Myers to McCauley: A Century of Military Psychology in Britain and Ireland

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"Operational readiness is the primary mission of military psychology, and this must be emphasised at every opportunity." (Ralph & Sammons, 2006, p. 384.)

Introduction

The development of military psychology is enmeshed with the history of psychology. This speciality has played a central role in the domains of clinical, organisational, research, and operational military systems throughout the centuries. Importantly, such processes were broadly informal for much of human history, but the post-enlightenment application of evermore scientific methods and increasing empiricism revolutionised psychology. These advances were soon applied to the psychology of military operations and processes.

There is an overlap in the development of military psychology between the United States (US) and that found in both Britain and Ireland (McCauley, Kennedy, & Zillmer, 2022). However, the specific origins and developmental context of this discipline in the United Kingdom (UK)[1] and Ireland reflects particular historical, jurisdictional, regulatory, and resource variations. In the current era of increasing joint medical operations, greater awareness of these international perspectives can enhance interoperability and operational readiness in military psychology.

Historical Features of Psychology in Military Contexts

A recognition of psychological features within military activities dates to antiquity. The Greek historian, Herodotus, appears to imply various psychogenic, somatoform and dissociative features evident in extreme psychological trauma for troops at the Battle of Marathon in 490 BC:

> "A strange prodigy happened at this fight. Epizelus, an Athenian, was in the thick of the fray, and behaving himself as a brave man should, when suddenly he was stricken with blindness, without blow of sword or dart; and this blindness continued thenceforth during the whole of his afterlife…he said that a gigantic warrior, with a huge beard, which shaded all his shield, stood over against him by, and slew the men at his side." (Crocq, 2000, p. 47)

Implicit psychological processes within military service received ongoing attention across the centuries, as evident in training systems, along with traditions and customs that addressed operational performance; whilst pertaining to social and cognitive facets of morale, loyalty, and unit cohesiveness (Sherman, 2010; Tzu, 2010). Other reflections on the psychological consequences of war were conveyed in the arts, such as Shakespeare's 1597 play, Romeo and Juliet, as seen in Mercutio's description of Queen Mab:

> *Sometime she driveth o'er a soldier's neck.*
> *And then dreams he of cutting foreign throats.*
> *Of breaches, ambuscadoes, Spanish blades,*
> *Of healths five fathom deep; and then anon*
> *Drums in his ear, at which he starts and wakes,*
> *And being thus frighted, swears a prayer or two,*
> *And sleeps again.* (Shakespeare, 1597/1990, p. 1017)

The discipline of psychological science advanced considerably during the eighteenth and nineteenth centuries, as evident in the documented observations from within the asylum facilities, in addition to the academic and clinical advances from William Wundt, William James, Sigmund Freud, and others (Holmes, 1998; Weinman, 1981). Writings of the time included references to psychological trauma in terms of railway spine, soldiers' heart, etc. (Hacker Hughes & McCauley, 2019; Harrington, 1996). Most psychological endeavours across this period, however, were anchored within research, measuring and theorising, rather than work pertaining to clinical practice. Prior to World War One (WWI, also known as the Great War), clinical mental health provision was generally reflected in the inpatient systems across the UK rather than services for non-hospitalised patients. Importantly, psychology was an activity and area of study undertaken by various disciplines (McCauley, Kennedy & Zillmer, 2022). Professionals from medicine, philosophy, neurology, mathematics, anthropology, etc. undertook psychology-based work and, as such, they commonly referred to themselves as psychologists.

One of these early psychologists during the nineteenth century was Charles Edward Spearman, known for *Spearman's Rho*. He had a career as an Army officer in the field of military engineering, serving in the Munster Fusiliers, one of the many Irish Regiments of the British Army. Spearman went on to complete training in psychology with Wilhelm Wundt at Leipzig University, Germany in 1906. He worked as an academic in psychology, based at the University of London, whilst returning to military service during the Second Boer War and rising to the position of Deputy Assistant Adjutant-General (Hacker Hughes, 2016).

1 n.b., The island of Ireland was part of the UK until 1922, when twenty-six Irish counties left to form the Irish Free State, a self-governing dominion in the British Empire. Six northern Irish counties remained in the UK and became known as Northern Ireland, with the Irish Free State later becoming known officially as Ireland. Ireland left the British Empire (later the Commonwealth of Nations) in 1949, having declared itself a Republic (Duffy, 2005). Therefore, the term 'island of Ireland' is used to refer to both Northern Ireland and Ireland. Ireland and the UK continue to engage in joint military training and deployed operations.

World War One and the birth of Military Psychology in Britain and Ireland

Psychology in the UK experienced a significant evolution during WWI. The conflict witnessed the largest mobilisation of men for military service that the British armed forces had ever witnessed. These fit and mostly young service personnel were drawn from a variety of social and educational backgrounds, entering the first industrial war of the modern era. This resulted in the British military suffering significant losses, with approximately 50,000 Irish personnel losing their lives. Many troops were exposed to immense and unprecedented operational stress and trauma, which led in an unparalleled number of psychological casualties, with thousands evacuated from frontline duties. Such cases were commonly found to be without a comorbid physical injury or known medical cause. This required military clinicians to reconceptualise their understanding and medical approach to mental illness (Linden, 2018; Jones & Stone, 2020).

In response to the mental health crises in the military, a concerted efforted was initiated by command to address the clinical needs of such personnel, whilst also seeking to return as many personnel to duty as possible. In 1915, Dr. Charles Myers became the first military psychologist in Britain and Ireland, following his commissioning as an Army officer in the Royal Army Medical Corps (RAMC). He established the first specialised treatment centre and appointed Dr. William Brown (a former pupil) to oversee the facility (Shephard, 2002). Myers—originally trained in medicine—was heavily influenced by research and enquiry in the field of anthropology. He is renowned for undertaking an ethnographic and socio-cultural systems research endeavour with fellow psychological scientists to the Torres Straits, located near Australia and Papua New Guinea. Myers also held academic posts in experimental psychology at King's College London, and he was appointed the UK's first academic chair in psychology. He progressed to an academic post at the University of Cambridge, establishing a psychology research laboratory and becoming the unit's director (Hacker Hughes, 2016).

Myers was appointed Consultant Psychologist to the Army and he proceeded to establish several Forward Psychiatry 'Not Yet Diagnosed Neurological' (NYDN) Hospitals. Such facilities sought to address the growing numbers of psychological casualties with the application of care pathways, which included psychological treatments. Myers was famous for his 1915 Lancet paper, which was the first to involve the use of the term shell shock (Myers, 1915). Importantly, though, there were no rigid and fixed criteria for diagnosing shell shock. Yet, it did harbour some of the symptoms of what became known as post-traumatic stress disorder (PTSD), whilst entailing a range of medically unexplained somatic symptom presentations, facets of dissociation, and psychophysiological anxiety symptoms (McCauley, Kennedy, & Zillmer, 2022):

> "The soldier, having passed into this state of lessened control, becomes a prey to his primitive instincts. He may be so affected that changes occur in his sense perceptions; he may become blind or deaf or lose the sense of smell or taste. He is cut off from his normal self and the associations that go to make up that self. Like a carriage which has lost its driver he is liable to all manner of accidents. At night insomnia troubles him and such sleep as he gets is full of visions; past experiences on the battlefield are recalled vividly; the will that can brace a man against fear is lacking." ('The Times, 1915, 25 May' in Shephard, 2002, p. 28.)

After some period, Myers' fellow clinical officers and command pushed back on his psychological approaches, preferring a more behaviourist and overtly functional perspective on returning personnel to duty (Shephard, 2002). Myers continued his military service back in the UK, especially in research. After the war, Myers declined to participate in the 1922 Southborough Commission on shell shock, finding his operational experiences too painful to revisit. He went on to establish the National Institute for Industrial Psychology (NIIP) and was also the first president of the British Psychological Society (BPS). Importantly, in 1940, he published 'Shell Shock in France', a ground-breaking study of 2,000 cases of shell shock, where he was able to identify several cases which did not directly involve explosions, demonstrating that shell shock could have a psychological aetiology. Finally, as World War Two (WWII) arose, he served as an advisor on War Office Selection Boards (WOSBs), before his death in 1946. (Hacker Hughes, 2016; McCauley, Kennedy, & Zillmer, 2022; Shephard, 2002).

Dr. William H.R. Rivers was a contemporary of Myers. Rivers had also trained in medicine but forged a career that encompassed aspects of anthropology and ethnography. He had also joined Myers on the renowned expedition to the Torres Straits. His work centred on psychology, serving as the joint editor and founder of the *British Journal of Psychology*, whilst also becoming an academic in experimental psychology at the University of Cambridge. Like Myers, Rivers went on to receive a commission as an Army officer with the RAMC (Hacker Hughes & McCauley, 2019; McCauley, Kennedy, & Zillmer, 2022). He is especially known for his psychological treatment of British Army officers suffering from shell shock at Slateford Military Hospital, Craiglockhart, in Edinburgh. His patients included the poets and writers Siegfried Sassoon and Wilfred Owen, both of whom were traumatised during service in the war. Owen's 1918 poem 'Mental Cases' captures much of the psychological turmoil of the time. It conveys the importance of narrative in the context of trauma, as it relates to conceptualisations of self, perceptions of safety and threat, notions of moral injury, and dynamics of psychological processing and social learning:

Who are these? Why sit they here in twilight?
Wherefore rock they, purgatorial shadows,
Drooping tongues from jays that slob their relish,
Baring teeth that leer like skulls' teeth wicked?
Stroke on stroke of pain—but what slow panic,
Gouged these chasms round their fretted sockets?
Ever from their hair and through their hands' palms

Misery swelters. Surely we have perished
Sleeping, and walk hell; but who these hellish?

—These are men whose minds the Dead have ravished.
Memory fingers in their hair of murders,
Multitudinous murders they once witnessed.
Wading sloughs of flesh these helpless wander,
Treading blood from lungs that had loved laughter.
Always they must see these things and hear them,
Batter of guns and shatter of flying muscles,
Carnage incomparable, and human squander
Rucked too thick for these men's extrication.

Therefore still their eyeballs shrink tormented
Back into their brains, because on their sense
Sunlight seems a blood-smear; night comes blood-black;
Dawn breaks open like a wound that bleeds afresh.
—Thus their heads wear this hilarious, hideous,
Awful falseness of set-smiling corpses.
—Thus their hands are plucking at each other;
Picking at the rope-knouts of their scourging;
Snatching after us who smote them, brother,
Pawing us who dealt them war and madness.

(Owen, 1918/2004)

Other mental health clinicians were also notable during this period. These included Sir Gordon Holmes, an Irishman educated at Trinity College Dublin (TCD), who initially studied medicine and neurology. Following his commission as an officer with the RAMC, Holmes provided mental health services for UK personnel. His approaches to treatment focused less on underlying psychological processes and instead reverted to behavioural symptom extinction and potential biological features of the patient's presentation. Such care aligned more closely with the various practices of the time that entailed electric shock and medication interventions. Dr. Willian McDougall, a founder of the BPS, also served as an RAMC officer during the war. Initially trained in medicine, he is also known for his psychological treatment to cases of shell shock. After the War, McDougall became a Professor of Psychology at Harvard University (Hacker Hughes, 2016; Shephard, 2002).

In 1918, a shell shock conference was held at the Maudsley Hospital in London, a facility that had assessed and treated many thousands of mental health patients during the war. One major figure in this and other military mental health facilities was the aforementioned Dr. William Brown. Brown was an officer in the RAMC and trained in philosophy and mathematics before studying medicine. He became director of the Institute of Experimental Psychology at Oxford and is also known for his treatment of shellshock patients during WWI (Jones & Wessely, 2005; Shephard, 2002). The Great War saw thousands of military and civilian medical staff involved in caring for the mental health needs of the UK's military personnel. New clinical management systems had been established both on overseas operations and in the UK, which included advances in psychological models of care (Howorth, 2000). It became increasingly clear that early and in-theatre assessment and treatment contributed to effective outcomes. During this time, the concept of assessment and treatment known as proximity, immediacy, expectancy, and simplicity (PIES) also emerged (Jones & Wessely, 2003; McCauley & Breeze, 2019).

Many of those treated for shell shock were returned to duty, with large numbers assigned to non-combat roles. Additionally, these early-intervention principles remain the foundation of combat stress intervention since that time, along with the concept and practice of deployed combat stress units (Jones & Wessely, 2003; McCauley, Kennedy, & Zillmer, 2022; Shephard, 2002). Such care also included rehabilitation and convalescence via hospitals across Britain and Ireland. One particular unit was the Leopardstown Park Hospital in Dublin, which is still providing healthcare to veterans from more recent conflicts (Kinsella, 2017).

In the years following WWI, the profession of psychology in the UK continued to grow, but largely as an academic discipline, with some increased involvement in testing, assessment and selection, human factors, and organisational functions. The professional identity and training pathways for psychologists became more formalised. Across the military and civilian medical settings, the realm of clinical work remained predominantly the domain of psychiatrists and nurses. The armed forces retained some psychologists for non-clinical roles. Nevertheless, the psychological research arising from WWI excited many of the leaders in UK mental health. They felt that the lessons for understanding and treating psychological trauma from a broader psychosocial and psychotherapeutic perspective would help to address many of the symptoms found in civilian mental health facilities (Jones & Wessely, 2005).

However, there was a gradual neglect of psychological medicine in many mental health facilities from the 1920s onwards. Medical schools often disregarded much from the discipline, whilst clinical services reverted to broadly biomedical perspectives of care. Furthermore, psychoanalytically trained psychiatrists were not commonly used in mainstream inpatient mental health facilities. Ultimately, the field of psychology languished during the 1920s and 1930s, with membership of the BPS remaining stagnant for many years (Hacker Hughes, 2016)

World War Two

A renewal of psychology in the UK emerged during WWII. The British armed forces once again mobilised large numbers of citizens for military service. During WWII, approximately 70,000 from Ireland joined the British military, with many serving in the UK's Irish regiments. Thousands also remained in Ireland, choosing to serve in the nation's Defence Forces (DF; Doherty, 2004; Duggan, 1992; Jackson, 2016; Kelly, 2012). The era witnessed an expansion of the UK's defence mental health services, such as the increased numbers of military psychiatrists, mental health nurses and support staff. Additionally, the Royal Navy recruited eight civilian psychologists to develop various psychological tests for officer selection. A further ten 'industrial' psychologists

and approximately 300 assistants, mainly from the Women's Royal Naval Service (WRNS), who were tasked in related psychology duties (Hacker Hughes, 2007).

Across the British Army, various officers and non-commissioned officers were involved in psychometric selection and screening duties via the Adjutant-General's Department. Nineteen men and women were commissioned as psychology officers, working alongside hundreds of uniformed support personnel in related human factors, administrative, and research tasks. This involved the Directorate of Scientific Research and the Directorate of Biological Research within the War Office Medical Department. The Royal Air Force (RAF) retained several civilian advisors in psychology for training methods, along with over one hundred selection officers and junior psychology technical assistants, many of whom were sourced from the Women's Auxiliary Air Force (WAAF). Other Air Ministry psychologists contributed to various aviation psychology tasks in the design of aircraft and the training of aircrew (McCauley, Kennedy, & Zillmer, 2022; Olson, McCauley, & Kennedy, 2013).

The expanded clinical military mental health services saw the recruitment of psychiatrists with strong psychotherapy leanings. Such professional orientations enhanced the psychological perspectives to care and recovery. One such individual was Dr. Edward Bennet, an Irishman who had trained in theology at TCD, going on to serve as a chaplain during WWI. He retrained in psychiatry after the Great War, developing a specialist interest in Jungian theories of psychotherapeutic treatment. He returned to the Army during WWII, serving as a clinician and officer in the RAMC. He was later promoted to the rank of Brigadier General and led military mental health services in India (Webb, 2011).

The Post-War Years

The use of psychology in the military receded after WWII. However, military psychiatry continued to be influenced by emerging psychological theories on mental disorders and therapeutic approaches to treatment. Having left the Commonwealth of Nations 1949, Ireland retained natural and longstanding political, cultural, and economic bonds with Britain. As such, many Irish continued to serve in the UK armed forces, with notable members of the Irish DF having previously served in the British military (Bartlett & Jeffery, 1997; Bowen & Bowen, 2005; Duggan, 1992; McIvor, 2006).

During this post -WWII period, military mental health services in Ireland entailed contracted civilian psychiatrists, geographically located at strategic military medical facilities across the country. They provided peripatetic clinics, receiving referrals from medical officers, whilst inpatient facilities remained outsourced to the civilian sector. Ad hoc utilisation of clinical psychology services in the military did occur across Ireland, which entailed the provision of occasional neuropsychology and other psychological testing services. However, little to no formal psychotherapy provision was provided. Additionally, there was no deployed overseas provision, rather in-theater Medical Officers (MO) managed psychiatric cases and chaplains were used for issues of morale and non-clinical supportive counselling; whilst, on occasion, repatriations would occur (Tobin, 2022). Meanwhile, in Britain, clinical psychology was reflected in the military via peripatetic roles providing specialist services such as neuropsychological assessment in inpatient settings; located, for example, at Haslar Hospital for Naval personnel and the Queen Elizabeth's Military Hospital in Woolwich for Army service members.

The Late 20th Century

The late 20th Century saw the growth and integration of psychological models to care across the military mental health services, reflecting the similar shift in civilian mental health systems. For example, Irish consultant psychiatrist Dr. Morgan O'Connell was commissioned as an officer into the Royal Navy in the 1960s. Throughout the 1970s and 1980s, he and others brought an increasing psychological approach to the care of service personnel, and he was a leading figure in developing psychological and therapeutic services for treating PTSD in the aftermath of the Falklands War. This was mirrored in the work of Scottish consultant psychiatrist, Dr. Gordon Turnbull. Commissioned as an officer into the Royal Air Force in the 1970s, he developed and delivered new military psychological services, later used in addressing the mental health needs of returning hostages in the 1980s and 1990s (Turnbull, 2012).

Large numbers of psychologists continued to support the UK military during this period, which pertained to the provision of psychological research and human factors scientific endeavours. Importantly, the discipline of clinical psychology in Britain and Ireland formalised its training and professional identity during the mid to late 20th Century. As such, further to the growing psychological trends in military mental health, clinical psychologists were soon recruited into the structures and systems of defence medical services. After a brief period during which there was no clinical psychology resource in UK defence healthcare, a rebirth occurred.

As noted by Norris and McCauley (2019), Dr. Stan Renwick, consultant clinical psychologist, was appointed as Head of Clinical Psychology for the UK's Ministry of Defence in the mid-1990s. He also served as Consultant Advisor in Clinical Psychology and operated under the direction of the then Tri-service Defence Secondary Care Agency, which was associated with the Director of Defence Psychiatry at Duchess of Kent's Psychiatric Hospital (DKPH), Catterick Garrison. Dr. Renwick endeavoured to establish a new nation-wide defence clinical psychology service. Supporting military psychiatrists and psychiatric nurses, the growing team of clinical psychologists developed a consultative and liaison service. This assessment, treatment, and consultation resource delivered expertise in neuropsychology, PTSD, psychological therapies, and substance misuse across military outpatient and inpatient settings, including the Defence Medical Rehabilitation Centre.

The 21st Century: A New Era for Military Psychology in Britain and Ireland

"A young Lieutenant in 3 PARA [3rd Battalion, Parachute Regiment] wrote in his journal… 'This was a different kind of war. They were fighting day in and day out: facing danger again and again; experiencing a lifetime of trauma in a week.'" (Butler, 2014, p. 8).

Following the closure and outsourcing of the UK's military general and psychiatric inpatient facilities [the last general hospital, Royal Navy Hospital Haslar in Portsmouth was built in 1752 and closed in 2009], a new effort was undertaken to expand the team of clinical psychologists across the British armed forces. Such resources were assigned to the growing network of tri-service military mental health outpatient teams throughout the UK and at larger overseas medical facilities. Leadership of the UK's defence clinical psychology team transferred to Dr. Jamie Hacker Hughes, a consultant clinical psychologist with the Ministry of Defence. A former Army officer, Dr. Hacker Hughes had experience across various deployed theatres and sought to enhance the operational utilisation of clinical psychology in the British military.

As the operational tempo increased across campaigns in Iraq and Afghanistan, Dr. Hacker Hughes was able to develop the military psychological resources across the UK and Germany, with consultation services to deployed medical units in the Middle East and visiting clinics in Cyprus and Gibraltar. Such improved and expanded provision bolstered the UK's military mental health assets during this challenging period of ongoing operations. This era also saw the reintroduction of uniformed military psychologists to the British Army, beginning with the commissioning of Dr. Duncan Precious as a clinical psychology officer with the RAMC in 2013 (see https://www.bps.org.uk/volume-28/january-2015/uniformed-clinical-psychologist-british-army). Additionally, a research stream was initiated by psychologists via the newly formed Academic Centre for Military Mental Health, part of the King's College Centre for Military Health Research (Hacker Hughes & McCauley, 2019; McCauley & Breeze, 2019; Norris & McCauley, 2019).

Such advances in UK military psychology were accompanied by the work of various military psychiatrists and psychiatric nurses. Of note, Dr. Neil Greenberg, a consultant psychiatrist and officer with the Royal Navy, became renowned for his development of a psychological trauma response system (i.e., Trauma Risk Management or 'TRiM'), now offered across the British armed forces (Sturgeon-Clegg & McCauley, 2019). The clinical psychology cadre came under new command, following the appointment of Dr. Rachel Norris as Head of Service. She built on the work of Dr. Hacker Hughes, and there are now over 100 uniformed and civilian psychologists working across the UK armed forces. Approximately, thirty of these are clinical psychologists who operate within military mental health clinics staffed by military psychiatrists, psychiatric nurses (increasingly trained in Cognitive Behavioural Therapy), social workers, and mental health therapists. Many of the psychologists serve as clinical leads within such teams (McCauley, Kennedy, & Zillmer, 2022; Norris & McCauley, 2019).

The non-clinical roles for military psychology address tri-service human factors research and development-related matters for training and operational contexts; including contribution to recruit and officer selection and instruction systems. Meanwhile, in the Irish DF, after the establishment of a uniformed military psychiatry service during the 1990s (most notably led by Dr. John Tobin), a uniformed military clinical psychology cadre was introduced, beginning with the commissioning of Dorota O'Brien as an Army Medical Corps officer. There now exists a team of military and civilian mental health clinicians in the Irish DF, representing clinical psychology and psychiatry (McCauley et al., 2017; O'Brien & McCauley, 2020). Additionally, there is a uniformed military industrial/organisational psychology team in Ireland and further wellbeing support is provided by uniformed military welfare personnel, along with civilian occupational social workers (McCauley & O'Brien, 2017; McCauley, et al., 2017; O'Brien & McCauley, 2020). Indeed, in 2015, one hundred years after Dr. Charles Myers was commissioned as the first uniformed military psychologist in Britain and Ireland, the author of this article, an Irishman, was commissioned as the first reserve uniformed military clinical psychologist in either of these islands.

Systems and Care Pathways of Today's Military

As with the U.S. armed forces, military mental health services in Britain and Ireland are rooted in the principles of occupational medicine. There is a duty of care to the patient, alongside the priorities of supporting the overall mission of the armed forces. Medical grading systems are used to address concerns relating to fitness and suitability for duty. Risk management procedures are applied, with specific systems associated with certain occupational specialties (McCauley, Hacker Hughes, & Liebling-Kalifani, 2008; Norris & McCauley, 2019).

Clinical psychologists contribute to the military mental health domains of promote, prevent, detect, and treat. Multidisciplinary teams (MDT) work as a foundation of care pathway models. Within these teams, clinical psychologists collaborate with other mental health disciplines, various medical specialists, and command. Such assets and services are delivered across healthcare and non-medical settings, including primary and secondary care facilities, liaison with outsourced tertiary and specialist psychiatric units, military rehabilitation clinics, training centres, and line and command formations (Hacker Hughes & McCauley, 2019; Norris & McCauley, 2019).

Operational mental health provision differs across deployments, reflecting the variability of UK operational tours (e.g., peacekeeping, humanitarian, expeditionary, training). The PIES model remains relevant to deployed psychological services. Mental health first aid and trauma -risk management resources are applied to varying degrees, so as to address subclinical transitory symptomatic need. On larger and more established operational deploy-

ments, the UK has operated Field Mental Health Teams, which entail psychiatric nurses and visiting psychiatrists. Clinical psychologists provide a consultative and visiting in-theatre service as needed. Other deployments may entail clinical psychologists deployed across a given tour with MDT colleagues (McCauley & Breeze, 2019; Norris & McCauley, 2019) and psychologists may also deploy on operational mental health research duties.

The Irish DF specialises in operations such as peacekeeping, peace-enforcement, crisis-stabilisation, humanitarian and training missions, and other military operations other than war. The Irish military commonly deploy medical officers within larger operational formations. Such clinicians provide immediate clinical assessment and care. Associated support for subclinical mental health input is offered via forms of mental health first aid, along with non-clinical emotional support from chaplains, and input from intermittent visiting military welfare support staff. Military clinical psychologists are a deployable asset. Indeed, specialist remote and in-person consultation and liaison from military clinical psychologists and psychiatrists is retained, which may entail theatre visits as required (McCauley & O'Brien, 2017). Future miliary psychology contributions to DF operations are likely to involve greater use of emerging technology to improve access to stepped care, which may entail increased application of remote telehealth systems (O'Shea, McCauley & O'Brien, 2019).

Conclusion

The history of military psychology in Britain and Ireland is rich and dynamic. It reflects and parallels the growth of psychology as a scientific discipline, along with the development of clinical psychology as a healthcare speciality in such jurisdictions. The early endeavours of the profession were conducted by various professionals functioning as psychologists, whilst holding a range of core qualifications, including medicine. Great advances in psychological models of training and clinical care were attained in WWI and WWII, which blossomed into the extensive contributions now evident in military mental healthcare. Additionally, psychologists continued to deliver a range of non-clinical expertise in the military, aiding in the organisational and human factors arenas of defence operations. As Brigadier General Martin Bricknell, UK Surgeon General, stated (2019, p. 65): "[As] military psychology enters its second century, it is highly appropriate to celebrate the history and achievements that this speciality has brought to our armed forces."

Clinical psychology is a valued asset within UK and Irish defence healthcare. Current generations of clinicians can acknowledge the immense achievements of those early psychologists who persisted in developing this specialist military discipline and are truly standing on the shoulders of giants. There exists great scope for international defence clinical psychologists to collaborate individually with military psychologists from other nations, either as augmentees or as part of combined operational formations; for as a famous Irish saying goes "Ar scáth a chéile a mhaireann na daoine" (i.e., "In the shadow of each other, we live"). Ultimately, military psychology remains a crucial force multiplier in Britain, Ireland and across the world, and there are exciting times ahead.

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