts.

## **Bibliography**

### **Primary Sources**

Allen, Clifford. "Acute War Neuroses." The Lancet. July 13<sup>th</sup> 1940, 53.

Baillie, William. "A Summary of 200 Neurological and Psychiatric Admissions from the Canadian Army Service Forces." The American Journal of Psychiatry 97:4 (January 1941), 753-749.

Boyer, George. "The Psychoneuroses Of War." The Canadian Medical Association Journal. 42:6, (July 1940), 53-60.

Cederburg, Fred. The Long Road Home. Toronto: Stoddart, 1985.

Craske, Nellie and William Sargant. "Modified Insulin Therapy in War Neuroses." The Lancet Aug 23 1941, 212-214.

Dancey, T.E. and B.H. McNeel. "The Personality of the Successful Soldier." American Journal of Psychiatry. 11:5 (Nov 1945), 336-340.

Gundry, C.H. "Classification and Reallocation of 'Exhaustion' Casualties in a Theatre of War." American Journal of Psychiatry. 51:5 (May 1946), 820-834.

Halton, Mathew. "Losing Your Nerve." CBC archives, Dec 4<sup>th</sup> 1944. Available at <http://archives.cbc.ca/400d.asp?id=1-71-636-3451> (March 25 2006).

MacCurdy, John. The War Neuroses. Toronto: The Cambridge University Press, 1918.

"Management of Critical Incidence Stress in the Canadian Forces." Canadian Forces Administrative Order 34-55. (11 March 1994).

McKerracher, D.G. "Psychiatric Problems in the Army." The Canadian Medical Association Journal. 5:49 (May 1943), 398-412.

Mowat, Farley. And No Birds Sang. Toronto: Mclelland and Stewart Ltd., 1979.

"Neurotics in the Forces." The Lancet. September 7 1940. 299.

Russel, Colin. "The Nature of the War Neuroses." Canadian Medical Association Journal 41:6, (Dec 1939), 545-562.

Routley, TC. "Editorial." Canadian Medical Association Journal. 41:6 (October 1939), 390.

Sargant, William and Eliot Slater. "Acute War Neuroses." The Lancet, July 6<sup>th</sup> 1940, 1-8.

Van Nostrand, F.H. "Three Years of Neuropsychiatry in The Canadian Army." Canadian Medical Association Journal. 10:49 (October 1943), 295-301 and 368-372.

### Secondary Sources

Copp, Terry and Bill McAndrew. Battle Exhaustion. Montreal: McGill-Queen's University Press, 1990.

Gabriel, Richard. A History of Military Medicine. 2 Vols. New York: Greenwood Press, 1992.

Gal, Reuven and Franklin Jones. "A Psychological Model of Combat Stress." In The Textbooks of Military Medicine. Washington: The Office of the Surgeon General of the United States, 1995, 133-148.

Glass, A.J. "Lessons Learned." In, Neuropsychiatry in World War II. 2 Vols. Ed A.J. Glass. Washington, DC: Office of The Surgeon General, US Army; 1973. 989-1027.

Holmes, Richard. Acts of War – The Behaviour of Men in Battle. New York: Simon and Shuster, 1985.

Jones, Franklin. "Chronic Post Traumatic Stress Disorder." In The Textbooks of Military Medicine, Washington: The Office of the Surgeon General of the United States, 1995, 409-430.

Jones, Franklin. "Traditional Warfare Combat Stress Casualties." In The Textbooks of Military Medicine. Washington: The Office of the Surgeon General of the United States, 1995, 35-61.

McAndrew, WJ. "Recording the War: Uncommon Canadian Perspectives of the Italian Campaign." Canadian Defence Quarterly 18:3 (Winter 1988), 43-50.