ROYAL NAVAL PSYCHIATRY: ORGANIZATION, METHODS AND OUTCOMES, 1900–1945

By Edgar Jones and Neil Greenberg

In contrast to the Army and to a lesser extent the Royal Air Force, psychiatry in the Royal Navy has received scant coverage. In part, this neglect was a function of the smaller numbers involved but it also reflected a tacit view that as the ‘senior service’ with a long tradition of successful engagements, there were relatively few psychiatric casualties of battle. In 1924, for example, Surgeon Captain Meagher claimed that only 16 cases of shell shock were reported by the navy in the last year of the First World War, though he did concede that medical officers preferred to use the term ‘neurasthenia’ of which there had been at least 20,000 cases during the entire period of the conflict.1 ‘Anxiety neurosis’, suggested the official history of the Second World War, ‘was less common in the Navy than the other services’, a conclusion explained by the close-knit nature of ships’ crews, effective selection processes and pride in the performance of duties.2 More recently, on the basis of UK and US experience, Grossman argued that ‘in the twentieth century, psychiatric casualties during naval warfare have been nearly nonexistent’.3 The impersonal nature of naval combat and the fact that battles were often conducted at a great distance were cited as reasons why sailors rarely broke down on warships. Whilst no evidence has emerged during the period of this study to suggest that the Royal Navy suffered from a crisis of morale, psychological disorders were not negligible during the First and Second World Wars and their incidence cannot be explained solely by the dilution of the regular service by volunteers, reservists and conscripts.

In this paper, using original and once classified sources, we chart the rise of the Royal Naval psychiatric service and identify issues unique to combat at sea. We ask to what extent was the organization itself, and the fact that psychiatrists rarely served on warships, responsible for the apparently low prevalence of psychological disorders.

NINETEENTH CENTURY

At the end of the Napoleonic Wars Sir Gilbert Blane (1749–1843), Physician of the Fleet, argued that the incidence of insanity in the Royal Navy, which he estimated at one in a thousand, was seven times that of the general population.4 To explain this striking disparity, he identified head injuries, sometimes the result of intoxication in the close confines of warships, together with the shock and blast experienced by gun crews. Indeed, it was observed that the majority of inmates of a London asylum were seamen who had been sent there after the Battle of the Glorious First of June in 1794.5 Mental illness amongst sailors exposed to combat may be related to the phenomenon of ‘wind contusions’ or tingling, twitching and even partial paralysis.
described in soldiers who have been close to the passage of a projectile or its explosion but not suffered a physical wound. 6

During the nineteenth century naval doctors acting as advocates for their patients used mental illness as a criminal defence. Captain G. Scott of the Stately wrote to Nelson on the recommendation of Dr John Snipe to request that the application for a court martial for John Burn, a royal marine, who had struck an officer, be withdrawn on the grounds that the ‘offence was occasioned by insanity’. 7 Implicit in this defence was the idea that sailors who had experienced the effects of brutal battles could have their reason disturbed and hence not be fully responsible for their actions.

The number of sailors suffering from mental illness was sufficient for the Royal Navy to make special provision for their treatment. 8 Between 1794 and 1818, for example, 1083 officers and ratings were admitted to Hoxton House asylum, which had been founded in 1695 with Chatham Chest funds to treat naval and government cases. 9 Most of these admissions were then transferred to the Bethlem Hospital at Moorfields for further care, though 364 were regarded as cured. 10 As a Crown institution, the Bethlem was obliged to admit patients referred by the Sick and Wounded Seamen’s Office and the War Office. However, from its opening in 1753, the Royal Hospital at Haslar had admitted psychiatric patients and subsequently Rear Admiral Garrett was reported as saying that ‘a seaman who has lost his reason in the service of the Crown should receive the love and attention on a scale not less than a seaman who has lost a limb in the same cause’. 11 In August 1818 the navy opened a Lunatic Asylum at Haslar. By the 1820s the emphasis was on ‘moral treatments’ and patients were encouraged to work in the gardens, take exercise and undertake tasks in the hospital. Case notes showed that most of those admitted were either psychotic or severely depressed, rather than troubled by the acute effects of battle; most were regarded as ‘incurable’. 12 In 1910 a purpose-built psychiatric unit, ‘N [now G] Block’, was constructed at Haslar, comprising two wards of 12 beds and a padded cell. 13 G Block acted as an assessment centre and sailors who required long-term treatment were transferred to a psychiatric unit at Great Yarmouth. 14

The naval hospital at Great Yarmouth had been constructed between 1809 and 1811 to treat the sick and wounded of the North Sea Fleet. Taken over by the army in 1844, it housed a ‘Military Lunatic Asylum’ until the outbreak of the Crimean War when the Admiralty re-acquired the building. 15 The RN (Mental) Hospital, Great Yarmouth, continued to serve as a naval psychiatric unit throughout the First World War. In the mid-1930s it had 212 beds and an increased emphasis was placed on occupational therapy with the construction of workshops so that patients could do leatherwork, carpentry, tailoring, as well as more traditional gardening. 16 By June 1942 the hospital had been transferred to wartime quarters in Lancaster.

FIRST WORLD WAR
In 1915 Surgeon Lieutenant Thomas Beaton estimated the incidence of ‘mild neurasthenic conditions’ at three to four per cent of a battleship’s company sailing in home waters over a period of five and a half months. 17 Although the crew, who were largely Royal Naval Reserve, were not involved in combat, they experienced the ‘always-present possibility of attack by submarine or by ships of a superior force’.
Beaton believed that breakdown rates were low on warships, in part, because neurasthenic sailors were transferred ashore:

The whole ship’s company depend for their existence very often on the conduct of any one individual, and as these patients [neurasthenic] are highly unstable, the risk to a ship of their behaviour under any acute stress is not at all negligible and it is far wiser to keep them in positions where they can do no harm.18

Admissions for psychological disorders at the Royal Naval Hospital, Chatham, rose steadily throughout the First World War (Table 1). Not simply a function of the navy growing in size, Beaton believed that this reflected an increasingly stressful war: ‘this variation may be explained by the increase in the potency of the submarine, as a weapon of offence in the calmer weather conditions prevailing in the summer’.19 In 75 per cent of cases, Beaton suggested, there was evidence of constitutional vulnerability to breakdown, though in the remainder ‘the disorder was to be regarded as the definite outcome of actual war stress’.20 Diagnostic categories were, in essence, the same as in the army: neurasthenia, hysteria and shell shock. However, naval medical officers avoided use of the term shell shock, perhaps because of its association with trench warfare, and favoured the diagnosis of neurasthenia. Beaton defined this as encapsulating ‘the exaggerations of the personal traits, the fatigue states, the anxiety states, the introspective states &c., without any actual local physical disability of functional nature, which were sufficient to negate the continued useful employment of the individual’.21

<table>
<thead>
<tr>
<th>Year</th>
<th>First quarter</th>
<th>Second quarter</th>
<th>Third quarter</th>
<th>Fourth quarter</th>
<th>Annual total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1914</td>
<td>45</td>
<td>95</td>
<td>140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1915</td>
<td>112</td>
<td>150</td>
<td>198</td>
<td>175</td>
<td>635</td>
</tr>
<tr>
<td>1916</td>
<td>212</td>
<td>240</td>
<td>240</td>
<td>196</td>
<td>888</td>
</tr>
<tr>
<td>1917</td>
<td>215</td>
<td>248</td>
<td>370</td>
<td>310</td>
<td>1143</td>
</tr>
<tr>
<td>1918</td>
<td>345</td>
<td>305</td>
<td>440</td>
<td>300</td>
<td>1390</td>
</tr>
</tbody>
</table>


Surgeon Captain Meagher found little ‘nervous disorder’ among sailors after the Battle of Jutland. He suggested that its relative absence, when compared with infantrymen, was a result not only of the higher mortality rates suffered by frontline troops but also protective factors:

It is not improbable that the sailor had a psychological advantage compared with the soldier. The life of the sea habituates him to dangers. He fights on board ship, on his own ground as it were. He cannot fail to recognize that the promptings of the instinct to flee from danger are impossible of fulfillment, and is therefore freed from a mental conflict... and, in addition, he probably has the advantage of having experienced many battle practices, and is not the least gun-shy.22
Although it is consistently claimed that breakdown rates in fighting ships were low, the non-action sections of casualty returns recorded large number of sailors as ‘accidentally drowned’ or ‘lost overboard’.23 To what extent these deaths were self-inflicted as a result of intolerable stress, it is impossible to say.

SECOND WORLD WAR

During the interwar period naval psychiatry had focused on the treatment of major mental illness, the two regular specialists being deployed at Haslar and Great Yarmouth. The rapid expansion of the service caused by the outbreak of war led to the recruitment of large numbers of civilian psychiatrists.24 Desmond Curran, a Maudsley-trained consultant at St George’s Hospital, was put in charge of the new department of neuropsychiatry and rapidly promoted to surgeon captain, though he had no previous military experience. His appointment may have owed to the influence of Edward Mapother, medical superintendent at the Maudsley and involved with much prewar planning. J.R. Rees, director of the Tavistock Clinic, had been appointed consultant psychiatrist to the army, and Mapother and Aubrey Lewis were concerned that the Maudsley establish a position of influence within the armed forces. Under Curran, a number of Maudsley-trained psychiatrists were recruited including W.P. Mallinson, E.W. Anderson and Geoffrey Tooth.25 By the end of 1943 there were 35 naval psychiatrists, which compared with 43 in the RAF and 227 in the army.26

Most naval psychiatrists were deployed to hospitals or barracks. Although it became a requirement in 1944 that medical officers who wished to specialize in neuropsychiatry should serve at least six months at sea, shortages necessitated their immediate deployment in specialist roles. Because there was no safe escape from a warship at sea, it was assumed that evacuation syndromes would be encountered only in ports. As a result, naval psychiatrists were based in barracks at Chatham, Plymouth, Devonport and Gosport, together with the Clyde area, Scapa Flow and HMS Royal Arthur, because once admitted to a UK hospital ‘it becomes difficult to get him [the sailor] into a proper frame of mind for going to sea again’.27

At the beginning of the war, to prevent the elaboration of symptoms, cases of ‘war neurosis’ were treated in general naval hospitals rather than specialist units. Neuropsychiatric wards were opened at Royal Navy Auxiliary Hospital (RNAH) Barrow Gurney, near Bristol, and RNAH Kingseat, Newmachar, Aberdeen, Scotland. Curran based himself at Barrow Gurney (Table 2). However, because of the practical difficulties of treating severe or chronic psychiatric cases in general hospitals, specialist units were opened at Knowle, near Fareham, under Surgeon Commander G.V. Stephenson, and at Cholmondeley Castle, Malpas, Cheshire, under Surgeon Commander H. Scott-Forbes.28 Yet the number of psychiatric referrals continued to grow during 1944 and a third unit was opened at Wraxall Court, near Bristol, in 1945. Overseas, psychiatric units were set up in Alexandria, Colombo, Trincomalee and Sydney.

At first, published studies appeared to add weight to the assertion that war neurosis or hysterical states were rare in the Royal Navy. In their study of 100 psychiatric admissions to RNAH Barrow Gurney from December 1938 to June 1940, Curran and Mallinson demonstrated that only 13 suffered from hysteria, though a further seven had hysteria with anxiety and there were also 20 anxiety states.29 Their
findings were broadly confirmed by Surgeon Lt Commander Anderson who reported that of 376 neuropsychiatric admissions to Barrow Gurney over the six months from January 1940, only 63 (16.8 per cent) had a diagnosis of hysteria.30 However, outcomes were a cause for concern as only 33 per cent of the 100 admissions studied by Curran and Mallinson were returned to duty and 67 per cent were discharged from the service.31 In a further investigation of 88 consecutive admissions to RNAH Barrow Gurney diagnosed with depression, they found that only 28 per cent returned to duty.32 Figures from the Ministry of Pensions showed that discharges from the navy for psychoneurosis were far from negligible (Table 3).

As manpower shortages began to bite and to reduce potential claims for war pensions, greater effort was put into retaining as many ratings as possible within the service, albeit in combat-support roles. In March 1943 Mallinson found that of ‘200 unselected cases’ treated at RNAH Barrow Gurney, 67 per cent had been returned to some form of duty, 26.5 per cent were invalided from the service and 6.5 per cent transferred to specialist psychiatric units.33 However, he was unable to follow up these patients to establish the permanence of any treatment effects. It was claimed that relapse

Table 2: Principal Royal Naval Psychiatric Units

<table>
<thead>
<tr>
<th>Hospital</th>
<th>RN Psychiatrists deployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNAH Kingsseat, Newmachar, Aberdeenshire</td>
<td>Not known</td>
</tr>
<tr>
<td>RNAH Knowle, Fareham, Hampshire</td>
<td>G.V. Stephenson, D. Ross, D. Rice, E.S. Foote, N. Langdon-Down, J.H.D. Taylor, G.A. Betts</td>
</tr>
<tr>
<td>RNAH Cholmondeley Castle, Malpas, Cheshire</td>
<td>H. Scott-Forbes, J.B. Randell, J.C.W. Hopkyns, T.G. Williams, N.C. Chivers</td>
</tr>
<tr>
<td>RNAH Wraxall Court, near Bristol, Somerset</td>
<td>Not known</td>
</tr>
<tr>
<td>RN Hospital, Haslar, Gosport</td>
<td>Not known</td>
</tr>
<tr>
<td>RN Hospital, Gt Yarmouth, and later Lancaster</td>
<td>Not known</td>
</tr>
</tbody>
</table>

Table 3: Officers and other ranks discharged from the armed forces with a diagnosis of psychoneurosis between September 1939 and September 1941

<table>
<thead>
<tr>
<th>Service</th>
<th>Pension awarded</th>
<th>Pension claim rejected</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Navy</td>
<td>184 (14.2)</td>
<td>1113 (85.8)</td>
<td>1297 (100)</td>
</tr>
<tr>
<td>Army</td>
<td>938 (15.1)</td>
<td>5269 (84.9)</td>
<td>6207 (100)</td>
</tr>
<tr>
<td>Royal Air Force</td>
<td>51 (7.4)</td>
<td>634 (92.6)</td>
<td>685 (100)</td>
</tr>
</tbody>
</table>

Source: NA PIN 15/2403/55B, Approximate number of service cases dealt with by the Ministry of Pensions from 3 Sept 1939 to 27 Sept 1941.
rates in the Royal Navy were far lower than in the army because ‘of the good material, which was until recently self-selected by expressing a Naval preference at recruitment’.34

Published figures for RNAH Cholmondeley Castle were equally optimistic. The hospital had been opened to treat ‘cases of good morale, who are suffering from nervous breakdown usually as the result of operational stresses’. Physical training, occupational therapy, outdoor work and psychotherapy under naval discipline were designed to ‘harden’ patients.35 However, an attempt to follow up 450 cases succeeded in tracing only 235 (52 per cent) former patients. These figures suggested that at six months 94 per cent were still at full duty, a percentage that fell to 88 per cent at twelve months and to 68 per cent thereafter. These figures did not take account of the fact that 11 per cent of admissions were transferred to other hospitals because they were unlikely to benefit from the therapeutic regime practised at Cholmondeley Castle.36

Yet psychiatric casualties in the navy were far from negligible. In 1940 it was estimated that 5000 officers and ratings were referred to psychiatric units (principally Chatham, Barrow Gurney, Kingseat and Knowle) from warships.37 Similar figures were recorded for 1942 (Table 4). In the following year numbers rose to 492 officers and 5649 ratings, which represented about one per cent of all naval personnel. By early 1945 the navy had 736 psychiatric beds in the UK with plans to expand accommodation by a further 140.

Table 4: Admissions to RN Psychiatric Units in the UK, 1942–1944

<table>
<thead>
<tr>
<th>Year</th>
<th>Officers</th>
<th>Ratings</th>
<th>Out-patient consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1942</td>
<td>5000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1943</td>
<td>492</td>
<td>5649</td>
<td>19,911</td>
</tr>
<tr>
<td>1944*</td>
<td>284</td>
<td>3232</td>
<td>17,418</td>
</tr>
</tbody>
</table>

*First six months only
Source: NA ADM 116/5559, War Cabinet, Ministerial Committee on the Work of Psychologists and Psychiatrists in the Services, 1945, 52.

A postwar evaluation of sick days and invalidity from the US Navy and Marine Corps for the period 1942–5 based on official statistics showed that psychoneurosis (4.9 per cent) accounted for the greatest number of days lost from non-battle injuries and illnesses, followed by catarrhal fever (4.7 per cent), simple fracture (4.2 per cent) and malaria (3.1 per cent).38 Psychoneurosis was also the principal cause of discharge from the service (15.7 per cent) followed by personality disorder (11.5 per cent); duodenal ulcer was ranked fifth (3.8 per cent).

Breakdown at sea: surface vessels
Low levels of psychiatric casualties in the navy was considered a function in part of selection ‘since the Navy and the Air Force get the first pick of recruits, whereas the Army must take all that remain and consequently the average level of intelligence in
Army recruits tends to be lower than in the other two services. The protective effect of high morale was predicated on two distinctive factors: first, the notion of the ship’s company united by their loyalty to each other, and secondly, the fact that once at sea there was no opportunity for evacuation. Reporting sick to the ship’s doctor did not improve a sailor’s chances of survival and jumping overboard often resulted in almost certain death. In naval action, Surgeon Captain C.H. Joynt observed, ‘the safest activity is steady devotion to duty rather than flight’.

Veterans of the Second World War, albeit anecdotally, have confirmed some of these hypotheses. Vice Admiral Louis Le Bailley, who was an engineer officer on HMS *Niad* during her hazardous final service in the Mediterranean during spring 1941, recalled that

> Each of us has only a finite store of fortitude. The trick, I convinced myself, was to change people’s jobs. But it was not easy either to assess whose credit was getting low, or how to provide an adequate substitute.

Le Bailley believed that discipline reinforced courage and that Rear Admiral P. Vian’s ‘resolute and uncompromising attitude to dress and behaviour was a tonic to us all’. The most stressful tasks, he identified, were those where sailors were confined in isolation and without the support of comrades: ‘to be a watchkeeper, alone in a machinery compartment, in a ship undergoing intensive bombing or torpedo attack was itself an ordeal’.

Although officers such as Le Bailley recognized the limits on a sailor’s fortitude, Curran opposed the recognition of ‘an operational strain syndrome’, a form of sea-going shell shock. Perhaps because he had no experience of combat, Curran declared ‘in wartime there is a very real danger of over-emphasizing the dramatic, such as exposure to enemy action, when less dramatic events, such as the regimentation and frustration of service life, separation from home, and domestic difficulties, may really possess more significance’. He supported this observation with classified data prepared by Surgeon Commander J.A. Fraser Roberts, consultant in medical statistics, which suggested a significant difference in the incidence of psychological disorders ashore and afloat. Although no numbers were quoted, it was claimed that psychiatric referrals were sometimes ten times more numerous in naval barracks than on warships. These statistics misled Curran into concluding that these presentations were adjustment disorders related to the reduced tempo of life ashore rather than the acute stress of combat.

Yet in contrast to the army, which sent psychiatrists to forward positions, the navy treated psychological casualties only when they had reached the relative safety of port. Because even large warships were unable to accommodate psychiatrists, it appears that stress at sea tended to express itself in somatic form. Approximately 10 per cent of all admissions to principal naval hospitals were for conditions with an association with psychological stress such as functional gastric disorders or suspected peptic ulcer.

It is also unclear who broke down. The official line was that sailors with a pre-existing nervous disposition tended to be weeded out by their fellow crew members and transferred to other duties. By comparison ‘the really first-class officer or man whose breakdown is due to severe strain in battle’ was said to ‘recover quickly’. As a result,
professional sailors, both officers and men, rarely suffer from nervous troubles, except in cases of very direct and severe physical strain from explosions. Most mental cases are ‘hostilities only’ enlistments or reservists who, getting on in life, find it difficult to readjust themselves to the Navy after a long period as civilians.46

For the Royal Navy, hazardous operations such as Arctic convoys, which carried a significant risk of death in testing conditions, saw a significant number of stress-related disorders. The medical officer of HMS Eclipse recorded on his return to the UK: ‘since our visit to North Russia, with its action with enemy surface craft and the unrest of daily bombing attacks, there has been a marked increase in the sick parade’.47 The medical officer of HMS Leda concluded that because of the mental and physical demands of these convoys no one should sail them for longer than eighteen months. One medical officer recorded that the ‘prolonged and repeated stress and strain’ led to an ‘increase in the numbers attending the sick bay and, collectively, by the development of apathy and listlessness which had previously been quite foreign to the nature of the ship’s company’.48

Senior officers appear to have been at particular risk. At the end of a year’s service in Arctic waters, for example, nine officers, all with good records, were invalided from a single warship. By 1943 it was recognized that for a number of destroyers and smaller vessels, captains had been left in command beyond the point at which they were effective leaders. Studies of soldiers have shown that rank is a protector against psychological disorders.49 However, for the navy this was not necessarily true. As a general rule the higher the rank in the army, the further the soldier found himself from the front-line. Hazards were shared more equitably on warships, while senior officers also carried the heaviest burden of responsibility. Mid-way through the conflict, the navy accepted that even experienced sailors had a breaking point and introduced the term ‘fatigue’ for those who earlier in the war might have been diagnosed as suffering from an anxiety state.50 This was designed to avoid any stigmatizing label and to encourage natural recovery.

Few statistics of breakdown at sea survive. Casualties from naval engagements in the Mediterranean were treated at No. 64 General Hospital in Alexandria (Table 5). Brigadier G.W.B. James, responsible for army psychiatry in the Middle East, analysed admissions to all psychiatric units and found that nearly 90 per cent of naval psychological casualties were directly related to ‘battle conditions’ whereas the comparable figure for the army was 35 per cent.51 Naval engagements, such as the evacuation of

<table>
<thead>
<tr>
<th>Service</th>
<th>Officers</th>
<th>Other Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Navy</td>
<td>310 (19.9)</td>
<td>1019 (6.2)</td>
</tr>
<tr>
<td>Army</td>
<td>1045 (67.2)</td>
<td>13814 (83.3)</td>
</tr>
<tr>
<td>Royal Air Force</td>
<td>200 (12.9)</td>
<td>1744 (10.5)</td>
</tr>
<tr>
<td>Total</td>
<td>1555 (100)</td>
<td>16577 (100)</td>
</tr>
</tbody>
</table>

Source: G.W.B. James, ‘Narrative, Resume, Comments and Conclusions concerning the Middle East Force from September 1940 to July 1943’ (typescript, 1955), 105.
Crete, James noted, led to a ‘sharp rise in Naval psychiatric casualties and little wonder’ but he was impressed by the low levels given that ‘cruisers and destroyers were seen to be seriously damaged, and in some cases suffered heavy loss of life’.52

Breakdown at sea: submarines

A retrospective study of the German U-boat service by Curran and Critchley based on interviews of submariners and psychiatrists concluded that commanding officers were at greatest risk of breakdown because of the heavy burden of responsibility that they carried, while older captains were less able to stand the strain of combat than their younger counterparts.53 Petty officers had the lowest breakdown rates. In summer 1943, to give commanders a mature confidant and to buttress the morale of the crew, medical officers were deployed to U-boats. In practice the scheme failed and was abandoned. With no experience of submarine warfare, some of the physicians deployed were more of a liability than an asset. Herbert Werner described how the medical officer attached to U-230 spent most of their patrol in his bunk consumed by seasickness and anxiety.54 Furthermore, it was recognized that the skills of these doctors could be more usefully employed treating larger numbers of soldiers and civilians.

The Kriegsmarine, and U-boats in particular, were regarded as an elite force, limited to volunteers and granted special privileges. In the early years of the war, when it was still a relatively small service and, in the absence of effective anti-submarine technology, successful in sinking Allied shipping, morale was high. Increasingly, however, U-boats became the hunted rather than the hunter, 534 German submarines being sunk from May 1943 to the end of the war. Experienced crew members who survived were spread increasingly thinly in U-boats filled with seamen from other branches and raw recruits. Although volunteers never dried up there were signs that esprit de corps was undermined. By the end of the war the frequency of dyspepsia and rheumatic disorders among U-boat crews was reported as ‘considerable’.55 Psychiatric divisions were opened in two German naval hospitals: that at Wilhelmshaven under Professor Creutzfeldt for the North Sea and that at Kiel-Wyk under Professor Zuker for the Baltic.

PEPTIC ULCER

Langman has shown that the incidence of peptic ulcer grew steadily during the interwar period and probably rose to a peak prevalence in the mid-1950s.56 It has been shown that the form adopted by war syndromes characterized by medically unexplained symptoms reflected popular health fears and gaps in medical science.57 Because diagnostic tests were unreliable (occult bloods, fractional gastric analysis and barium meals), both physicians and radiologists erred on the side of caution. Indeed, it was recognized that the lengthy and imprecise methods of investigation made it ‘difficult to ensure his [a sailor’s] rapid return to duty for... the very performance of these tests has an adverse suggestive effect and increases the man’s resistance to facing active service conditions again’.58 Peptic ulcer presented particular problems for the navy, a point not lost on those who were reluctant to serve at sea, and recorded in a fictional account by Monsarrat, himself a captain of a frigate engaged in convoy protection.59
In 1941 Allison and Thomas reviewed 100 sailors with suspected ulcer and found significant differences from the typical peacetime presentation in that ‘the pain was usually more severe and it recurred at shorter intervals. It was often continuous and unrelieved by food or alkali’. An ulcer was confirmed by radiology in only 45 per cent of cases in their sample, suggesting that some were functional disorders. Given the risks and diagnostic limitations, anxiety states and somatization disorders, which manifested themselves as non-ulcer dyspepsia, could result in a transfer to a shore posting or even discharge. Contemporaries referred to the Second World War as the ‘gut war’ because of the high incidence of gastrointestinal disorders. Drawing a comparison between the tics and contractures of the First World War, one German naval psychiatrist observed, ‘in this war it is the stomach that shakes not the hand’. In May 1942 it was calculated that 13.8 per cent of discharges from the Royal Navy were for digestive disorders. In 1943 it was estimated that 10 per cent of admissions to the main UK naval hospitals were for gastrointestinal disorders and that on investigation between 40 and 60 per cent were diagnosed as peptic ulcer. A study of 28 consecutive admissions for dyspepsia by Surgeon Commander R.S. Allison, a physician at RNAH Barrow Gurney, found that 20 had a history of peptic ulcer and for the remaining eight ‘the history was indefinite and of the type associated with anxiety and other emotional causes’. Outcomes were not promising: 11 were discharged, 14 passed fit for shore service only, one transferred to the Labour Corps and only one returned to full duty.

**HMS STANDARD**

In an attempt to prevent men from being discharged from the navy, HMS Standard was opened in February 1942 to rehabilitate sailors whose conduct was problematic but did not indicate a major mental illness. Set up in a former Ministry of Labour training centre at Kielder in the Cheviots, its location was designed to make desertion difficult and to avoid the distractions of cinemas, pubs and air raids. The ethos of HMS Standard, which was not accorded the status of a hospital, was that hard manual work would instill self-discipline, while providing opportunities to reward good conduct. The number of trainees was limited to 100 and tasks included land drainage, reservoir construction and farm labour. In time the regime was modified with the introduction of physical training and games. Two naval psychiatrists were deployed to the camp. According to official statistics, of the 842 trainees admitted, 680 (81 per cent) were retained in the navy and of these 271 (32 per cent) went to general service. It is not known how they performed and to what tasks they were assigned. The establishment closed in July 1945 on the grounds that a smaller peacetime navy, for which there was no shortage of volunteers, would have no need for such a camp.

**EMPLOYMENT OF PSYCHOLOGISTS**

In 1938 Dr H. Bannister of Cambridge University conducted research on HMS Osprey to determine optimum operating conditions for asdic operators. In 1941 a committee, which included A. Rodger of the National Institute of Industrial Psychology, was set up to consider the introduction of intelligence tests at recruiting centres to serve as a screen and assist with trade selection. As a result elementary
tests were introduced and psychologists attached to training barracks. Psychologists were also employed to advise on the ergonomic design of shipborne instruments.

DISCUSSION

Psychiatric casualties

The apparently low rate of breakdown aboard warships during the First and Second World Wars may conceal more than it revealed. First, the sailor who feared for his life had no safe escape route, while adopting the sick role conferred no obvious benefit. In fact, if he had a vital task to perform, such as closing a watertight door or securing a magazine, deserting his post may have increased the risk that the ship could be damaged or sunk. Naval personnel were well aware that the sea, irrespective of war, was a hostile environment. The closed space of a warship may be analogous to some aspects of modern combat where there is no clear front-line and hence no obvious escape route. A further reason for the low rate of breakdown at sea was the decision to deploy psychiatrists to shore establishments. Doctors on board ships may have not detected psychological disorders as long as a sailor continued to perform his duties. Not labelling someone who somatized their distress, whether as a deliberate policy or by chance, may have allowed them to continue at duty and, in turn, prevent the emergence of recalcitrant psychological symptoms. However, the incidence of non-ulcer dyspepsia and effort syndrome found in sailors returning to port suggested that this defence mechanism was not uncommon.68

A measure of informal screening took place during training when captains transferred unreliable members of the ship’s company or referred them for a psychiatric opinion. With the exception of wounds, dyspepsia or suspected peptic ulcer appears to have been the most common medical route off a warship. Sailors were unique in the three services in that they fought from home and their commanding officers shared the dangers of their crew. While generals were often located well behind the front-line, this was not true of many admirals. Although rank has been shown to be a protector against breakdown in the army, this was not true of the navy, where captains were at risk because of the enduring burden of operational responsibility that they carried. Once a sailor had been referred ashore for psychiatric treatment, the chances of his returning to active duty were slim, though many were retained in non-combatant or base roles.

Management and disposal

At the beginning of the Second World War, before naval psychiatry was properly organized, the discharge rate for psychiatric and functional somatic disorders was relatively high. The opening of HMS Standard and a new policy designed to retain as many patients as possible, albeit in non-combatant roles, reduced discharge rates for psychological disorders. The emphasis on retaining traumatized servicemen and finding them productive employment may have value in the current climate, in which the diagnosis of post-traumatic stress disorder can lead to discharge and a prima facie case for financial compensation from the War Pension Agency.

It was argued that as the ‘senior service’, the navy had the pick of volunteers and that by selecting the best and introducing them to the professional environment of a
warship, the problem of psychiatric breakdown was all but eliminated. This investigation suggests that for some not even the protection of the ship’s environment and high morale were sufficient to counter either an inherent vulnerability to stress or the cumulative effects of exposure to hazard.

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References

9 National Archives (hereafter NA), NA ADM 105/28, Burnett, Papers relating to the state of the lunatics in the asylum at the Royal Naval Hospital at Haslar in September 1824, 2, App. 7.
11 Beach and Sharpley, ‘Historical Reflections’, 33.
12 NA ADM 305/102, James Scott, *Journal of the Lunatic Asylum of the Royal Naval Hospital Haslar, 11 Nov 1830 to 28 Feb 1842*.
13 NA ADM 1/8274, A.B. Marsh, RN Hospital Haslar, Survey and General Description, 1912, Lunatic Block.
17 T. Beaton, ‘Some Observations on Mental Conditions as observed amongst the Ship’s Company of a Battleship in War-time’, *Journal of the Royal Naval Medical Service*, 1 (1915), 447–52.
21 Ibid, 33.
25 Anon, ‘Dr Mapother’, *Lancet*, 1 (1940),

27 NA ADM 1/12067, Anon, War Cabinet, The Use of Psychologists and Psychiatrists in the Services, 1942, 6.

28 NA ADM 1/12067, Anon, Organization for handling Nervous and Mental Diseases in the Royal Navy, 1942.


31 Curran and Mallinson, ‘War-time Psychiatry and Economy in Man-power’.


33 NA ADM 101/624, P. Mallinson, RNAH Barrow Court, Quarterly Neuro-psychiatric Report, January to March 1943.


35 NA ADM 1/12067, Anon, Organization for handling Nervous and Mental Diseases in the Royal Navy, 1942.


39 NA ADM 1/12067, Anon, War Cabinet, The Use of Psychologists and Psychiatrists in the Services, 1942, 3.

40 C.H. Joynt, ‘The Royal Naval Medical Services’, in McNalty and Mellor, Medical Services in War, 39.

41 L. Le Bailley, The Man around the Engine (Kenneth Mason, Emsworth, 1990), 94.

42 Ibid, 96.

43 Ibid, 91.


45 McNalty and Mellor, Medical Services in War, 398.

46 NA ADM 1/12067, War Cabinet, The Use of Psychologists and Psychiatrists in the Services, 1942.


48 C.H. Joynt, ‘The Royal Naval Medical Services’, in McNalty and Mellor, Medical Services in War, 43.


50 Coulter, Royal Naval Medical Service, II, 99.

51 G.W.B. James, ‘Narrative, Resume, Comments and Conclusions concerning the Middle East Force from September 1940 to July 1943’ (typescript, 1955), 105.

52 Ibid, 47.

53 NA ADM 213/76, D. Curran and McD. Critchley, German Neuropsychiatry with reference to the Kriegsmarine, August 1946.


58 NA ADM 101/624, RNAH Barrow Court, Quarterly Medical Report, July to September 1943, 6.


60 R.S. Allison and A. Robinson Thomas, ‘Peptic Ulcer in the Royal Navy’, Lancet, 1


64 NA ADM 101/624, RNAH Barrow Court, Quarterly Medical Report, July to September 1943, 6.

65 NA ADM 101/584, R.S. Allison, RNAH Barrow Court, Quarterly Medical Report, July to September 1941, 2.


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