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“LMF”: The Use of Psychiatric Stigma in the Royal Air Force during the Second World War



Edgar Jones*

Abstract

“Lack of moral fibre” (LMF), a term introduced by the Royal Air Force in April 1940, was designed to stigmatize aircrew who refused to fly without a medical reason. This article explores the justification for this uncompromising policy, research by neuropsychiatrists into the psychological effects of aerial combat, and their attempts to modify LMF procedures. The reasons why the British Army and Royal Navy did not formally adopt the policy are analyzed in relation to the military context. What happened to airmen subjected to LMF assessment and treatment programs is also discussed in relation to recent British initiatives.

LACK of moral fibre” (LMF), an administrative term rather than a psychiatric diagnosis, first appeared in an Air Ministry policy proposal to deter aircrew from reporting sick without due cause or simply refusing to fly.¹ First suggested in March 1940 and formally introduced in

* I am grateful to the late Dr. David Stafford-Clark for giving me a copy of his unpublished paper and allowing me to interview him. Thanks are also owed to Dr. Henry Rollin who discussed his own service as a psychiatrist in the RAF and to Dr. Robin Woolven and Eunice Wilson for their comments on an earlier draft of this paper.

1. John McCarthy, “Aircrew and ‘Lack of Moral Fibre’ in the Second World War,” *War and Society* 2 (1984): 87–101; Allan D. English, “A Predisposition to Cowardice? Aviation Psychology and the Genesis of ‘Lack of Moral Fibre,’” *War and Society* 13 (1995): 15–34.

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April, it was a response to rising psychiatric casualties from the early operations of Bomber and Coastal Commands.² Facing the threat of invasion and presented with a shortage of aircrew, a group of senior Royal Air Force (RAF) officers decided to impose severe penalties on those who lost the confidence of their operational commanders without an extenuating reason. As a general deterrent, driven by the belief that anxiety was contagious, the RAF sent those suspected of LMF to assessment centres where they were shamed by the loss of rank and privileges.³ Subsequently, aircrew who were judged to have exhibited LMF were given no opportunity to redeem themselves, many being discharged from the service as expeditiously as possible. The calculated use of stigma gave the policy force, and the label “LMF” was designed to differentiate cases from psychiatric diagnoses such as flying stress, aeroneurosis, or aviator’s neurasthenia.⁴ These disorders, like shell shock in the First World War, attracted popular sympathy and carried an entitlement to a war pension, which the authorities were keen to avoid. However, the general causes of shell shock and LMF were the same: exposure to, or the immediate prospect of, life-threatening experiences. Treatment took place in “Not Yet Diagnosed Neuropsychiatric” (NYDN) Centres, a term adopted from specialist units set up by the British Army close to the front line in December 1916.

In general, opinion as to the value of the LMF system was divided operationally between squadron commanders who supported any initiative that deterred sickness and RAF psychiatrists who were attuned to the needs of their patients. Group Captain Leonard Cheshire, for example, believed that the LMF policy was justified in the context of a brutal and close-run war.⁵ Noble Frankland, a former Lancaster navigator, suggested that the high attrition rates in Bomber Command made it essential that crews be denied “sympathy and psychiatric treatment”; otherwise, “the withdrawal rate would have produced a front line of green novices.”⁶ By contrast, Squadron Leader David Stafford-Clark, a station medical officer who later trained as a psychiatrist, argued that by failing to take full account of an airman’s psychological predisposition and the traumatic nature of combat, it could “be very harsh indeed,”

2. Report of Flying Fatigue and Stress as observed in the RAF, c. 1941, 2, AIR20/10727, The National Archives, Kew, Surrey, United Kingdom (hereafter TNA).

3. M. K. Wells, *Courage and Air Warfare: The Allied Aircrew Experience in the Second World War* (London: Frank Cass, 1995), 192–93.

4. C. P. Symonds, “The Human Response to Flying Stress,” *British Medical Journal*, 1943, no. 2, 703–06.

5. Quoted from Charles Messenger, *Bomber Harris and the Strategic Bombing Offensive, 1939–1945* (London: Arms and Armour Press, 1984), 206.

6. Quoted from Ben Shephard, *War of Nerves: Soldiers and Psychiatrists, 1914–1994* (London: Jonathan Cape, 2000), 297.

though he acknowledged that the system did exercise a deterrent effect.⁷ Wing Commander Henry Rollin, a psychiatrist who served at various flying stations before being deployed to the Central Medical Establishment, recalled that when asked to give an opinion on LMF, he always declined to apply the label.⁸ Sydney Brandon, a postwar civilian consultant advisor in psychiatry to the RAF, concluded that “the use of the LMF label was neither necessary nor effective.”⁹

Official histories of the RAF medical service gave scant coverage to the issue of LMF, partly, no doubt, because of the controversy it had aroused among aircrew.¹⁰ Indeed, the papers of Wing Commander W. C. J. Lawson, who administered the Special Disposal and Releases branch, appear to have been lost. Growing interest in the theme of how servicemen had been motivated to undertake hazardous operations has produced a small number of publications on LMF.¹¹ Nevertheless, studies of psychological disorders in the RAF and their treatment are limited by comparison with research into the British and U.S. armies. Using restricted sources, this paper seeks to assess the impact of the procedure on morale and performance. It asks whether in a highly selected, volunteer service, characterized by close-knit groups, a policy of deterrent was needed to keep aircrew in their aeroplanes.

Lack of Moral Fibre Introduced

During December 1939, No. 3 Group of Bomber Command, based in East Anglia, mounted a number of reconnaissance missions and raids on

7. D. Stafford-Clark, “Bomber Command and Lack of Moral Fibre” (typescript, c. 1991), 43.

8. Henry R. Rollin, *Festina Lente, A Psychiatric Odyssey* (London: British Medical Journal, 1990), 23–45; interview of Dr. Henry Rollin by Edgar Jones, 15 October 2004.

9. Sydney Brandon, “LMF in Bomber Command, 1939–45: Diagnosis or Denouncement?” in *150 Years of British Psychiatry*, ed. H. Freeman and G. Berrios, vol. 2 (London: Gaskell, 1996), 128.

10. S. C. Rexford-Welch, *The Royal Air Force Medical Services*, vol. 1, *Administration* (London: HMSO, 1954); S. C. Rexford-Welch, *The Royal Air Force Medical Services*, vol. 2, *Commands* (London: HMSO, 1955).

11. McCarthy, “Aircrew and ‘Lack of Moral Fibre’”; Brandon, “LMF in Bomber Command”; English, “A Predisposition to Cowardice”; Wells, *Courage and Air Warfare*. For descriptions of U.S. airmen who had broken down in combat, see Donald W. Hastings, David G. Wright, and Bernard C. Glueck, *Psychiatric Experiences of the Eighth Air Force* (New York: Air Surgeon Army Air Forces, 1944), 132–33; Roy R. Grinker and John P. Spiegel, *Men under Stress* (London: J. and A. Churchill, 1945). For a more general account of the psychological effects of battle, see S. A. Stouffer et al., *The American Soldier*, vol. 2, *Combat and its Aftermath* (Princeton, N.J.: Princeton University Press, 1949).

Wilhelmshaven and other German naval bases. The Group was chosen, in part, because their Wellingtons were considered robust if flown in a tight formation,¹² yet in daylight against German fighters they proved vulnerable. A total loss of forty-one bombers and attrition rates of over 50 percent shook the faith of both senior commanders and crews, who at first were accused of poor tactics and lack of technical skill.¹³ Failures were detected not only in Bomber Command, but also in Coastal Command, where concerns about the reliability of engines fitted to elderly and under-armed aircraft had undermined the confidence of crews who aborted missions in the knowledge that a forced landing in the sea was unlikely to result in a successful rescue.¹⁴

High attrition rates in the Wellington, an aircraft considered among the RAF's best, caused a short-term crisis of confidence in elements of Bomber Command. While new tactics were designed to cut losses, it was also felt necessary to increase the pressure on crews to undertake hazardous missions. On 21 March 1940 a meeting was urgently convened between Air Vice-Marshal E. L. Gossage, newly appointed as Air Member for Personnel; Air Vice-Marshal C. F. A. Portal, Commander in Chief Bomber Command; Air Vice-Marshal J. E. A. Baldwin, Air Officer Commanding No. 3 Group; and Air Chief Marshal Sir Cyril Newall, the Chief of the Air Staff. They decided that "some procedure for dealing with cases of flying personnel who will not face operational risks" had to be devised.¹⁵ A draft policy "for the disposal of members of air crews" was drawn up by Gossage immediately after the meeting. In this document, he referred to "a residuum of cases where there is no physical disability, no justification for the granting of rest from operational employment and, in fact, nothing wrong except a lack of moral fibre."¹⁶

The LMF policy, therefore, was not the bureaucratic response of a civil servant but came from senior RAF commanders. Portal, who had been Air Member for Personnel before moving to Bomber Command, may have been the driving force as Gossage was new to office, having formerly commanded No. 11 Group, composed of fighter squadrons. Indeed, Portal added the following paragraph to the first draft: "It is of great importance that cases of loss of morale among flying personnel

12. Denis Richards, *Royal Air Force, 1939–1945*, vol. 1, *The Fight at Odds* (London: HMSO, 1974), 45–48.

13. John Terraine, *The Right of Line: The Royal Air Force in the European War, 1939–1945* (London: Hodder and Stoughton, 1985), 103.

14. C. P. Symonds and D. Williams, Flying Personnel Research Committee, The investigation of psychological disorders in flying personnel, December 1942, 22, AIR2/6252, TNA; R. W. White, Flying Stress in Coastal Command, 14 May 1942, 1, AIR20/10727, TNA.

15. Minutes from AMP to DPS, 21 March 1940, AIR2/8591, TNA.

16. Draft Air Council letter typescript, n.d., AIR2/8591, TNA.

should be frankly recognized and reported to higher authority and that no attempt should be made to obtain posting action on other grounds.”¹⁷

LMF also reflected an enduring fear of indiscipline among senior commanders. In August 1942, Portal, as Chief of the Air Staff, called a high-level meeting to discuss widely held concerns that “on the surface discipline seemed to be good at home, but it was apt to break down under fire.”¹⁸ A new Inspector General, Air Chief Marshal P. B. Joubert, was appointed to tour RAF stations to advise and report on questions of morale and management. In his report of May 1943, Joubert suggested that any “lack of military qualities” had arisen because

The vast majority [of airmen] had been born and brought up in conditions of security—a policeman at the end of the street to keep order . . . a benevolent government to insure them against the heavier blows of fate. The tough and riotous citizens who enlisted in 1914 are not to be found in the RAF of 1940/43. They were the product of a rougher, more robust period, where cruder virtues flourished in the place of refinement and comfortable living.¹⁹

Interestingly, commanders in 1914–15 had complained in a similar vein that the youth of the industrial conurbations lacked the physical strength and resilience of the farmhands who had fought in earlier wars.²⁰

The LMF label was adopted to avoid use of existing terms such as “aeroneurosis” and “flying stress,” just as the army had proscribed use of “shell shock” at the beginning of the war. It was argued that these psychiatric diagnoses encouraged aircrew to “expect” nervous symptoms and gave them “an escape from the hazards of operational flying without loss of privilege or honour.”²¹

The initial Gossage-Portal draft was then sent to Air Commodore R. D. Oxland, director of personnel services; Air Vice-Marshal P. Babington, director of postings; and R. Monk Jones, assistant secretary in the Air Ministry. They turned a general statement into a practical policy, which on 22 April 1940 was formally introduced by Charles Evans, a principal assistant secretary and a barrister by training, in a letter circulated to the heads of all Commands at home and overseas. Termed the “waverer

17. Draft, March 1940, AIR2/8591, TNA.

18. Notes of a meeting held by CAS on 11 August 1942 to discuss discipline in the RAF, 1, AIR20/3083, TNA.

19. Note by Inspector General II on Discipline and the fighting spirit in the RAF, 14 May 1943, 1, AIR20/3083, TNA.

20. Tim Travers, *The Killing Ground: The British Army, the Western Front and the Emergence of Modern War, 1900–1918* (London: Allen and Unwin, 1987), 37–40, 45–47, 51–55.

21. C. P. Symonds, Comments by the consultant in neuropsychiatry, c. April 1945, 2, AIR20/10727, TNA.

letter," it drew a distinction between two types of aircrew who refused to fly:

- a) The case of a man who is doing his best to fight against his weakness and is maintaining a show of carrying out his duties, but has nevertheless lost the confidence of his commanding officer.
- b) The case of a man who has not only lost the confidence of his commanding officer in his courage and resolution but makes no secret of his condition and states openly that he does not intend to carry out dangerous duties.²²

Once a commanding officer had satisfied himself that "a case is not one which can be cured by encouragement or one that can be suitably dealt with either by disciplinary action or as a medical case," it was to be referred to the Air Ministry for discharge.²³

Not Yet Diagnosed Neuropsychiatric Centres

Because the LMF procedure had been introduced in great haste, there had been no time to consult commanders or experts. Indeed, it soon became clear that the management of cases was far from simple. As R. Monk Jones commented, difficulties were immediately encountered in attempting to decide "which are cases of loss of courage and resolution, and which are genuinely medical cases where there is some definite nervous or mental disease."²⁴ In an attempt to clarify this distinction, on 16 July 1940, Air Commodore Oxland chaired a conference to consider medical aspects of LMF. He set the tone by declaring that "wavering was a matter which called for strong action to prevent the rot." The RAF consultant neuropsychiatrists, Group Captains H. L. Burton, a prewar regular, and C. P. Symonds, a recently recruited civilian neurologist, raised no fundamental objections, supporting the removal of all "waverers," though they "advocated sympathetic treatment of the borderline case, attributable to severe and shattering experiences on operational work, which might respond to careful handling."²⁵ This argument appears to have cut little ice as Oxland identified "the dangers of too lenient treatment of failures, from whatever cause, owing to the possible undermining effect on other officers striving to maintain their morale."

Shortly afterwards, a pamphlet was produced to help medical officers decide whether an airman's refusal to fly resulted from temperament or a medical disorder. However, in acknowledging that this was a matter of judgement, the guide failed to resolve the dilemma. The anony-

22. Charles Evans, Draft, 22 April 1940, 1, AIR2/8591, TNA.

23. *Ibid.*, 2.

24. Minute from R. Monk Jones to DGMS, 9 July 1940, AIR2/8591, TNA.

25. Minutes of the Conference held on 16 July 1940, 6, AIR2/8591, TNA.

mous author referred to shell shock in the First World War as a reference point and suggested that squadron doctors ask themselves

“if this man were in the infantry and reported sick with the complaint that he could no longer face shell fire, should I regard him as medically unfit and send him down the line?” If the answer is “yes,” he is entitled to consider the case one of neurosis and send the patient to a hospital with the label “NYDN.”²⁶

NYDN Centres, a title borrowed from the forward psychiatric units (“Not Yet Diagnosed Nervous”) set up in France during December 1916 to treat shell shock, were opened throughout the United Kingdom to assess and treat airmen removed from duties.²⁷ By 1942, a network of about twelve centres (including Blackpool, Cosford, Gloucester, Halton, Littleport, near Ely, Rauceby, St. Athan, Torquay, Wilmslow, Yatesbury, and Gleneagles, together with Kelvin House, the Central Medical Establishment in London) had been opened across the country.²⁸ On admission, aircrew had their flying badges and markings of rank removed. An atmosphere of shame and disgrace pervaded. Although regimes softened during the war as the complexity of the situation became better understood by administrators, the system operated on the assumption that a man was a coward unless he could prove otherwise. At the NYDN Centre in Brighton, for example, RAF personnel were forced to march along the seafront distinguished by uniforms which had been stripped of all badges.²⁹

Those who refused or were unable to return to operational duties after treatment at a NYDN Centre were sent to an Air Crew Disposal Unit to await the decision of the Air Council on their fate. If a man were found “lacking in moral fibre,” the policy dictated that there was “no question of [him] being given an opportunity to rehabilitate himself or given non-operational employment.”³⁰ Officers were discharged from the service, while airmen were either reduced to their basic trade or discharged. Furthermore, all were prevented from taking well-paid jobs in civilian life.

LMF Policy Criticized

Various meetings and several months of operation led to the publication of a more detailed letter of instruction, circulated by Evans on

26. Notes for guidance of medical officers on the differentiation between personnel unfit for flying (typescript, n.d.), 4, AIR2/8591, TNA.

27. Edgar Jones and Simon Wessely, “‘Forward Psychiatry’ in the Military: Its Origins and Effectiveness,” *Journal of Traumatic Stress* 16 (2003): 411–19.

28. Rexford-Welch, *RAF Medical Services*, vol. 1, *Administration*, 224; Rexford-Welch, *RAF Medical Services*, vol. 2, *Commands*, 127–28, 260–61.

29. Interview of Eunice Wilson, 15 June 2004.

30. Letter from Charles Evans, 28 September 1940, 3, AIR20/10727, TNA.

28 September 1940.³¹ It was, in essence, unchanged from the April type-script except that the procedure “by which commanding officers may, with the least possible delay, cause members of air crews, who have come to forfeit their confidence, to be removed from units” was clarified.

Among those asked to comment on the new procedure was Air Vice-Marshal K. R. Park, who commanded No. 11 (Fighter) Group at Uxbridge. He emphasized “the necessity for the speedy handling of such cases. . . . It is essential that any such cases be removed immediately from the precincts of the squadron or station.”³² The Battle of Britain was then at its height, and as a result of both physical and psychiatric casualties, Park was running short of pilots. Indeed, in 1941 it was estimated that the majority of the 250 “stress cases” that had arisen in all three Commands to date “occurred in the months of June, August and September 1940.”³³

Air Vice-Marshal Arthur Harris, then commanding No. 5 Group, opposed any suggestion that a medical officer should decide on an airman’s fitness to fly:

In view of the particularly heavy strain and personal danger of flying long-range heavy night bombers over enemy territory, and the not unnatural preference of most pilots for single-engine and single-seater flying, that, if the medical authorities are permitted to make classifications such as the above, it offers an outlet and encouragement to weaklings and waverers (who are otherwise sound) of the precise nature which it is intended to guard against.³⁴

When subsequently appointed to lead Bomber Command and presented with high casualties, Harris was firm in the application of LMF regulations.³⁵

It rapidly became apparent that the system was too crude to reflect the realities of combat. First, a sharp distinction was drawn between those who had a recognized physical illness (and were therefore excused operational duties) and all other cases. Certain psychological disorders, including anxiety states, for which there is no unequivocal organic sign, could be classified as malingering or cowardice. Furthermore, the policy took no account of an airman’s prebreakdown history, so a pilot who had flown forty missions and been decorated for bravery was treated the same as a pilot who refused to fly during training.

31. Letter from Charles Evans, 28 September 1940, AIR2/8591, TNA.

32. Letter from Air Vice-Marshal K. R. Park, 7 October 1940, AIR2/8591, TNA.

33. Report of flying fatigue and stress as observed in the RAF, n.d., 2, AIR20/10727, TNA.

34. Letter from Air Vice-Marshal Harris, 10 October 1940, AIR2/8591, TNA.

35. Henry Probert, *Bomber Harris, his Life and Times* (London: Greenhill Books, 2001), 212–13.

Although the final decision was taken by the Air Council, the system crucially relied on information supplied by the squadron medical officer and the psychiatric assessor at a NYDN Centre. Forced to act as the gatekeepers of the service, psychiatrists argued that they were not professionally qualified to make what in essence were managerial or disciplinary decisions. Squadron Leader E. C. O. Jewesbury, a psychiatric specialist at the NYDN Centre located in RAF General Hospital, Rauceby, argued that it was “not the neuropsychiatrist’s job to label a man with LMF. His job is to discover whether there is a medical reason why the man should not continue flying.”³⁶ Situated near Sleaford in a former mental hospital, RAF Rauceby treated aircrew referred from the nearby bomber stations. The scale of the problem was revealed in 1942, when Jewesbury reported that of the 621 aircrew seen in out-patients, 85 (21 percent) were assessed as lacking sufficient confidence to continue flying. The RAF consultants in neuropsychiatry took up the medical officers’ case, declaring that they had “neither the evidence nor the knowledge to decide whether a member of an air crew is lacking in moral fibre” as this was an operational rather than a diagnostic issue.³⁷

In practice, doctors and station commanders were reluctant to send an airman down the LMF route if he had proved himself in combat or had been through a particularly traumatic experience. As Symonds subsequently argued, commanding officers had exhibited a general reluctance

to sign the “death warrant” of men who, whilst they had given good service and were willing to undertake any operational duty required of them, were nevertheless “jittery” and as a consequence had forfeited the confidence of their commanding officers. It was highly desirable that they should be withdrawn from their squadrons.³⁸

Yet, under the terms of the September 1940 protocol, no administrative machinery existed to take account of the difference between “those who are judged to have given way to their nervous symptoms without a struggle, and those who have made a serious attempt to overcome them.”³⁹ In view of the harsh penalties imposed on those judged to have exhibited LMF, commanders tended to retain such aircrew to the detriment of squadron morale.

36. E. C. O. Jewesbury, *The Work and Problems of an RAF Neuropsychiatric Centre*, July 1943, 14, 6, AIR49/357, TNA.

37. Letter from Charles Evans, 19 July 1941, AIR2/8591, TNA.

38. Minutes of the meeting held on 20 October 1944 to discuss the “W” procedure, 1, AIR2/8592, TNA.

39. Letter from Air Commodore C. P. Symonds, 7 October 1942, 2, AIR20/10727, TNA.

In addition, Symonds objected to the term LMF, arguing that it was simply a way of avoiding use of the word cowardice.⁴⁰ The revised protocol of September 1941 had introduced the term “lack of confidence” to describe aircrew under assessment. Hence, a squadron medical officer might find himself unable to discover “evidence of physical or nervous illness, yet remain in doubt whether the case should be regarded as one of sickness or lack of confidence.”⁴¹ The term was less stigmatizing than LMF and carried the implication that confidence could be restored. Soldiers who had broken down in battle were admitted to army “exhaustion” centres to avoid implications of illness and to convey the idea that a man’s physical and mental well-being would be naturally restored.

In September 1942, Squadron Leader D. D. Reid proposed that a new term, “temperamental unsuitability,” be introduced as an alternative available to the Air Council when reaching a final decision to cover those who had struggled unsuccessfully against their “neurotic predisposition despite attempts to stimulate individual morale.” He recommended that such individuals be treated less harshly than LMF cases, being reduced to the ranks and losing their flying badges but without prejudice to their employment and promotion.⁴² This suggestion was not adopted, doubtless because it was made at a time when the Allied bombing offensive over Germany was just getting underway and commanders were reluctant to relax any strictures on crews engaged in such hazardous missions.

Controversy surrounded the removal of flying badges. Some argued that as a qualification, once passed, they should not be removed, a policy adopted by the U.S. Army Air Forces.⁴³ Evans and his colleagues stood firm on maintaining the stigma, arguing that “the badges are emblems indicating that the wearer is a member of an air crew either in the operational or training sphere.”⁴⁴ Symonds subsequently questioned whether an airman who had made “a fair contribution to such duties in the past” should lose his flying badges and stated that little good would come from inflicting “further penalty on the individual who has failed.”⁴⁵ This view was supported by Air Chief Marshal Sir Edgar Ludlow-Hewitt, Inspector General of the RAF, who at the beginning of the war had been in charge of Bomber Command. Having inspected the Air Crew Disposal Units at Blackpool, Uxbridge, and Brighton, where he found men labeled

40. Letter from Air Commodore C. P. Symonds, 7 October 1942, 1, AIR20/10727, TNA.

41. Disposal of Air Crew, 19 September 1941, AIR2/8591, TNA.

42. D. D. Reid, *The Psychological and Physical Stresses Imposed by Flight*, September 1942, 12, AIR20/10727, TNA.

43. Wells, *Courage and Air Warfare*, 167.

44. Letter from Charles Evans, 9 March 1942, AIR2/8591, TNA.

45. Letter from Air Commodore C. P. Symonds, 7 October 1942, 2, AIR20/10727, TNA.

as LMF who in fact had suffered severe wounds or other traumas, Ludlow-Hewitt argued that

men who elect to be taken off flying after the successful completion of one tour of operations should not be classified as “Ws” [waverers] and should normally be allowed to keep their badges though they may lose their rank. Similarly if a man who elects to withdraw from flying or operations after sustaining a really serious crash or other severe strain should not be classed as a “W.”⁴⁶

Causes of Breakdown

The scale of psychiatric casualties in 1940–41 took the RAF by surprise. In the prewar period planners had made little provision for such cases,⁴⁷ mistakenly assuming that a highly selected, volunteer service would be virtually immune from psychological breakdown.⁴⁸ When it had become clear that aircrew were as vulnerable as anyone else in combat, service chiefs set up a special committee in February 1941, under the chairmanship of Air Vice-Marshal H. E. Whittingham, to investigate flying stress in aircrew.⁴⁹

The data gathered from 1942 onwards enabled Symonds and Denis Williams to advise about operational limits for different types of aircrew.⁵⁰ Additionally, in investigating all three Commands in turn, they discovered a number of common factors, including the need for regular rest periods, responsible leadership, and group cohesion, together with well-armed and reliable aircraft.⁵¹ An initial report concluded that pilots with an average or better capacity for sustained effort could be expected to undertake fifteen to twenty sorties “without great effort” but “thereafter there is a gradual onset of mental fatigue which will ultimately end in evident flying stress and the probabl[e] development of a neurosis.”⁵²

Although this data was primarily designed to regulate tours of duty, it also informed LMF policy. According to the original policy, aircrew

46. E. R. Ludlow-Hewitt, Visits to Air Crew Disposal and Suspendair Centres, 26 December 1942, 5, AIR20/2859, TNA.

47. Treatment of airmen of unsound mind, Policy to be adopted in time of war, AIR2/4019, TNA.

48. Geoffrey E. Reid, “Aviation Psychiatry,” in *Aviation Medicine*, ed. J. Ernsting, A. N. Nicholson, and D. J. Rainford (London: Butterworth, 1999), 410.

49. Minutes of the first meeting of the committee on flying stress in aircrews, 4 February 1941, AIR20/10727, TNA.

50. Flying personnel research committee, AIR49/376, TNA.

51. C. P. Symonds and D. Williams, Investigation of Psychological Disorders in Flying Personnel, December 1942, 11, 22, AIR2/6252, TNA.

52. Report of Flying Fatigue and Stress as Observed in the RAF, c. 1941, 2, AIR20/10727, TNA.

who broke down during a second tour were to be treated no differently, though “the length and nature” of a first tour was to be taken into account.⁵³ Given the high attrition rates of Bomber Command (in 1942 it was estimated that the chance of surviving a single tour was 44 per cent and only 19.5 per cent of completing a second,⁵⁴ percentages that were to fall to 33 per cent and 16 per cent respectively in the following year),⁵⁵ it was unjust to label a man as suffering from LMF if he were unable to undertake or finish a second tour. This point was acknowledged though not broadcast, so that when a new policy letter was issued on 1 June 1943, all mention of aircrew on second tours was omitted.⁵⁶

The last wartime policy letter, issued on 1 March 1945, almost abandoned use of the LMF label. Henceforth, medical officers were required to assess whether aircrew refused to fly because of an “inability to stand the strain of flying duties.”⁵⁷ Thus, in the context of an air war that was virtually won, Symonds and his psychiatric colleagues were able to introduce a further element of psychological understanding to the original 1940 policy.

Treatment

The Palace Hotel, Torquay, overlooking Babbacombe Bay, was chosen as an officers’ hospital because its scenic location was considered therapeutic and it was mistakenly believed safe from air attack.⁵⁸ It incorporated an NYDN Centre, which was the subject of an investigation into aircrew breakdown by Wing Commander R. D. Gillespie, who unlike Symonds was a psychiatrist by training. Of the series of 100 studied, which included 87 pilots, Gillespie could identify a predisposing psychiatric history in only 51 cases.⁵⁹ These findings implied either that 49 exhibited LMF or that the intense stress of combat had caused reliable men to break down. Neither finding was reassuring as it suggested that the selection process, training, or management during operations was at fault.

In the absence of patient records, we cannot be certain how men were assessed and what remedies were offered. As understanding of the psychological limits of operations improved and the need for aircrew fell,

53. Memorandum on the disposal of members of air crews (typescript, August 1941), 11, AIR2/8591, TNA.

54. Table illustrating the effect of the Datum Line, c. 1942, AIR20/2859, TNA.

55. Martin Middlebrook, *The Battle of Hamburg: Allied Bomber Forces against a German City in 1943* (London: Allen Lane, 1980), 39.

56. Letter from R. Richards, 1 June 1943, AIR2/8592, TNA.

57. Letter from K. H. Sandford, 1 March 1945, 4, AIR2/8592, TNA.

58. Rexford-Welch, *RAF Medical Services*, vol. 2, *Commands*, 239–41.

59. H. Burton, Report on Analysis of Neuropsychiatric Cases at Torquay Hospital, n.d., AIR49/357, TNA.

it appears that the emphasis on punishment was lessened. The only way that a psychiatrist could prevent an airman from being labeled LMF was to find evidence of pre-service psychological disorder in the individual or his family. Generally, treatment was limited to rest, occupational therapy, and re-education, involving persuasion and suggestion. In some cases brief psychotherapy was employed, as Wing Commander R. F. T. Grace, a neuropsychiatric specialist at a NYDN Centre, observed, “conversations lasting only half an hour to one hour two to three times a week may achieve good results.”⁶⁰ However, “if special or intensive psychotherapy is required, patients are usually referred to RAF Hospital Matlock . . . provided the prognosis appears hopeful.”⁶¹ Opened in October 1939, this was the service’s specialist psychiatric unit set up in the former Rockside Institution, chosen for its central location and its distance from major settlements to avoid air-raids.⁶²

Airmen who did not return to operational duties on discharge from a NYDN Centre were initially sent to No. 1 RAF Depot at Uxbridge to await the decision of the Air Council. Concerned that their presence was having a detrimental effect on the morale of airmen in training, in October 1943 the Air Crew Disposal Unit was moved to Chessington Maintenance Command. There men were prepared for discharge or transfer to base duties by occasional lectures and visits (Chessington Zoo, St. Paul’s Cathedral, and Madame Tussauds).⁶³ The unit subsequently transferred to RAF Station Unsworth and from September 1944 was at Keresley Grange, near Coventry. Under Squadron Leader R. I. Barker, servicemen heard motivational lectures, attended occasional garden parties, saw patriotic films, and played in cricket matches in an attempt to restore self-esteem and commitment to the war effort.

Outcomes

Little accurate data about the incidence of LMF survives, and historians disagree as to the true rate.⁶⁴ Max Hastings, historian of Bomber Command, argued that

around one man in seven was lost to operational aircrew at some point between OTU [operational training unit] and completing his tour for morale or medical causes, merely because among a hundred

60. C. P. Symonds and D. Williams, Review of Reports (1942), 11, AIR2/6252, TNA.

61. E. C. O. Jewesbury, The Work and Problems of an RAF Neuropsychiatric Centre, July 1943, 14, 6, AIR49/357, TNA.

62. Rexford-Welch, *RAF Medical Services*, vol. 1, *Administration*, 223–24.

63. Air Crew Disposal Unit IIM FP 129/1, AIR29/603, TNA.

64. Shephard, *War of Nerves*, 287.

aircrew whom I have interviewed myself, almost all lost one member of their crew at some time, for some reason.⁶⁵

However, this calculation assumed that those interviewed were representative of Bomber Command, which is unlikely given that they were willing participants and plausibly had a story to tell. Historian Mark K. Wells concluded that Bomber Command suffered about 6,000 psychiatric casualties and of these between 1,000 and 1,200 (200 a year) were identified as LMF.⁶⁶ Stafford-Clark broadly agreed with these figures and estimated an annual rate of between 160 and 240 cases in Bomber Command alone.⁶⁷ In his postwar report, Wing Commander W. C. J. Lawson, head of the “Special Disposal and Releases” branch responsible for the policy’s execution, estimated that a total of 4,059 cases were assessed, and of these 2,726 were eventually classified as LMF. For the U.S. Eighth Air Force, operating from British bases, 1,716 psychiatric casualties were referred to the Central Medical Board, and of these about 30 per cent (510) were judged to have exhibited LMF.⁶⁸

Table 1. Incidence of Psychological Disorders and LMF among RAF Aircrew

	<u>Neurosis</u>	<u>Lacking in Confidence</u>
1942–43	2503	416 (16.6%)
1943–44	2989	307 (10.2%)
1944–45	2910	306 (10.5%)

Source: C. P. Symonds and Denis Williams, *Investigation into Psychological Disorder in Flying Personnel*, p. 1, AIR2/6252, TNA.

Research conducted from 1942 by Symonds and Williams, who had access to internal service records, probably provides the most accurate statistics (Table 1). Between 300 and 400 cases were adjudged as LMF every year in the latter stages of the war. Most (34.5 percent) were pilots, while navigators, air gunners, and wireless operators each accounted for a sixth of cases. Bomber crews exposed to the hazards of night flying and German anti-aircraft defenses suffered high attrition rates and accounted for a third of all LMF cases. Surprisingly, a further third arose during training before aircrew flew on combat missions.⁶⁹ The vast

65. Max Hastings, *Bomber Command* (London: Michael Joseph, 1979), 214.

66. Wells, *Courage and Air Warfare*, 204–5.

67. Stafford-Clark, “Bomber Command and Lack of Moral Fibre,” 39–42.

68. Wells, *Courage and Air Warfare*, 174.

69. Minute by H. E. Whittingham, 25 April 1945, AIR2/6252, TNA.

majority of airmen sent to NYDN Centres for assessment were grounded (Table 2). It was claimed that between 23 percent and 35 percent were returned to full flying. However, these statistics have to be treated with caution as Symonds and Williams had considerable difficulty in following cases through the system. In September 1944, for example, they had tracked down only 1,184 of the 2,989 cases then under review.⁷⁰ How many broke down for a second time was not investigated. Symonds believed that “trying to patch up pilots who were not wearing well was on the whole unprofitable from a military standpoint” and that effort was more effectively directed at reducing the likelihood of breakdown.⁷¹

Table 2. Outcomes of RAF Aircrew Treated for Psychological Disorders

	<u>1942</u>	<u>1943–44</u>	<u>1944–45</u>
To full flying	35.1%	32.3%	22.5%
To limited flying	7.1%	5.3%	3.5%
Grounded	55.9%	60.2%	72.1%
Invalided	1.8%	2.1%	1.9%

Source: C. P. Symonds and Denis Williams, *Investigation into Psychological Disorder in Flying Personnel*, p. 5, AIR2/6252, TNA.

Some have argued that officers, particularly prewar regulars, were treated more leniently than noncommissioned officers (NCOs). Both Hastings and Stafford-Clark believed that this was to avoid the adverse publicity that a court-martial (necessary to deprive a commissioned officer of his rank) would have created in a volunteer service.⁷² In such cases, a discreet transfer to nonoperational duties was sometimes arranged.

LMF in the British Army and Royal Navy

Officially, the LMF label and procedure remained exclusive to the RAF. Reportedly low levels of psychological casualties in the Royal Navy (RN) and concern to protect its reputation discouraged the authorities from introducing an equivalent system. However, in the RN Fleet Air Arm, pilots who refused to fly without a valid medical reason were unof-

70. C. P. Symonds and D. Williams, Flying Personnel Research Committee, *The Occurrence of Neurosis in RAF Air Crew 1943–44*, September 1944, 4, AIR2/6252, TNA.

71. Quoted from Lord Moran (C. Wilson), *The Anatomy of Courage* (London: Constable, 1945), 80.

72. Hastings, *Bomber Command*, 216; Stafford-Clark, “Bomber Command and Lack of Moral Fibre,” 25–27.

ficially labeled LMF. The absence of a formal procedure allowed greater flexibility in their management, and some were transferred to base jobs where they continued to wear their flying badges.⁷³

By contrast, the large numbers of psychiatric battle casualties suffered by the British Army effectively ruled out an LMF system, while manpower shortages encouraged a treatment and return-to-duty policy. However, during 1940–41 it appears that the LMF label was unofficially adopted by Eighth Army doctors in the early stages of the Western Desert campaign.⁷⁴ With the introduction of the term “exhaustion” to describe soldiers who were unable to continue fighting but were not suffering from a recognized illness, and the setting up of “Divisional Rest Stations” and “Exhaustion Centres” to treat such cases,⁷⁵ LMF dropped out of use.

These service comparisons highlighted the importance of context. Only in the RAF were a comparatively small number of highly trained men asked to undertake exceptionally hazardous missions and inadvertently provided with an opportunity to opt out. Based in comparative safety in the United Kingdom, aircrew in Bomber Command were not defending their families and friends in the way that fighter pilots had done during the Battle of Britain but flew to distant targets where the military gain was not immediately apparent. Plausibly, submariners, another elite group, were in a similar position, though they had no means of withdrawing until they reached harbor.

Stigma in the Military

By October 1944 and with the prospect of a postwar election, the political sensitivities of the LMF procedure were discussed, and the Secretary of State for Air commented that certain aspects would be “quite indefensible in parliament.”⁷⁶ Historians John McCarthy and Allen D. English have both suggested that the LMF label was dropped “entirely” in 1945 to avoid embarrassing the government.⁷⁷ Although this may have been true of formal policy, the term had become part of RAF culture, and it continued to be used in peacetime until the 1960s as an explanation as to why aircrew might fail in training or once they had become opera-

73. Interview of Mr. Lesley Paine, 16 June 2005.

74. Mark Harrison, *Medicine and Victory: British Military Medicine in the Second World War* (Oxford: Oxford University Press, 2004), 121.

75. G. W. B. James, Narrative, resumé, comments, and conclusions concerning the Middle East Force from September 1940 to July 1943 (typescript, 1955), 307.

76. Minutes of meeting held on 20 October 1944 to discuss the “W” procedure, AIR2/8592, TNA.

77. McCarthy, “Aircrew and ‘Lack of moral fibre,’” 96; English, “A Predisposition to Cowardice?” 15.

tional.⁷⁸ Ultimately it fell out of use because new psychiatric terms were devised. The diagnosis “combat fatigue,” originally adopted by U.S. forces engaged in the Vietnam War, gradually spread to the United Kingdom, while the formal recognition of post-traumatic stress disorder (PTSD) in 1980 shifted the emphasis from the individual to the event itself.⁷⁹ In essence, aircrew labelled with LMF had been considered constitutionally weak, and any blame was ascribed to their personal response to danger. By contrast, a diagnosis of PTSD carried the implication that the traumatic exposure was the primary cause of any symptoms and behavioural response, relegating predisposition and preparedness to less important roles.

Not only did conceptions of psychological injury evolve in the post-1945 era, but the military context within which aircrew operated also changed. In March 1940, when the LMF policy was introduced, Britain faced the threat of an invasion and exaggerated fears of fifth column activities circulated, while aircrew and aircraft were in short supply. Since the Second World War, Britain’s survival as a nation state has not been threatened and in an era of shorter localized conflicts, it was no longer necessary to shame airmen into undertaking hazardous missions.

However, in 2002 a group of U.K. veterans brought a class action against the Ministry of Defence for negligence in the detection and treatment of post-traumatic stress disorder. They argued that psychiatric stigma within the military inhibited servicemen from asking for help. In his judgement, Mr. Justice Owen agreed that

there can be no doubt that that amongst serving soldiers and many NCOs and officers there was a stigma attached to psychiatric/psychological disorder. It was seen to be a sign of weakness which, if revealed, would expose an individual to ridicule, and would be the “kiss of death” to a military career.⁸⁰

Furthermore, Mr. Justice Owen identified shortcomings: “no doubt there could have been more rapid change. No doubt more could have been done to address the persistent stigma attaching to psychiatric/psychological disorder, particularly in the ranks.”⁸¹ By contrast, others have argued that a measure of stigma is needed to prevent both conscious and unconscious resort to psychological disorders as an exit from situations

78. LMF (lack of moral fibre) and (W) and waverers: the disposal of aircrew who forfeit the confidence of their commanding officers, July 1941 to November 1959, AIR19/632, TNA.

79. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* (Washington: American Psychiatric Association, 1980), 238.

80. Mr. Justice Owen, *Multiple claimants versus Ministry of Defence*, May 2003, 166.

81. *Ibid.*, 187.

of personal danger. This gatekeeper case was forcefully argued during the First World War when it was thought that the new diagnosis of shell shock gave men an easy exit from the trenches, while at the same time opening a door to a war pension.

There is perhaps an unwritten convention in the military that a psychiatric breakdown, or what from the mid-1980s was called combat stress reaction (CSR), has to be earned. By the end of the Second World War all three services recognized that everyone has a breaking point if repeatedly exposed to enemy fire. It followed that a serviceman who had proved himself in combat was entitled to sympathetic management when he was no longer able to function in battle. In practice, this entailed treatment or transfer to a less stressful role. Indeed, to force back a man in an unstable mental state would probably result in his death or serious injury. Lord Moran, a regimental medical officer during the First World War, who studied aircrew during the Second, concluded that courage was akin to a bank account. Each action reduced a man's reserves and because rest periods never fully replenished all that was spent, eventually all would run into deficit.⁸² To punish or shame an individual who had exhausted his courage over an extended period of combat was increasingly regarded as unethical and detrimental to the general military culture. Conversely, it was also clear that morale would be damaged if servicemen in training or about to go into battle for the first time were readily allowed to withdraw on the grounds that they feared for their personal safety.

Soldiers and aircrew require a culture of toughness and resilience if they are to function effectively. The dilemma facing the armed forces is how to create an environment that allows soldiers to report psychological symptoms without feeling shamed or diminished but at the same time does not open the door to scrimshanking and malingering. Whether it is possible to satisfy both the needs of the exhausted veteran, while deterring the retreat of the faint-hearted, is open to question. In time of national crisis, the RAF placed the emphasis on the latter, slowly decreasing the pressure on aircrew as victory drew closer.

Conclusions

No reliable method has been found to predict how recruits will behave in combat. Attempts to screen for psychological vulnerability by the U.S. armed forces in the Second World War proved a disaster, weeding out thousands who, when they were subsequently enlisted, proved

82. Moran, *Anatomy of Courage*, 68–69.

average or exceptional soldiers and airmen.⁸³ Predisposition is not an infallible guide to future performance. In 1942, for example, Symonds had examined 100 consecutive cases referred to medical boards at RAF Halton with severe psychological disorders. Of these, 35 had completed more than half of an operational tour. Had mild disposition been used as a screen on entry to the RAF, Symonds calculated that 27 would have been rejected, and yet 8 of these cases had been decorated for gallantry.⁸⁴

In one sense, the RAF appeared to have no need of the LMF policy. The numbers found to lack moral fibre were relatively small, though admittedly we can never know how many had been deterred from refusing to fly. In a highly trained and selected service, strong bonds between squadron members or crews of the same aircraft served as protectors against breakdown. Confidence in engines, airframes, and armaments was also important. High morale set within a realistic appreciation of the dangers, Stafford-Clark believed, gave crews the best chance of survival.⁸⁵ For those who struggled against their fears, there was often sympathy from colleagues, and the possibility that such an individual could be tarred with the ignominy of LMF caused resentment and plausibly damaged morale. The LMF policy reflected the anxieties of senior officers that fear could run through entire stations like wildfire.⁸⁶

Although the U.S. Eighth Air Force adopted a similar policy, commanders were more lenient in terms of its operation. In part, this was a reflection of the hazards faced by crews flying by day, and the greater numbers available to the American air force. The RAF did not have reserves of manpower and equipment and so was forced to deploy everyone at its disposal.

In a sense, LMF was the Second World War's counterpoint to shell shock in the First World War. The differences between the two labels owed much to their origins. LMF was an operational term introduced by senior commanders primarily concerned with the effective conduct of the war, while shell shock was a diagnosis employed by doctors seeking to categorize what appeared to be a novel postcombat syndrome. Although both categories were treated in NYDN Centres, shell shock legitimized psychiatric injury by offering a wound stripe, sometimes led

83. E. Jones, K. Hyams, and S. Wessely, "Screening for Vulnerability to Psychological Disorders in the Military: An Historical Survey," *Journal of Medical Screening* 10 (2003): 40–46.

84. C. P. Symonds, A Series of cases with psychological disorder (c. 1942), 10, AIR2/6252, TNA.

85. Interview of Dr. David Stafford-Clark, 15 January 1999; D. Stafford Clark, "Morale and Flying Experience: Results of a Wartime Study," *Journal of Mental Science* 95 (1949): 10–50.

86. Robin Neillands, *The Bomber War: Arthur Harris and the Allied Bomber Offensive, 1939–45* (London: John Murray, 2001), 93–94.

to invaliding from the service, and validated a claim for a war pension. By contrast, LMF equated breakdown with temperamental unsuitability and carried the implication of cowardice. While it often led to discharge from the forces, LMF carried no right to financial compensation. The faults of both were clear: shell shock produced something of a pension epidemic, which in the aftermath of the First World War, the state could not afford; LMF sometimes stigmatized brave men exhausted by the stress of combat. During the First World War senior military figures gradually undermined the status of shell shock, culminating in a recommendation by the 1922 War Office Report that it be “eliminated from official nomenclature.”⁸⁷ Similarly, senior doctors gradually eroded the scope and authority of LMF during the Second World War. Both labels reflected the unavoidable tension between commanders who of necessity put servicemen’s lives at risk and military physicians, who having trained to save life, were required to preserve the strength of the fighting force. There is, perhaps, no simple solution to the dilemma of how to deter instincts of self-preservation and yet offer sympathetic management to the deserving veteran. What can be concluded, however, is that the unpopular LMF system could be justified only in the context of a war for national survival when trained aircrew were at a premium. When victory became increasingly likely and the psychological effects of combat became better understood, it was more difficult to sustain such an inflexible policy.

87. Lord Southborough, *Report of the War Office Committee of Enquiry into “Shell-shock”* (London: HMSO, 1922), 190.