

**Problems, politics and personalities  
in the treatment of mental and nervous casualties  
in the British Army 1914-1918**

**Incorporating a statistical and analytical study of 500 case histories**

**Thesis submitted for the degree of  
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**by**

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## ABSTRACT

The Great War of 1914-1918 continues to attract scholarly attention, not least in the field of neuropsychiatric medicine. The term 'shell shock' is firmly cemented into the language, such that it represents for many the entire neuropsychiatric experience of the war. This thesis challenges that view, seeking to establish a new point of departure for the study of Great War neuropsychiatric medicine.

Based on a major study of previously unresearched medical case histories, a much less central role is assigned to shell shock and 'war neuroses' generally. Novel aspects such as the effects of mental disorder on the smallest military social unit - what is called here the 'comradely group' - are explored. By maintaining throughout a clear distinction between functional nervous disorders and the ubiquitous exhaustion syndrome of 'neurasthenia', a radically altered view of their relative importance emerges. At the same time, much of the confusion and conflation of previous studies is avoided.

The British Army's approach to these problems depended crucially on the availability of appropriately skilled medical practitioners. This thesis maintains that the historical hiatus between the public asylum medical service and the medical profession as a whole constituted an influential and previously unrecognised factor in the evolution of these policies and practices. As war approached, the growing influence of Freudian psychology raised questions as to where the legitimate authority on mental health matters should lie. When circumstances forced the Government to seek help from the asylums in coping with the rising tide of casualties of all kinds, the weight of advantage in this controversy swung decisively in favour of the asylum doctors. This, it is suggested, constituted a major factor in the developmental pattern of mental health services in post-war Britain, a factor which has up to now been largely overlooked.



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To an extent only she and I can fully appreciate, the completion of this thesis has depended crucially on the patience, understanding and practical help given to me by my wife Janet. Despite her increasingly heavy commitments as a senior partner in a large law firm, I have never sought her help in vain, whether to test out an abstruse point of understanding or expression, or to take advantage of her enviable computer skills. As a wholly inadequate recognition of my indebtedness, this work is dedicated to her, with my deepest affection and heartfelt gratitude.



## CASUALTY IDENTIFICATION

A long-running campaign has sought, so far without success, to obtain posthumous pardons for British soldiers who were tried by military courts-martial during the Great War and executed by firing-squad.<sup>1</sup> From time to time, attempts are made to have the names of 'cowards' and 'deserters' inscribed on war memorials, similarly without success. Although frustrated at governmental level, one result of this campaign has been the unveiling of a 'Shot at Dawn' memorial in the National Memorial Arboretum in Staffordshire, on 21 June 2001, an event attended by relatives of the executed men, representatives of the Royal British Legion and many members of the public. In addition to a symbolic sculpture, the names and units of 306 soldiers are permanently displayed.<sup>2</sup> The circumstances surrounding these executions have also been the subject of scholarly attention, notably by Putkowski and Sykes through their research into capital courts-martial. In their work also, these 'criminals' are clearly identified.<sup>3</sup>

In view of the wide and continuing publicity given to this aspect of the Great War, it seems entirely invidious that the identities of men who became mental and nervous casualties should continue to be concealed in academic theses and elsewhere, implying that there was something inherently shameful in what happened to them. Whatever stigma attached to these disorders at the time, it has thankfully long ceased to matter to the men concerned. It would be naïve, however, to argue that mental illness in particular can be discussed as openly and unemotionally as a broken arm or a bout of influenza. The author is well aware, therefore, that the discovery of a relative's name in the following pages might be unwelcome or even give offence.

If this should be the case, the author wishes firstly to apologise, and to state that this thesis is predicated on the strongly held view that those who suffered from neuropsychiatric disorders were as much casualties of the Great War as their comrades who fell victim to gunshot, shrapnel or gas. They are therefore identified here solely for reasons of historical veracity, and in the firm belief that these men also deserve our unqualified respect, gratitude and admiration.

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<sup>1</sup> For a summary of the case for the executed soldiers, see Babington A., 'A Stain on Army Medicine', *The Lancet*, 20 November 1993, pp.1253-4.

<sup>2</sup> Boorman D., 'The Unveiling of the Shot at Dawn Memorial', *Bulletin of the Western Front Association*, No.61, October 2001, pp.28-9.

<sup>3</sup> Putkowski J. and Sykes J., *Shot at Dawn*, Leo Cooper, (London 1996).



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**CONTENTS**

|   |     |
|---|-----|
| INTRODUCTION  | 1   |
| PART ONE: HISTORICAL CONTEXT  |     |
| Chapter 1. Mental health in Britain before 1914.  | 14  |
| Chapter 2. Hegemony, resistance and reform on the eve of the Great War.                                   | 26  |
| PART TWO: ASPECTS OF THE PROBLEM  |     |
| Chapter 3. 500 mental and nervous case histories analysed.  | 52  |
| Chapter 4. Neurasthenia - from middle-class <i>ennui</i> to combat fatigue syndrome.                      | 92  |
| Chapter 5. Cohesion and dissolution in the 'Comradely Group' - the neuropsychiatric casualty as outsider. | 142 |
| PART THREE: CASUALTIES ON THE CONTINENT   |     |
| Chapter 6. Charles Samuel Myers and the struggle for front- line treatment.                               | 178 |
| Chapter 7. New policies, new practices: therapeutic strategies at the 'N.Y.D.N.' Centres.                 | 222 |
| PART FOUR: CASUALTIES IN THE UNITED KINGDOM   |     |
| Chapter 8. Crises and solutions: the Asylum War Hospitals Scheme.   | 247 |
| Chapter 9. Stigmatized soldiers: Sarah Elizabeth White and the asylum doctors.                            | 267 |
| Chapter 10. R.G. Rows and the influence of the Moss Side Military Hospital.                               | 291 |
| Chapter 11. W.H.R. Rivers: past reality - present myth.   | 309 |
| Chapter 12. Conclusion.   | 323 |



**CONTENTS (continued)**

|                         |     |
|-------------------------|-----|
| Glossary                | 337 |
| Bibliography (Part One) | 340 |
| Bibliography (Part Two) | 353 |

## LIST OF FIGURES

|            |  |      |
|------------|--|------|
| Figure 1.  | Neuropsychiatric casualties admitted to certain UK hospitals. 20 August 1914 - 6 March 1916. | 58a  |
| Figure 2.  | 500 cases study: Side 1 of case analysis form.   | 60a  |
| Figure 3.  | 500 cases study: Side 2 of case analysis form.   | 60b  |
| Figure 4.  | 500 cases study: cumulative list of symptoms noted: (ranges 1-21 and 22-42)                  | 60c  |
| Figure 5.  | 500 cases study: cumulative list of symptoms noted: (ranges 43-64 and 65-8)                  | 60d  |
| Figure 6.  | Admissions to study group hospitals: August 1914 to June 1919 inclusive (graphical).         | 72a  |
| Figure 7.  | Admissions to study group hospitals: August 1914 to June 1919 inclusive (numerical)          | 72b  |
| Figure 8.  | Mental and nervous disorders: causational events.  | 86a  |
| Figure 9.  | Distribution of mental and nervous disorders by arm of service.                              | 87a  |
| Figure 10. | Nervous disorders: comparative incidence   | 92a  |
| Figure 11. | Mental and nervous disorders exhibiting delusions of persecution.                            | 142a |
| Figure 12. | Diagram of an Advanced Neurological Treatment ('N.Y.D.N.') Centre - France and Belgium 1917. | 222a |

## LIST OF TABLES

|          |   |     |
|----------|---|-----|
| Table 1. | 500 cases: recorded pre-enlistment mental and nervous medical histories.  | 76  |
| Table 2. | Admission and disposal of cases of nervous disorders in Army Areas: weeks ending 30.3.18 and 30.4.18, and from 8.6.18 to 7.12.18. | 108 |
| Table 3. | Diagnosis and final disposal of 'N.Y.D.N.' cases sent from Army Areas to the Base: June - December 1917                           | 109 |
| Table 4. | Proportion of nervous disorders to total sick and wounded admitted to hospital.   | 109 |
| Table 5. | C.S.Myers: synopsis of 12 early cases of shell shock.   | 189 |
| Table 6. | British Expeditionary Force: location of Advanced Neurological ('N.Y.D.N.') Centres.  | 222 |
| Table 7. | R.G.Rows: list of physiological and psychological diagnostic tests - Moss Side Military Hospital, February 1915.                  | 299 |



**PART ONE**  
**HISTORICAL CONTEXT**

## INTRODUCTION.

In the opening chapter, this thesis traces the development of British approaches to the management of mental illness from the middle years of the nineteenth century to the outbreak of the Great War. The aim is to set the events of the Great War firmly into their contemporary social, cultural, military and medical contexts. The decision to devote space to 'setting the scene' was taken consciously, and after a wide-ranging review of the literature had confirmed that previous studies had treated the events of the Great War very much in isolation, without appropriate regard for historical contingency. For example, insufficient weight had been given to the fact that, at least in the early stages of the war, mental and nervous casualties were treated by the cadre of practitioners available at the time.

This body of expertise, such as it was, was drawn from a variety of backgrounds - psychology, physiology, neurology and anthropology, as well as medical staff from the asylum system of the day. There were therefore few, if any, of what would be recognised today as 'psychiatrists'. In previous studies, there has been a regrettable tendency to gloss over this fact, giving the impression of a cohesive body of expertise, sharing settled views on mental and nervous disorders. A central argument of this thesis is that this interpretation is misleading. The disparate antecedents of these men, added to the fact that there was an almost complete lack of consensus regarding the treatment of civilian mental and nervous disorders, constituted a major factor in the therapies adopted and in their success or failure.

These developments - the evolution of the public asylums, the emergence of a formalised medico-legal system of certification, committal and incarceration, and the gradual emergence of a new professional group of 'psychiatrists' practising 'psychiatry' - did not go unchallenged. Chapter Two introduces the interdependent themes of reform and resistance. The urge to reform the monolithic structure of the asylums came from a number of quarters, not least from the junior ranks of the asylum medical officers. With almost unmanageable numbers of patients to care for, poorly rewarded, and subject to irksome and often humiliating constraints on their personal lives, demands for reform were becoming more insistent as the war drew near.

When the pressure of numbers forced the authorities to look to the asylum system for help in dealing with neuropsychiatric casualties, resistance came, perhaps surprisingly, from the medical profession at large. Chapter Two examines the nature of the ensuing controversy between the public asylum system and the wider medical profession, looking at the background of some of the major participants. The controversy, largely ignored by previous studies, had important consequences for the therapeutic policies and practices of the later war years, in particular the comparative neglect of those suffering from mental disorders.

### **Psychiatry, terminology and understanding.**

The use of the now familiar terms 'psychiatry' to describe the diagnosis, study, treatment and prevention of mental disorders, and 'psychiatrist' to denote a medical practitioner specialising in those areas of medicine, were not fully



recognised in Britain until well into the early decades of the twentieth century. Before that time, the variety of terms used seems at times almost as great as the number of writers involved, with labels such as 'psychic', 'psychical', 'psychopathic', and 'psycho-pathological' often being employed interchangeably to refer to the workings of the mind in general, and 'psychological medicine', 'mental hygiene', 'mental medicine', 'mental science' and an array of combinations and variations of these and other labels, used synonymously to refer to the treatment of its disorders.

In an editorial of April 1910, the *Journal of Mental Science*, for long the official voice of the asylum medical officers, spoke at length in justification of its title, and of the philosophy implicit in its accompanying rubric; '*Published by authority of the Medico-Psychological Association*'. Objections to this title, the editorial maintained, were largely based on the mistaken assumption that to have chosen 'psychological science' for example, would have excluded the still influential metaphysical aspects of mental disease. It was true, the *Journal* went on, that the intrusion of spirituality, philosophy and organised religion into considerations of mental health did not help the cause of reform. Metaphysics and medicine made uneasy bedfellows, however, and there were increasingly persistent calls for the adoption of a more pragmatic approach to mental health, an approach in which a more representative and inclusive identity might help. *The Journal* offered some alternatives:

...mental physiology, or mental pathology, or psychology, or psychiatry (a term much affected by our German brethren) would have been more correct and appropriate...<sup>1</sup>

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<sup>1</sup> *The Journal of Mental Science*, Vol. 56, April 1910, p.272.

The term 'alienist' to refer to a specialist in mental disorders persisted for many years, with some older practitioners taking a perverse pride in retaining the title.<sup>2</sup> There is the added confusion that some of the terms - 'psychic' and 'psychopathic' are particular examples - are still in use, but have assumed quite different connotations in the meantime. Today, 'psychic' is reserved for parapsychological phenomena or a person claiming powers in that field. As an adjective, 'psychopathic' has become firmly attached to assumptions of intrinsic amorality, antisocial behaviour, and the absence of conscience in connection with criminal social transgression. In the professional psychiatric discourse, however, 'psychopath' is today largely obsolescent as a diagnosis, on account of its inability to describe accurately the wide range of symptoms it necessarily embraces. Clinically, the term 'antisocial personality disorder' is now more generally used, although both the noun 'psychopath' and its adjective 'psychopathic' are immovably fixed in the vocabulary of the popular communications media, and seem likely to remain so.

Before the turn of the century, the terms most commonly used when speaking of disordered conditions of the mind were 'insanity' and 'lunacy'. The first is an uninformative generalisation in any diagnostic or descriptive sense, and the second an anachronism, reflecting an age-old belief in the influence of lunar proximity on the minds of susceptible individuals. The main reason why these terms had become so widely recognised and applied was that 'insanity' was in fact a legal and not a medical term, as also were 'lunacy' and its adjective 'lunatic'. The ambiguity surrounding disorders of the mind, and the seemingly unbridgeable

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<sup>2</sup> For an accomplished summary of the processes through which psychiatry and psychiatrists passed on the way to their present positions, see Crammer J.L., 'Training and Education in British Psychiatry 1770-1970' in Freeman H. and Berrios G., (Eds.), *150 Years of British Psychiatry, Vol.2: The Aftermath*, Athlone, (London 1993), pp.209-242.



linguistic gulf between charming eccentricities at one end of the spectrum, and uncontrollable murderous mania at the other, was a subject to which *The Lancet*, for one, returned repeatedly in the latter decades of the nineteenth century:

Every medical practitioner and ordinarily intelligent layman knows what is meant by insanity, but as yet no expert or general observer has been found able to frame a definition of the abnormal state which shall cover the disease [...] There will be a red-letter day in the chronicles of legal medicine, and a new era in lunacy practice...when, if ever, a satisfactory definition is accomplished.<sup>3</sup>

and in the following year:

What is the standard of mental health by which insanity is to be recognised or gauged? It is high time that this practical question received a sober-minded answer from the collective common-sense judgment of the medical profession. At the present moment "insanity" would seem to mean anything experts choose to make it. There is no clearly formulated ideal of sanity, and the least "strangeness" or weakness is held to be...sufficient proof of insanity to deprive an individual of liberty and social privilege.<sup>4</sup>

It is significant that *The Lancet* called for a definition of insanity based on a consensus of the generality of the medical profession, in preference to that of the 'experts' - the mental specialists. The implications are clear enough. Not only was it implied that the mental specialists lacked sound judgment, they are also accused of erecting spurious nosologies in order to conceal a lack of substance in their specialism. These comments were some of the more forthright in a conflict of opinion between the medical profession as a whole, and the somewhat isolated sector of the profession which laid claim to expertise in the field of mental health. The outbreak of war not only postponed a resolution of the controversy, it arbitrarily shifted the balance of the argument in favour of the asylum mental specialists. This delay was to have profound implications for the treatment of

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<sup>3</sup> *The Lancet*, 27 March 1880, p.497.

<sup>4</sup> *ibid.*, 25 June 1881, p.1034.



neuropsychiatric casualties, as well as for the development of psychiatry as a discrete and fully accepted branch of the medical profession.

All of the terms referred to above had, over the course of the nineteenth century, been legitimated by their incorporation into the vocabulary of the asylum system. Legally certified 'insanity' was the indispensable prerequisite for admission to 'lunatic asylums' - institutions under the governance of the 'Lunacy Commission'. The genesis of these institutions, the nature of their relationships, and their effect, directly and indirectly, on the treatment of the neuropsychiatric casualties of the Great War, constitute the major themes of the following chapters.

Between 1881 and the outbreak of the Great War *The Lancet's* pleas for a generally agreed definition of insanity went unanswered, with new classes and sub-classes of mental disorder being piled one on top of the other. In 1912, reviewing yet another publication advocating the re-classification of mental diseases, the *British Medical Journal* complained that, not only did this give rise to 'regrettable confusion', but that this continual shifting of the nosographical goal-posts rendered impossible the task of compiling comparative statistics.<sup>5</sup> Meanwhile, the asylum population, and the number of asylums, rose year by year. According to the Annual Reports of the Lunacy Commissioners, the number of patients in public asylums in England and Wales rose from 15,845 in 1860 to 97,580 in 1910, and the number of asylums from 41 to 91 respectively. To those striving for reform of the mental health system, it must have seemed at times that the whole population was sliding

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<sup>5</sup> *British Medical Journal*, 20 April 1912, p.896.

inexorably into madness, disappearing at an ever-increasing rate behind the walls of these institutions.<sup>6</sup>

One apparently simple change that did take place around the turn of the century, was that the terms 'psychiatry' and 'psychiatrist', broke through some kind of lexicographical barrier, and very quickly became cemented into the British medical vocabulary. The reasons why this happened so quickly are unclear. At this same time, however, Freudian ideas were being canvassed more widely by enthusiasts like Ernest Jones and David Eder, and it seems highly likely that the terminology was disseminated along with the doctrine.<sup>7</sup> Bearing in mind the frustration expressed by the medical press over the tortuous complexities of language surrounding the whole subject of mental health, any simplification must have been welcome.

### The politics of language

A striking feature of the medico-historical literature of the Great War is the frequency with which the terms 'mental' and 'nervous' are confused and conflated. The reasons for this are complex, but are due, at least in part, to society's atavistic fear of mental aberration, and a consequent tendency to employ euphemism rather than confront those fears directly. 'Nervous breakdown' - still the accepted social code for a range of acute emotional disorders - came into regular use during the Great War period. Even when

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<sup>6</sup> Jones K., *Asylums and After*, Athlone, (London 1993) p.116.

<sup>7</sup> Porter R., 'Two Cheers for Psychiatry!', in Freeman H. and Berrios G.E., *150 Years of British Psychiatry: Volume 2 - The Aftermath*, Athlone, (London 1996), p.388.



dealing with cases of severe mental disorder, patients' families were told that their relative was under treatment for 'nervous breakdown'.

One of the arguments advanced in this thesis, however, is that there was a considerable degree of mis-diagnosis. This, it is contended, was due to a number of factors, not least inexperience and incompetence on the part of medical officers at the Front. Specific case histories are cited in support of this argument. There is also evidence to support the allegation that, in the case of officers, the largely subjective nature of 'neurasthenia' - at the time a widely recognised condition - was used to conceal more serious neuropsychiatric disorders.<sup>8</sup> Whilst avoiding the use of potentially confusing synonyms, there is nevertheless the need for a compound adjective to embrace the whole range of non-physical conditions experienced during the Great War. A number of alternatives were considered but rejected, mostly on the grounds of existing associations. The term 'neuropsychiatric' however, has been in use for many years; it was eventually chosen as the most accurate and inclusive.<sup>9</sup> The overall effect, it must be confessed, is inclined to be repetitive. In defence of this policy, however, one of the stated aims of this thesis is to clear away at least some of the thicket of metaphor and synonym that has been allowed to surround the subject of Great War psychiatry. Accordingly, the thesis strives throughout to set out its arguments and to express its ideas in straightforward language, using the minimum of technical terms.

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<sup>8</sup> For discussion of policy and practice in respect of officer neuropsychiatric casualties, see Chapter Four, p.127 *et seq.*

<sup>9</sup> See Reber A.S., *The Penguin Dictionary of Psychology*, Penguin, (London 1985) and also Glossary.

Part Two begins with a major study of 500 cases of mental and nervous disorder admitted to U.K. hospitals between August 1914 and January 1919. The study is based on two sets of medical case histories held at the Public Record Office, Kew, the majority of which are recently released and previously unresearched primary sources. The results of the study are set out in textual, graphical and tabular form, illustrated by individual case histories drawn from the primary evidence. Rather than simply produce a mass of unrelated statistics, however, the aim of the study has been, firstly, to support some of the arguments advanced by this thesis, notably the conflation of disparate disorders. This has been a regrettable characteristic of some modern studies. Secondly, the aim has been to highlight the neglect of mental casualties. Where justified by the evidence, inferences are drawn and some correctives offered regarding the historical statistical record.

### **Neurasthenia - the convenient complaint.**

Society's inclination to camouflage the disturbing realities of mental illness is nowhere more vividly illustrated than in the case of the now almost forgotten condition of 'neurasthenia'. In support of academic theses predicated on the centrality of 'shell shock', modern studies have conflated the two conditions, omitting any examination or explanation of neurasthenia itself. Its importance as a medical entity during the Great War, however, may be judged from the fact that it accounted for no less than 119 of the 500 cases studied in Chapter Three. Embracing as it did a complex psychological, neurological and physical symptomatology, neurasthenia was applied to a wide range of disorders. In mid-



1915, for example, William Aldren Turner, who at that time was the British Army's senior neurologist, published a major article in which he reviewed the arrangements for the care of neuropsychiatric casualties arriving from overseas. He stated:

The term "neurological" is used in this paper to refer to *unwounded* cases suffering from neurasthenia, the functional paralyses, hysteria, and the milder psychoses.<sup>10</sup>

Chapter Four examines in detail the nature of neurasthenia, as well as its significance within the context of neuropsychiatric casualties generally. Specifically, the argument is advanced that, as a matter of policy, neurasthenia was diagnosed in officer casualties as a means of limiting public awareness of potentially destabilising social, cultural and military disciplinary factors.

Within the army's strict hierarchy, antipathy between the officer class and other ranks encouraged the formation of what is described here as the 'Comradely Group'. Evidence drawn from secondary and previously unresearched primary sources is used in support of the argument that such groups were a fundamental part of the military social structure. Within the 'comradely group', it is contended, soldiers sought protection from the countless petty restrictions and sanctions to which they were subject. Mental and nervous disorders imposed intolerable strains on relationships within the comradely group, often resulting in the persecution and exclusion of the sufferer. Case histories in which these factors played a significant part are

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<sup>10</sup> Turner W.A., 'Arrangements for the Care of cases of Nervous and Mental Shock coming from Overseas', *Journal of the Royal Army Medical Corps*, Vol.27, July-December 1916, p.621. An excellent illustration in support of the argument for careful control of language. Turner's phrase 'milder psychoses' in modern usage is a contradiction in terms, since by definition 'psychosis' now identifies the more severe mental disorders. See Reber A.S., *The Penguin Dictionary of Psychology*, Penguin, (London 1985), p.596.

analysed, as is the question of whether mental and nervous disorders were the cause, or the consequence, of these disruptive social forces.

### **Treatment at home and abroad**

Part Three is set out in two chapters, describing respectively aspects of the forms of treatment adopted in Continental Europe and in the United Kingdom. Through the wartime career of Charles Samuel Myers, Chapter Six examines the changes in policy and practice that took place, largely at his instigation, between the outbreak of hostilities and the Battle of the Somme in mid-1916. The most significant outcome of this re-alignment in policy was the introduction of what became known as the 'N.Y.D.N.' ('Not Yet Diagnosed - Nervous') Centres, intended to provide treatment immediately behind the front line. It was in bringing about these changes, however, that professional and military politics played a significant part, resulting in the eventual departure of Myers from France and his marginalisation in subsequent events. Chapter Seven describes the therapeutical strategies adopted at these centres, assessing their influence on the British Army's military medical policies.

Part Four deals, in Chapters Eight and Nine, with the arrangements made for the treatment of neuropsychiatric casualties in the United Kingdom. Chapter Eight deals specifically with a previously unresearched aspect of these arrangements - the Asylum War Hospitals Scheme. Under the scheme, a quarter of the public asylums were handed over to the military, initially for use as general medical and surgical hospitals. The fact that some were put to use as centres for the treatment of mental and nervous casualties gave rise to



widespread concern, not least on the part of those for whom the reform of the asylum system had been a pre-war ambition.

The theme of treatment in the United Kingdom is pursued in Chapters Ten and Eleven through an examination of the wartime careers of two major figures, Ronald Rows and William Rivers. Coming as they did from markedly different backgrounds, and having followed separate and distinct professional paths to involvement in the events of the Great War, these two men made significant contributions to the history of neuropsychiatric medicine during the conflict. Following a pre-war career as a psychopharmacologist in a number of public asylums, Rows took charge of what was arguably the most influential treatment centre for mental and nervous casualties, the Moss Side Military Hospital near Liverpool. An ardent reformer and dedicated disciple of Freudian psychiatry, Rows led a disparate and frequently changing gathering of psychologists and neurologists, whose successes eventually placed the hospital at the forefront of wartime treatment strategy. The effectiveness of Moss Side was also instrumental in convincing a sceptical and at times hostile Army establishment of the value of psychological therapies. His post-war career, however, brought perhaps less distinction than he deserved, and Rows's achievements are confined largely to the Great War period. The thesis benefits from having unearthed some of Rows' original casenotes from Moss Side, giving unique insights into his clinical methods, and throwing new light on the clinical approaches of one of the most influential wartime figures.

After an eclectic pre-war professional experience, W.H.R. Rivers has emerged without doubt as the best-known 'psychiatrist' of the Great War. A prolific and highly regarded writer on his own specialities, much of the Rivers myth, and his reputation as a prototypical psychiatrist, rests on his involvement with literary figures such as Siegfried Sassoon and Robert Graves. Concentrating on evidence other than Sassoon's fictionalised memoirs, and discounting modern fictional references such as Barker's *Regeneration*, Rivers' wartime contribution is re-evaluated. In particular, his early involvement with Rows's Moss Side hospital is subjected to re-appraisal in the light of his contemporaries' views, and some important qualifying factors in the evolution of his reputation are examined.



## CHAPTER ONE

### MENTAL HEALTH IN BRITAIN BEFORE 1914.

#### 1.1 Cure *versus* incarceration.

Like most long-established professions, the medical profession tended to view innovation with a cautious eye. In 1901, *The Lancet*, under the heading 'Psychopathic Hospitals' reported a decision by the authorities in New York State to set up such a hospital for the treatment of early and incipient cases of mental disorder. The report observed that the 'curative treatment of insanity was as yet... in its infancy'. That particular volume of *The Lancet* listed 'psychopathic', 'mental disorder', and 'insanity' in its index, but made no mention of 'psychiatry'.<sup>1</sup> Later that same year a similar proposal in respect of the Royal Infirmary, Edinburgh, formed the subject of a major editorial under the heading 'The Edinburgh Scheme for a Psychiatric Clinique.' *The Lancet* came down firmly in favour of the scheme, maintaining that it was 'not only excellent in itself but is worthy of the most careful consideration at other hospital centres.'<sup>2</sup>

Adopting a curative rather than a carceral approach to mental illness was, as *The Lancet* pointed out, an idea that was 'not entirely new', and one that was having one of its periodic airings at the time. Psychiatric clinics attached to general hospitals were part of an agenda for reform of the British mental health system, an agenda which included better training for medical students, postgraduate courses in psychiatric medicine for the benefit of those wanting to make a career in the speciality, and, of prime importance, a change in the law to allow voluntary in-patient treatment at existing asylums. Use of the designation 'mental hospital' in place of 'asylum' was very gradually making headway at this

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<sup>1</sup> *The Lancet*, January-July 1901, Index p.xxv.

<sup>2</sup> *ibid.*, 29 June 1901, p.1841.

time, and was one of the outward signs of inward grace which reformers sought. Also, the change of title from 'Lunacy Commission' to 'Board of Control' in 1913 was seen as symbolic of a desirable move away from an emphasis on lunacy, lunatic asylums and incarceration, towards mental illness and voluntary treatment in 'mental hospitals'.

The relationship between universities, hospitals and psychiatric research in countries such as Austria and Germany had historically been much closer than in Britain, with psychiatric clinics commonly utilised for training and clinical experience by students and hospital teaching staff. It seems probable, therefore, that the term, already in use on the Continent, was deliberately chosen by the sponsors of the scheme - 'the chief physicians of Edinburgh' - to identify their initiative as a radical departure from the asylum system. A careful search has failed to identify any formal decision by this or any other relevant professional body, or by the medical press, to adopt the new terms. From that time onwards, however, 'psychiatry' and 'psychiatrist' became the nouns of choice, with articles, editorials, correspondence, etc. employing them routinely. On this point, however, John Crammer sounds a cautionary note:

Use of the words 'psychiatry' and 'psychiatrist' in common English really date from the 1930s (though first imported as early as 1846, but very rarely used). [...] This is a warning that the medical specialism so named, and the special doctors who practise it, are new, and that the kinds of illness accepted for treatment and the kinds of treatment given have changed very considerably since about 1900.<sup>3</sup>

It must be said that few modern writers have chosen to heed Crammer's timely warning, the terms often being misapplied without apology to practitioners of

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<sup>3</sup> Crammer J .L., 'Training and Education in British Psychiatry 1770-1970', in Freeman H., and Berrios G .E., *150 Years of British Psychiatry, Volume 2: the Aftermath*, Athlone (London 1996), p.209.



decades and even centuries prior to their emergence. In defence of the modern writer, however, it must also be admitted that the availability of such universally recognised terms is a great convenience. To ignore their usefulness and to insist on the employment of archaic terms would not only complicate an already difficult subject, but would also invite a charge of unhelpful pedantry. In the interests of clarity and consistency, therefore, the convention described above is adopted throughout this thesis. Where the context demands otherwise, the employment of archaic terminology is explained.

One final point regarding terminology may be made. In order to maintain as clear a distinction as possible between the two main groups discussed in the present work, the terms 'mental' and 'nervous' are routinely applied. As a convenience, however, the term 'neuropsychiatric' is also employed to refer collectively to the mental and nervous disorders examined here.

## **1.2 Professional consciousness - professional conflict.**

Psychiatry in Britain in the decades before the Great War can best be described as being in the late stages of emerging as a specialism within the broader framework of medicine. For a number of reasons - social, political, religious and professional - the generative process had been protracted and difficult.<sup>4</sup> Some of the later events in the development of psychiatry in Britain bear directly on the strategies adopted by the military medical authorities for the treatment of mental and nervous casualties during the Great War, and are thus relevant to the aims of the present work. In tracing the antecedents of those influences, a signpost may be most conveniently placed in 1841, with the foundation of the Association of

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<sup>4</sup> Jones, *Asylums and After*, p.93.

Medical Officers of Asylums and Hospitals for the Insane, marking the first public moves toward the professionalisation of psychiatry. As a distinct speciality within medicine, psychiatry emerged, not as the result of its being an established specialisation in an expanding medical profession, but as the result of a developing community of interest within the ranks of mad-house proprietors and the increasing numbers of medical staff in public asylums. By the 1830s almost all the public asylums had a resident Medical Superintendent.

Before the reforms of the nineteenth century, the ranks of the mad-house proprietors included candidates for sainthood, humanitarians, entrepreneurs, profiteers, scoundrels and monsters of cruelty and depravity. At their worst, their activities were the subject of scandal and public outcry and, from the first two decades of the eighteenth century, attempts to curb their excesses through legislation. The desire to establish a distinct identity within the medical profession was made more fervent by the prospect which surrounded mental specialists on every side during the middle decades of the nineteenth century. Emergent physical disciplines were being adopted as legitimate components of the wider profession of medicine almost as a matter of course. This was especially true of neurology, some aspects of which bordered closely on those of psychiatry, and of psychology which, springing as it did from roots in philosophy, had already become firmly established, albeit as more of an academic than a clinical discipline.

There is no evidence in the medical journals that the pleas of psychiatry to be likewise admitted to the charmed circle were overtly rejected, and it would be difficult to find rational professional grounds for such an exclusion. Even so, signs were appearing of divisions between psychiatry itself, as represented by the



proprietors of private 'mad-houses', and the medical staff of public asylums, and also between these two groups and the wider medical profession. As far as the medical press of the time was concerned, however, the whole question of whether or not to pass the warm cloak of fraternity around the shoulders of those engaged in the business of madness was not actively pursued. Although specific objections remained unvoiced, and although matters of mental health such as articles and asylum reports appeared routinely in *The Lancet* and the *British Medical Journal*, efforts to secure wholehearted acceptance for psychiatry were sporadic and inconclusive. As Freidson (1970) has pointed out:

Any profession bases its claim for its position on the possession of a skill so esoteric or complex that non-members of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly.<sup>5</sup>

It was clear that psychiatry and psychiatrists failed in some vital sense to meet the criteria demanded for full acceptance of themselves and their specialism by the medical profession at large. The solution to the problem, however, was not made easier by the fact that many of the proprietors of private asylums, and all the medical staff of public asylums, were medically qualified. Their claims to be recognised could not, therefore, be rejected on that score. At the same time there were undoubtedly reservations concerning psychiatry's lack of respectable antecedents, with the whiff of scandal, cruelty and neglect scarcely yet dispersed. Within the 'mad business' itself, divisions between the medical staffs of private licenced houses and public asylums were becoming increasingly evident. In the private sector there was resentment of the fact that public asylums were, in effect, supplied with patients by the legal system, while the mad-houses prospered

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<sup>5</sup> Freidson E., (1970), (Cited in Scull A., *Museums of Madness*, Allen Lane, (London 1979), p.165.



or starved on the strength of their reputations alone. Paradoxically, it was the earlier excesses of some mad-house proprietors that attracted most opprobrium, whilst, in a rigidly stratified society, they considered themselves socially superior by virtue of their housing a better class of patient:

The division reflected wide differences in the social status of the patients treated by the two sets of practitioners, and the inevitable divergences of interest and outlook between salaried public employees and private, fee-dependent entrepreneurs.<sup>6</sup>

In addition to the problems of demarcation and the persistence of scandals associated with the madness business, there existed a deep suspicion that much of the expertise claimed by its exponents lay in the invention of untestable hypotheses and ambiguous terminology. There was, it was thought, something contrived, something artificial, about psychiatry's increasingly complex vocabulary, a suspicion that its claims stood at something of an angle to what was regarded as acceptable scientific rigour. Obscurantist nosologies, it was thought, were no substitute for reproducible research.

The only practical value of these impenetrable excursions was to the writers themselves, in the sense that they could be used to support their claim that insanity was too complex a subject to be understood by other than themselves. But that was precisely the kind of abstruse contention with which the rest of the medical profession took issue. It was not simply that managers of the mad business surrounded themselves with a thicket hedge of words. To some extent that was expected of all putative specialisms, and the medical profession was generally tolerant towards jargon. The sticking point lay in the fact that little or nothing in the way of cure or alleviation emerged from the 'verbal gymnastics' employed by

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<sup>6</sup> Scull A., *Museums of Madness*, Allen Lane, (London 1979), p.165.



the mad business. As self-proclaimed experts in the field, asylum doctors were expected to make tangible progress in elucidating the mysteries of the disordered mind. Plucking new definitions out of the air and adding ever more sub-classifications of the various mental maladies only deepened the suspicion that psychiatry depended more on smoke and mirrors than on solid evidence-based science. The inclusion of medical terms and phrases did not transform flawed reasoning, nor did complexity beguile the medical profession - itself no stranger to linguistic sleight-of-hand. As Andrew Scull observes, however, the crucial point was that such evasions 'made no progress at all' towards the identification of hard facts concerning mental ill-health:

Indeed, their uselessness for all practical purposes [...] is so great that many of these very same writers cheerfully concede, elsewhere in their treatises, that their formal distinctions are of no help whatsoever when it comes to the question of deciding someone's sanity.<sup>7</sup>

The situation had apparently improved very little thirty years later. Posing the question 'What is insanity?' in an editorial of 1880, *The Lancet* maintained that any competent medical practitioner was capable of recognising a lunatic. The main difficulties lay not in identifying the 'strongly marked' cases of lunacy; they were likely to be all too obvious. The real difficulty arose when the symptoms were mild, intermittent or transitory. The medical man under pressure to decide whether or not the patient before him was insane, found that the interposition of the law in what ought to be a purely medical judgment 'cripples his action', making it impossible for him to reach the only decision for which he had been trained. It was all too likely, *The Lancet* argued, that at a later stage and in wholly altered circumstances, a judge and jury, without benefit of medical skills or knowledge of the initial circumstances, might overturn the verdict of the doctor and declare the

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<sup>7</sup> Scull, *Museums of Madness*, pp.235-6.

patient to be sane. In such cases the doctor suffered not only loss of reputation and personal anguish, but might also 'be cast in a suit for damages' and ruined.

This points to one of the oddities of early psychiatry, namely that a seemingly inexhaustible flood of literature had emanated from the lunatic asylums from the very beginning, yet here was *The Lancet* arguing - and apparently reflecting a prevalent opinion - that no one, not even the greatest supposed experts in 'mental medicine' had defined what it was they were talking about. But the editorial went a good deal further. The greatest single obstacle to a truly effective system of treatment for mental illness, it argued, was that medicine was in thrall to the legal profession, a burden endured by no other profession. Until those bonds were loosened mental diseases would continue to go untreated. Doctors, no matter how expert or experienced in the field of mental medicine, had to face the prospect of their professional decisions being set aside, not by superior medical expertise, but by wholly unskilled laymen.

Another pitfall which lay in the path of the unsuspecting doctor was the not infrequent case where the family of a patient plotted to have him or her declared insane in order to lay hands on his property. Mrs. Georgiana Weldon was a beautiful and eccentric lady 'of considerable means and some social position'. Her husband, who held the Crown appointment of Windsor Herald, had deserted her in 1875, leaving her with a house and £1000 a year. In 1884 he conspired with one Dr. Forbes Winslow, the proprietor of a private asylum, and petitioned to have Mrs. Weldon committed there. As the law stood at the time, a married woman's property might legally belong to her husband. Dr. Winslow, with the husband's consent, arrived at the house to force an entry and to carry off Mrs. Weldon.



Having got wind of these plans, however, the lady had contacted the Alleged Lunatics' Friend Society, with whose help she escaped, disguised as a nun.

In Kathleen Jones's words, the case contained 'all the features of a popular *cause celebre*' - high society, a beautiful and wronged lady of fortune threatened with incarceration, and with greed, infidelity and cupidity at the heart of it all.<sup>8</sup> The case eventually gave rise to changes in the law of married women's property, but not before the redoubtable Mrs. Weldon, with some success, had sued husband, doctors, press and anyone else within range, and had hired the Covent Garden Opera House to put her case before the public. These events were only a few years in the future when *The Lancet* expressed the following complaint:

In the case of no other class of patients is the medical adviser so strangely placed. It is not enough that a sick person is brought to him for instant judgment, he is confronted at the outset by the danger of a legal penalty in the event of a failure to recognise that he is being hoodwinked by the friends, or misled by the fancies, of his patient.<sup>9</sup>

There was clearly more than a hint of criticism in the editorial, and more than a faint distaste for the fact that, as the nineteenth century drew to a close, asylums had degenerated from their early promise as hospitals for the treatment and cure of mental diseases, into what Andrew Scull has famously called 'Museums of Madness' - vast warehouses for the anonymous storage of the detritus of an increasingly intolerant and uncaring society, and a perfect example of the tendency to treat symptoms rather than the disease.

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<sup>8</sup> Jones, *Asylums and After*, pp.102-3.

<sup>9</sup> *The Lancet*, 27 March 1880, p.497.

Whether good, indifferent or execrable, mad-house proprietors were nevertheless in daily contact with mental deviance in all its forms. Not only that; by their nature they dealt with the moneyed classes. It was natural and inevitable, therefore, that the best of them should in time wish to cleanse their profession of the mire of scandal, and to seek a respectable place in society for themselves and their calling. In time they were able to attach labels to differing conditions, could mark the differences between male and female sufferers, gain practical experience in handling violent and intractable cases, as well as differentiating between what appeared to be curable and incurable conditions. This semiology, supported by comparisons systematised over time, allowed a complex nosology to be built up. Knowledge and familiarity, insulated by exclusivity, begat confidence and a desire to impress, and a new class of specialists in mental disorders began to coalesce around their own social and professional interests:

...this new group of 'experts' was the creation of their own professional organization, the Association of Medical Officers in Asylums and Hospitals for the Insane [which] drew its membership from the medical staff of both public and private asylums.<sup>10</sup>

The turnkey was thus progressively transformed into the amateur expert, then the 'mad-doctor', the 'alienist' and, finally, the 'psychiatrist'. The whole process, from the mid-eighteenth to the mid-nineteenth centuries, was accompanied by increasing professionalisation, but one which took place away from the daily attention of the public and of the medical profession as a whole. This characteristic separateness ranked amongst the most potent factors contributing to the tardiness of professional recognition for psychiatry and its adherents. Paradoxically, the fact that, from the middle years of the nineteenth century, asylum doctors worked under a regulatory regime unprecedented in its stringency

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<sup>10</sup> Scull, *Museums of Madness*, p.164.



did not inspire confidence in the public, nor did it confer respectability in the eyes of their medical brethren. On the contrary, the very stringency of the lunacy laws was taken as proof of psychiatry's relative immaturity as a medical discipline. No other branch of medicine was so hedged about with legislation, nor so dependent for its position on the goodwill of lay committees - 'Managers of the Mad', as Andrew Scull has termed them.<sup>11</sup> Predictably, the rise of the public asylums accelerated the expansion of the professional management of insanity. Within the social and professional constraints outlined above, the number of asylum doctors was increased to cope with the added burdens of administration under successive Lunacy Acts, and to care for the physical health of sometimes hundreds of patients, often at the expense of their mental well-being.<sup>12</sup>

As a discrete group, their influence was strengthened by the later legislation, which allowed medical practitioners to lay exclusive claim to the post of medical superintendent. Towards the end of the nineteenth century, the public asylums achieved a virtual monopoly of madness, and the privately run asylum tended to become an increasingly rare feature. This new-found prominence, however, could not erase the fact that psychiatry was the doubtful offspring of the mad-house. As a specialism it had not emerged, as had other medical specialisms, from increased medical knowledge and the general expansion of the profession, but from a desire on the part of mad-house entrepreneurs and later the asylum doctors, to formalise their empirical practices as a means of legitimising their hegemony. Roy Porter puts it thus:

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<sup>11</sup> Scull, *Museums of Madness*, pp.171-80.

<sup>12</sup> Jones, *Asylums and After*, p.116.

...the eighteenth-century private madhouse became the formative site for the development of psychiatry as an art and a science. Asylums were not instituted for the practice of psychiatry; rather psychiatry was the practice which developed once the problem of managing asylum inmates arose.<sup>13</sup>

It was an accident of birth that was to result in chronic professional and social disadvantages for the fledgling profession. Lacking the recognition and support of a paternal medical profession which would have conferred legitimacy as a matter of course, psychiatry was obliged to seek respectability by some other route. It was also necessary for time to elapse, in the hope that the sordid circumstances of its parturition might be forgotten. Ironically, one of the reasons for procrastination in the search for professional respectability was the 'class distinction' that existed between the private and public asylums. Given its dubious history, it might be expected that the private sector would accept that the public asylums, legitimated as they were by Act of Parliament, would take precedence. As it was, medical practitioners in private asylums regarded themselves very much as the superior beings, largely on the basis of the class of lunatics in their care. These and related differences lessened the effectiveness of what might otherwise have been a potent force in the struggle for recognition. Certainly, the diluted influence of the Association 'hampered moves to unify the profession'.<sup>14</sup> It was a factor - arguably the most significant factor - in the failure of psychiatry to achieve its professional goals before the nineteenth century drew to a close.

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<sup>13</sup> Porter R., 'Madness and its Institutions', in Wear A. (Ed.) *Medicine in Society: Historical Essays*, Cambridge University Press, (Cambridge 1993), p.289.

<sup>14</sup> Scull, *Museums of Madness*, pp.164-5.



## CHAPTER TWO

### HEGEMONY, RESISTANCE AND REFORM ON THE EVE OF THE GREAT WAR.

#### 2.1 The hegemony of the public asylum system.

The preceding chapter has examined some of the factors which prevented psychiatry acquiring the status and influence to which its protagonists aspired. All of these were closely bound up with the history of the treatment of insanity, and all were responsible to a greater or lesser extent for the public perceptions of psychiatry and psychiatrists. After the reforms of 1845, when the worst excesses of the private asylums had been swept away, legislation established the framework within which public management of asylums was made possible. Those powers had been acted on in most counties, and the second half of the nineteenth century saw the number of public asylums rise from 24 to 77, and the number of inmates from 2,140 to 77,004. Judged solely by the criteria of buildings and patients, therefore, public asylums were an unqualified success.<sup>1</sup>

But this apparent success came at a price not paid by other medical specialisms, namely, the attachment of a strong and eventually dominant legal element, which would permanently characterise the care of the mentally disordered. Its stated aim was to protect citizens from unlawful confinement. Its effect, however, was to seriously and permanently constrain the freedom of the medical profession to extend the care of the mentally disordered into the early and incipient stages. As with all bodily ailments, early treatment of mental disorders was generally regarded as a desirable objective, but as the

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<sup>1</sup> Jones K., *Asylums and After*, Athlone, (London 1993), p.116.

process of regulation developed, so fears of unlawful incarceration grew. In response to these fears, the Alleged Lunatics' Friend Society was founded in 1845 by Luke James Hansard, son of the Parliamentary printer. The Society attracted strong support, particularly from MPs, and soon set about investigating specific complaints of unjust confinement, using its influence in the House of Commons to publicise abuses. This influence was strengthened by the fact that, at the time, the Commons contained proportionately more lawyers than is the case today. They in turn were able to bring pressure to bear on the government through the Lord Chancellor, the head of their profession. An important result of the Society's campaigning was that the Lord Chancellor's Office assumed control of the Lunacy Commission and, by extension, exerted a crucial influence over the asylum system as a whole:

Legal interest in lunacy law was focused on the protection of the sane against illegal detention, rather than on the care and treatment of the insane. While the medical profession stressed the importance of early treatment, the legal profession piled safeguard on safeguard to prevent it.<sup>2</sup>

After the Lunatics Act of 1845 reached the statute book, the rules for admission to a public asylum assumed Byzantine complexity. Under an entirely new Lunacy Commission, formal certification of insanity had to be made by two qualified medical practitioners, supported by statements from each that they had enquired into the patient's medical and social history. In the case of pauper lunatics, the petition was also to be signed by a magistrate, supported by detailed statements from the parish authorities. For the first time, the entire system for the care of the insane in England and Wales was brought under one over-arching authority, incorporating arrangements for certification, admission

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<sup>2</sup> Jones, *Asylums and After*, p.94.



to institutions, inspection, record-keeping and final disposal of the case. Its very comprehensiveness, however, was to prove inimical to change of any kind, and its very complexity militated against the belief that early treatment held out the best hope for recovery.<sup>3, 4</sup>

The reforms of 1845, like those that were to follow, approached insanity as a social rather than a medical problem, and thus failed to realise the potential of the asylum system to become the cornerstone of a curative ethos for mental illness. The legacy of the mad-house, and the barbarity and neglect to which the lunatics of the second half of the eighteenth century had been routinely exposed, ensured the postponement of any progress towards a genuinely curative approach to mental illness. While the 1845 reforms set the pattern for the care of the insane for the next forty-five years, they were no more a solution to the underlying problem of mental ill-health than anything that had gone before. Any moves towards establishing hospitals for the treatment and cure of the mentally ill were thrust aside by the perceived need to remove embarrassing and possibly dangerous deviance from the gaze of decent people.

This effort to rewrite the legal rules concerning the treatment of the insane gave rise to opposition from an unexpected quarter. It necessarily involved interference with the 15,000 or so poor law administrations, which had previously possessed authority to dispose of the insane, together with other

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<sup>3</sup> Scull A. *Museums of Madness*, Allen Lane, (London 1993), p,111.

<sup>4</sup> The lunacy laws in Scotland were always separate and distinct enactments, and are not included in the remarks recorded here.

indigents, with virtually total freedom from central supervision and control.<sup>5</sup> Almost before the ink on the 1845 statute had dried this factor, and renewed accusations of corruption, unlawful detention, neglect of patients, peculation and a host of other complaints kept the subject before the public gaze.

This in turn prompted the formation of pressure groups, ensuring publicity for the two main opposing causes in the management of lunacy. Firstly, the threat to personal liberty - the main preoccupation of the legal interest and, secondly, fears that hordes of homicidal maniacs might be let loose upon an unsuspecting populace. Both were guaranteed to increase newspaper sales, and were thus assured of space. And in all of this 'the asylum doctors were the villains of the piece', largely on the grounds that, having laid claim to exclusive expertise in the matter of madness, any attempt on their part to evade the concomitant responsibility was resented.<sup>6</sup> In 1877, a government Select Committee was set up to look into alleged abuses, partly as the result of the publication in 1863 of Charles Reade's novel *Hard Cash*.<sup>7</sup> This purported to be a true account of conditions as they existed in some asylums, based, according to the author, on 'a multitude of volumes, journals, pamphlets, reports...and people I have sought out'.<sup>8</sup>

Kathleen Jones believes this statement was 'probably true', but goes on to point out that the novel is set firmly 'in the post 1845 period' and that the details of admissions and discharges quoted by Reade are those of the 1845 Act,

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<sup>5</sup> Scull, *Museums of Madness*, p.84.

<sup>6</sup> Jones, *Asylums and After*, p.104.

<sup>7</sup> Reade C., *Hard Cash*, Cassell, (London 1863), 1909 Edn..

<sup>8</sup> Jones, *Asylums and After*, p.98.



whereas most of the abuses cited are clearly drawn from earlier years and are illustrative of the conditions the Act was designed to remedy. For the average reader, however, the full implications of the conflation would tend to be lost in the thrill of horror as the fictional hero was kidnapped, beaten and drugged.<sup>9</sup>

## 2.2 Reform and resistance.

1877 was an especially prolific year for high-profile investigations into British mental health provision. In that year, as well as the Select Committee, *The Lancet* set up its own fact-finding commission under the title *The Care and Cure of the Insane*. Concentrating on London and the Home Counties, and taking in private as well as public asylums, the commission found a disquieting state of affairs. After a brief period of tangible reforms following the introduction of the 1845 Lunacy Act, the old ways had been allowed to re-establish themselves, with little effort by the authorities to root out those responsible.

At Hanwell, where John Conolly's policy of total non-restraint 'had done much to give substance to the claim that asylum treatment of the insane represented a humanitarian advance',<sup>10</sup> the commission found that, though there was no overt physical ill-treatment of the patients, it was 'difficult to believe that there was any progress'.<sup>11</sup> At Dartford, the stairways were draughty and damp and the patients' clothing 'worn and dirty'. In the worst cases there was a general air of cynicism, resignation and monotony. The

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<sup>9</sup> Jones, *Asylums and After*, p.99.

<sup>10</sup> Scull, *Museums of Madness*, p.187.

<sup>11</sup> Jones, *Asylums and After*, p.101.

medical staff, the members of the commission concluded, took insufficient interest in what was going on, with the result that:

Everywhere, attendants, we are convinced, maltreat, abuse and terrify patients when the backs of the medical officers are turned. Humanity is only to be secured by watching officials.<sup>12</sup>

But the picture was not one of unrelieved gloom. At Bethlem and St.Luke's 'outstanding' work was being done, although both were said to be overcrowded. The latter institution's work was said to be 'starved and crippled' for lack of endowment, a fact which, the commission complained, 'reflects dishonour on our great City firms and the wealthy classes of the metropolis.'<sup>13</sup>

In that same year (1877) attempts were made in Parliament to reform the asylum system by making it an 'Imperial' responsibility and thus taking control out of the hands of local authorities. But government in Britain had not yet reached the stage where 'the State' could replace the essential parochialism of the British social landscape. As *The Lancet* observed with some asperity, Liberal administrations were not noted for their love of centralisation, and reforming ideas came to nothing. Agitation for reform of the lunacy laws continued for the next decade, fuelled by newspaper accounts of unlawful confinement on the one hand and of murderous attacks by escaped lunatics on the other. In Parliament, Lunacy Bills, amendments to Bills, withdrawal of Bills and all the intricacies of the political process occupied the time and energies of innumerable interested parties until 1890, when a new Lunacy Act finally

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<sup>12</sup> Jones, *Asylums and After*, p.101.

<sup>13</sup> Quoted *ibid*.



surmounted all the hurdles and became law. It was destined to remain in force until 1959:<sup>14</sup>

...the Act was an extremely long and intricate document, expressing few general principles, and providing in detail for almost every known contingency. Nothing was left to chance, and very little to future development.<sup>15</sup>

Despite its comprehensiveness and devotion to minutiae, the reforms of 1890 failed to address some of the long-standing difficulties surrounding mental illness which, if tackled with understanding and commitment, would have significantly improved the quality of treatment given to the mental and nervous casualties of the Great War.

## 2.2 The cry at the gate: pressure for early treatment.

The first, and arguably the most important of these problems was that of early treatment. The 1890 Act, like all the lunacy statutes before it, was concerned not with mental illness, but with insanity as a medical, legal and social problem. It was still the case that unless and until the medical and legal professions agreed that a person was in fact insane, there was no avenue of treatment available to those who lacked the means to pay for private care. At the annual meeting of the British Medical Association on 30 July 1902, the President, Sir John Sibbald, referred to a proposal 'recently submitted to the profession in Edinburgh' to the effect that wards for the treatment of the early stages of mental disease in 'persons of the poorer classes' should be established

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<sup>14</sup> For an accomplished account of the evolution of later lunacy legislation and especially the influence of the Commissioners in Lunacy, see Hervey N., 'A slavish bowing down: the Lunacy Commission and the psychiatric profession 1845-60', in Bynum W.F., Porter R. and Shepherd M., *The Anatomy of Madness: Vol.2*, Tavistock, (London 1985), pp.98-131.

<sup>15</sup> Jones, *Asylums and After*, p.101.

in general hospitals. Recognising that the asylum authorities had tried to make their institutions 'more and more efficient as hospitals', Sir John maintained that, despite their efforts, committal to an asylum still carried with it a stigma that was liable to remain with the sufferer for life:

...justly or not, [they are] handicapped in their future careers after being discharged as recovered. The friends and relatives of patients therefore felt a natural reluctance to avail themselves of the benefits to be obtained in asylums.<sup>16</sup>

In many general hospitals there were wards for the emergency admission of those suffering from 'acute alcoholic or other forms of mental excitement or delirium'. Such cases, however, were admitted only as a temporary expedient. If they improved quickly they were discharged; if their condition worsened, certification and transfer to an asylum would normally follow:

The present situation might be summed up in two propositions: first, persons suffering from mental disorders in their early stages were not, and under British lunacy law could not be, provided for in asylums; and, secondly, such patients were at present, as a rule, unprovided with hospital treatment of any kind.<sup>17</sup>

All that was being suggested, Sir John went on to say, was that general hospitals should provide for incipient mental illness as they provided for any other kind of bodily malaise. The patients' stay would be limited to no more than six weeks. This would actively prevent the wards being used for 'any except incipient cases'. At the same meeting it was reported that, during the previous five years, 3129 cases of mental disorder had been treated at the Mill Road Infirmary in Liverpool. Of these, no less than 1006 (32%) had been discharged as 'recovered' within 17 days, the maximum stay allowed. It was

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<sup>16</sup> *The Lancet*, 9 August 1902, p.382.

<sup>17</sup> *ibid.*



understood that similar results had been achieved at hospitals in Manchester and Glasgow.<sup>18</sup>

Others attending cited a recent report from Copenhagen stressing the value of the Danish policy of employing female nurses in general hospital wards dealing with the early stages of mental illness. In contrast to the proposal of attaching mental wards to general hospitals, some speakers advocated the provision of special mental hospitals, quite separate and distinct from asylums and general hospitals, where patients presenting with the early symptoms of mental illness could be treated without the need for certification. Such ideas, it was claimed, were now very much 'in the air' within the medical profession. This latter proposition, however, failed to attract any substantial support, on the grounds that there was:

...an insuperable objection to this scheme...by whatever attractive name such hospitals might be designated they would be classed by the public as "asylums," and the patients whom it was wished to benefit would accordingly shrink from entering them.<sup>19, 20</sup>

A significant benefit of establishing special mental wards or even special mental hospitals, was the opportunity it presented to the medical profession - students and practitioners alike - of being able to examine cases of mental disorder in the very earliest stages. Action could then be taken at the most critical period, before the condition had advanced to the stage where 'certification and sequestration in an asylum' was the only course left open. Other speakers at the

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<sup>18</sup> *The Lancet.*, 9 9 August 1902, p.383.

<sup>19</sup> *Ibid.*

<sup>20</sup> The implications of 'asylum stigma' for the treatment of military mental and nervous casualties are discussed at length in Chapter Nine.

<sup>20</sup> *The Lancet*, 9 August 1902, p.383.

meeting stressed this aspect as potentially one of the greatest gains, holding out as it did the prospect, not only of an entirely new approach to the treatment of mental illness, but one that promised significant improvements in the rate of recovery. Dr. Woods of Cork stated that he:

...would welcome any scheme that tended to promote the cure of mental disease in an early stage, as it was a fact that in the class of cases admitted to asylums the recovery rate was very low and it could be maintained as a general proposition that no more than 5 per cent of the population of our asylums were curable.<sup>21</sup>

As far as methods of treatment were concerned, however, it was clear from comments made during the discussion that the therapeutic strategies favoured by some of the speakers were not drawn from experience with the 'poorer classes', requiring as they did not only appropriate medication and a therapeutically regulated diet, but also prolonged rest in bed and 'continuous nursing day and night.' To put it mildly, these were conditions unlikely to be enjoyed by the working classes. As one delegate pointed out:

non-certifiable mental ailments such as hypochondriasis, hysteria and other like conditions [are] far more frequent in the social grades above that of the poor who, as a rule, had to work for their living and did not develop such neuroses and psychoses.<sup>22</sup>

It really was not much use *The Lancet* complaining in 1912 of the 'difficulties' under which psychiatry laboured, nor to note - somewhat petulantly - that English psychiatrists were not accorded the 'honoured place' given to other British medical professionals.<sup>23</sup> The facts were that the management of the mentally ill in Britain had grown directly from the horrors of the eighteenth

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<sup>21</sup> *The Lancet*, 9 August 1902, p.383.

<sup>22</sup> *Ibid.*

<sup>23</sup> *The Lancet*, 6 April 1912, pp.934-5.



century mad-houses, and had been transferred seamlessly (and without apparent demur on the part of the medical profession) into the monolithic public asylum system. By the final decade of the nineteenth century the asylums, and that branch of the medical profession serving in them, had settled into a state of stagnation and administrative routine. Innovation, such as it was, consisted of closer and yet closer observation of the huge asylum population, largely to ensure their continued bodily health, relying more on 'bed and bromide' and the passage of time for the recoveries that were effected.

The 1890 Lunacy Act was the great missed opportunity in British psychiatry. It offered the chance of reversing the long-established trend towards regarding the mentally ill as injurious to the public weal, and therefore to be dealt with as criminals. Indeed, as Kathleen Jones has argued, the criminal law was taken as the paradigm for the prescriptive structure of the lunacy law, enshrining in it the assumption 'that what is not forbidden is allowed'.<sup>24</sup> Such prescriptions may well envisage a multitude of possible transgressions; unlawful detention, cruelty, neglect of patients, avaricious relatives and so on. They also facilitate preventive rules; maintenance of records, frequency of inspections or medical examinations, dietary provision, clothing and exercise. Where prescription fails, however, is that it:

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<sup>24</sup> Jones, *Asylums and After*, p.112.

...could not (and cannot) cure patients, manage an asylum or a hospital, ensure that patients are treated with humanity, or improve staff morale. It could damage all these useful activities by a negative approach which encouraged the observance of the letter of the law at the expense of the spirit which originally inspired legislation.<sup>25</sup>

Those same laws provided that the day-to-day administration of public asylums should be in the hands of a medically qualified person, supervised by a 'Visiting Committee' consisting largely of magistrates. These laymen could, and in many cases did, issue the most detailed directives as to the conduct of the institution and could, if necessary, enforce their views by using their power to dismiss a superintendent without further appeal at any time. In speaking of 'the asylum system', therefore, we are speaking of a uniquely constituted medico-legal arrangement, under which the medical functions of asylum superintendents were always influenced, if not actually dictated by, the need for the most stringent economy in the conduct of the institution.<sup>26</sup>

Such powers were indeed invoked in a number of widely publicised cases during the latter half of the nineteenth century, none of which, incidentally, resulted in the superintendent concerned winning restitution, much less reinstatement. The subservience of even the most senior ranks of the asylum medical service to unqualified invigilation was thus one of the significant factors in dictating the relatively low status of psychiatry during the period.<sup>27</sup>

Another, and in the eyes of the medical profession as a whole even more telling

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<sup>25</sup> Jones, *Asylums and After*, p.113.

<sup>26</sup> Scull A., *Museums of Madness*, p.174.

<sup>27</sup> For commentary on the relationships between Medical Superintendents and Visiting Committees, see Wright D., 'The Discharge of Pauper Lunatics from County Asylums In Mid-Victorian England', in Mellin J. and Forsyth B., (Eds.) *Insanity, Institutions and Society 1800-1914*, Routledge, (London 1999), esp. pp.107 and 183-5.



point, was the inability of the asylum doctors to demonstrate the efficacy of the battery of 'therapies' inflicted on a defenceless clientele, subjected at various times to:

Hypodermic injections of morphia...bromides, chloral hydrate, hypocyminine, phsysotigma, cannabis indica, amyl nitrate, conium, ergot, pilicarpine ... electricity...the Turkish bath and the wet pack, and other remedies too numerous to mention, (all) have had their strenuous advocates during late years.<sup>28</sup>

Asylums in the eighteenth and early nineteenth centuries tended to be relatively small institutions: in 1827 there were nine 'city and county' asylums holding 1,046 patients, an average of 116 each. By 1900 the number of asylums had risen to 77 and the total population to 74,004, an average of 961 for each institution. In the smaller asylums it was possible to maintain at least some personal contact between staff and patient. In the 'warehouse asylums' of the late nineteenth and early twentieth centuries, all pretence of care for the individual patient had long since gone by the board. The emphasis was on cost-efficiency, patients carrying out the bulk of the manual work within the buildings themselves. Asylums were sited usually in ample grounds containing farms and large kitchen gardens. These were conducted with the sole aim of providing as much of the food as possible. Everything in these vast depositories of human wreckage had the single aim of working with the least possible cost to the rates, and the minimum of trouble for the staff.<sup>29</sup> By 1910, there were 91 county and borough asylums in England and Wales alone, holding 97,580

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<sup>28</sup> Tuke D. H., *History of the Insane*, (1882), p.485, (Quoted Scull, p.170).

<sup>29</sup> Jones, *Asylums and After*, pp.118-9.

patients.<sup>30</sup> From the establishment of the Lunacy Commission in 1829, the numbers admitted had risen steadily, to the stage where some 20,000 individuals disappeared behind the asylum walls every year. Every town of size had its asylum close by, hidden from the public gaze behind high walls and, by the very style of their architecture, organisation and administration, inward looking and anonymous.

By the final decade of the nineteenth century, Janet Saunders contends, asylums had largely discarded earlier reformist principles of care and cure, and had become an integral part of the late Victorian societal ethos of the institutional control of deviancy. Therapeutic treatment of the mentally unsound, Saunders maintains, had been:

...superseded by a policy of 'quarantine', in which isolating problem people from society became a key role of the institution.<sup>31</sup>

The mentally ill leisured classes, on the other hand, were in no need of employment, and their wealth made it possible for them to be housed in comfort and security until improvement, recovery or death supervened. However, to infer that complacency was the overwhelmingly prevalent attitude would be to mistake reality for mute acceptance. As the new century dawned, the shortcomings of the existing system of managing mental health came increasingly into question. In P.J.Lynch's words:

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<sup>30</sup> Jones, *Asylums and After*, p.116.

<sup>31</sup> Saunders J., 'Quarantining the weak-minded: psychiatric definitions of degeneracy and the late-Victorian asylum.' In Bynum W.F., Porter R. and Shepherd M., (Eds.), *The Anatomy of Madness, Vol.3, The Asylum and its Psychiatry*, Routledge, (London 1988), p.273.



From 1890 to 1914, then, one of the major factors influencing the study and treatment of the functional nervous diseases in Britain was the lack of coherent dialogue between the proponents of the established anatomo-pathological conception of mental disease, and those who felt that mental problems should be studied in terms of the mind, and not of the brain.<sup>32</sup>

Here again the terms 'functional nervous diseases' and 'mental disease' are used synonymously. Conflation of this kind is regrettably all too common, even in scholarship of an otherwise high order. The attitude of the wider medical profession to the asylum system and, more especially, to asylum medical officers, was one of ambivalence. During the first decade of the twentieth century, doctors were uniquely influenced by the ubiquitous presence of the asylum system, and by the role of the medical profession in the implementation of the lunacy laws. Asylum medical officers played no part in the actual process of certification and, indeed, the 1890 Act forbade such involvement for fear of collusion. Every medical practitioner, however, was authorised under the law to participate with another doctor in the certification of lunatics. General practitioners were thus an integral part of the established medico-legal system. Had the medical profession actively campaigned for reform, changes might well have been brought about. As it was, the introduction of psychiatric clinics, mental wards in general hospitals, and a properly constituted mental health service was sacrificed to a system deeply coloured by fears of wrongful detention, and intent on guarding against the excesses of the worst type of mad-house. Having agitated for rigid controls and an end to entrepreneurialism in the care of the insane, the medical profession found itself tied down by the

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<sup>32</sup> Lynch P. J., 'The Exploitation of Courage', Unpubl. M.Phil. thesis, University of London, (1977), p.19.

same rules, and unable unilaterally to extend its concerns into the increasingly important areas of preventive medicine.

Within the asylum service most, if not all, medical officers did their best to keep their thousands of patients clean, fed, docile and physically healthy. Outside, general practitioners had no option but to wait. Only when early symptoms had worsened to the stage where they or other doctors could certify insanity could their patients become eligible for admission to an asylum. In the hope of at least some relief patients were required to sacrifice liberty, dignity and, in all too many cases, any hope of restoration to a normal life. In some ways the relationship between the asylum system and the mentally disordered resembled that of pre-anaesthetic surgery. There existed the same deep-seated dread of the treatment itself, with the same recognition that, for some disorders, there was no practicable alternative. In the sense that it separated the insane minority from the sane majority the asylum system, once invoked, worked coldly, impersonally and efficiently. At the same time it reflected little credit on the medical profession, which conferred lower status on the practice of mental medicine; on successive governments, which continued to prevaricate on preventive mental health; and on society in general, which remained content as long as its human detritus was kept out of sight.

### **2.3 The battle of the therapies: physiological *versus* psychological approaches.**

Belief in organic factors as the primary causes of nervous and mental diseases, and the consequent fervent adherence to somatic remedies such as flogging, bleeding, purging, hot and cold baths etc., had been the mainstay of the



madness business since antiquity. In 1910 in Britain, the conviction that the cure for insanity lay in the restoration of some kind of 'nervous tone' or balance of humours' still had a substantial body of adherents, as yet untouched by the ideas coming from the Continent. In the case of neuroses too, assumptions of a physical foundation held sway, and gave way only gradually to an acceptance of psychological causes. Introducing J.T.McCurdy's work on war neuroses, W.H.R.Rivers in 1918 pointed to the changes in perception that had been brought about by the experiences of the war:

One of the lines upon which McCurdy's book will exert a strong educative influence lies in the clearness and definiteness with which it brings out the essentially psychological character of the war neuroses. In the early days of the war the medical profession, in accordance with the materialistic outlook it had inherited... was inclined to emphasise the physical aspect of the antecedents of a war neurosis.<sup>33</sup>

On the eve of war, then, the view that mental and nervous disorders had a physical origin still exerted a powerful influence, and was to be equally influential in determining the policies and practices adopted by both the civil and military authorities for the treatment of psychological and neurological casualties during the Great War. The outcome of these were, in the aftermath of war, to bestow on psychiatry and its practitioners a legacy under which emphasis on psychological rather than physical factors involved in mental disorders was strengthened. Moreover, because so many neurological conditions - paralysis, paraplegia, functional anaesthesia and others - had eventually been recognised as having a psychological rather than a neurological basis, the conflation of the two disciplines that had been so prominent a feature of

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<sup>33</sup> Rivers W.H.R., Introduction to McCurdy J.T., *War Neuroses*, (Cambridge University Press, (Cambridge 1918), p.vi.

treatment in the early days of the war was thus partially clarified.<sup>34</sup> The present clearer distinction between neurological and psychological disorders had its origin, at least in part, in the war-time recognition of the power of the mind to exercise a previously unsuspected degree of influence over bodily functions. In that sense at least, the effects of the Great War on psychiatry persist to the present day.

As a descriptive term, 'psychiatry' was by this time firmly established, at least within the medical profession itself, and was commonly used in the medical press and by those seeking enhanced status for the specialism. In March 1912, the Council of the Royal Society of Medicine resolved to establish a Special Section devoted solely to the interests of psychiatry. A meeting of a sub-committee of the Council followed in June and, on 22 October following, Sir George Savage delivered an Inaugural Address as President of the new section.<sup>35</sup>

There can be little doubt that the institution of a Special Section of the Royal Society of Medicine marked a turning-point in the fortunes of psychiatry in Britain. In the first place, it demonstrated a significant shift of opinion on the part of the majority of the medical establishment, in favour of the view that psychiatry ought to be allowed to stand alongside existing medical specialisms. Secondly, it conferred on psychiatry the official status of a cohesive and fully recognised discipline within the broader framework of the

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<sup>34</sup> Macpherson W.G., *et al*, (Eds.), *History of the Great War based on Official Documents: Medical Services: Diseases of the War*, Vol.2, H.M.S.O., London 1922), p.27.

<sup>35</sup> *The Lancet*, 26 Oct. 1912, pp.1134-7.



medical profession. Finally, and perhaps in the long term most importantly, it set psychiatry's feet on the path to achieving those other marks of professional, political and social approbation; the granting of a Royal Charter, self-governance within the framework of the wider medical profession, and the power to grant its own recognised qualifications. In short, the unquestioned respectability for which its adherents had yearned for so long.

The new section was to be under the Presidency of Sir George Savage (1842-1921), Consultant Physician and Lecturer on Mental Diseases at Guy's Hospital. At the age of seventy, Sir George had enjoyed a long career as a nerve specialist and was editor of the influential *Journal of Mental Science*, the official voice of the asylum medical service. His best-known work, *Insanity and Allied Neuroses*, written with Eric Goodall in 1884, was one of the standard texts, appearing in its fourth edition in 1907. In his inaugural address, Savage reproved some of his colleagues for their blinkered approach to the new ideas then coming from the Continent. Having given a brief historical sketch, he turned to the contemporary scene, and to the often narrow and dismissive attitudes being adopted:

Some among us see in the inquiries of Freud dangerous dwelling on the unhealthy side of our organic nature, but, just as we make use of powerful and poisonous drugs in treating disease, so we may have to make use of means which, if ill-judged, may be dangerous. There is always more danger directly we approach subjects which cannot be fully recognised by our senses.<sup>36</sup>

Savage went on to cover a wide range of topics of concern to contemporary psychiatry, including the relationship of the nervous system to psychological

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<sup>36</sup> *The Lancet*, 26 October 1912, p.1134.



medicine - what today would be referred to as the 'psychosomatic' aspects of medicine. Of particular significance to the subject of mental and nervous casualties of the Great War, however, was that of inherited predisposition to mental and nervous illness. This was a subject on which Sir George's views were tinged with poetical metaphor:

Waves of thought roll on and leave shore lines and raised beaches. Most of us have watched the tide of evolutionary thought as represented by Darwin, Herbert Spencer and Wallace rise, and [leave] a shore that will not be obliterated. [...]. Just as it is clear that many of the most fixed racial and specific characters are transmitted [...] there is no doubt that in certain cases there is transmitted a tendency to nervous or to mental disorder, but... only a certain proportion of cases in asylums can be proved to have had insane relations.<sup>37</sup>

This view of a hereditary predisposition to nervous and mental disease reflects Savage's personal stance in a debate over heredity that had occupied the minds of many over the centuries, namely, the extent to which parentage and/or environment, (the 'nature-nurture' debate) influenced human development and behaviour.<sup>38</sup> Savage's view as expressed above conforms to the general run of opinion at the time, and predictable in a practitioner of Savage's vintage. They were views he was to carry into the war years, and he strove personally to put his principles into effect in his work of examining Army recruits. That so many men of poor mental and nervous standard found their way into the British Army is testimony to the fact that not many doctors applied as high a standard.

Equally unsurprising is that such views find distinct resonances in those expressed by Frederick William Mott, probably Savage's most distinguished

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<sup>37</sup> *The Lancet*, 26 October 1912, p. 1136.

<sup>38</sup> An unusually clear and concise summary of the arguments involved may be found in Reber A.S., *The Penguin Dictionary of Psychology*, (London 1985), pp.320-1.



protégé. Significantly for the purposes of this thesis, Mott was destined to exercise considerable influence on official policy regarding mental and nervous casualties through his work at the 4th London Territorial General Hospital and his numerous publications, but was also influential in training others.<sup>39</sup> Although he was obliged by the evidence adduced by men such as Charles Myers, William Brown and Ronald Rows to accept a major role for psychological factors, Mott never quite embraced them with any real enthusiasm. Both during the Great War and in the enquiries held into the subject of mental and nervous casualties following the Armistice, Mott continued to advance strongly physicalist hypotheses.

In the clinical case histories which form the subject matter of the following chapter of the present work, the question of a positive or negative mental or nervous family history features prominently, and the existence of a transgenerational link is repeatedly taken as sufficient explanation for the condition under observation. A fuller examination, as well as a statistical analysis of this aspect is also presented in the following chapter.<sup>40</sup>

Respectability was one thing, however, and the creation of an effective scheme of mental health in Britain something else entirely. The foundation of a Section of Psychiatry of the Royal Society of Medicine, though deeply symbolic and portentous, did nothing to change the asylum system, or to reform the way in which psychiatry was taught and practised in Britain. Medical students

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<sup>39</sup> See Chapter 7 for a discussion of the role of American psychiatrists in the treatment of British mental and nervous casualties.

<sup>40</sup> See Chapter 3, esp. p.75 *et seq.*

continued to be taught how to recognise insanity by looking at extreme examples in their local asylum. The main aim of such training as they received was to instil in them the bureaucracy of the certification process. They were given no training in how to recognise the early signs of mental disease. The new Psychiatric Section did not set up a single post-graduate course in psychiatry, nor did it advance the cause of prevention and early treatment in any way. As war approached, the medical profession in Britain was sadly lacking in the kind of expertise that was soon to be desperately needed.

## 2.5 A dawning deferred: psychiatry on the eve of war.

In contrast to the recognition accorded to the term 'psychiatry', 'psychiatrist', as a description of a medical practitioner specialising in the areas outlined above, had not achieved anything like as wide a currency at the outbreak of war. True, labels such as 'mad-doctor' were by this time mostly used pejoratively, but others such as 'alienist' were still in frequent use, particularly by the older practitioners. Proponents of new doctrines in psychological medicine such as Carl Jung, who might be expected to heartily embrace the newer terminology, continued to think in earlier terms. More than fifteen years after the first appearance of 'psychiatrist' in *The Lancet*, Jung, addressing the Section of Psychiatry, could refer to 'alienists' without explanation, confident in his audience's acceptance of the old label.<sup>41</sup>

With the establishment of the Special Section of the Royal Society of Medicine, psychiatry had achieved acceptance as a legitimate discipline by the

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<sup>41</sup> Compare Sir George Savage in *The Lancet*, 4 Sept. 1915, and Jung in *The Lancet* of 19 July 1919 *passim*.



majority of the medical establishment, even if a good deal of what the psychiatrists had to say was regarded as having an unnecessary mystique. Most medical practitioners were only too aware that the position of the profession as a whole depended to a very considerable extent on the maintenance of such fictions. What was important, however, was that psychiatry itself had long passed the point where a case for its very existence needed to be made. But the campaign to remove remaining impediments and to bring psychiatry fully into the mainstream of British medicine was still far from securing all its aims. In particular, there was the feeling that Britain lagged behind the Continent in original thinking, and that too much attention was being paid to the custodial aspects of mental health. In April 1912 *The Lancet*, one of the most consistent advocates of change, summarised the situation thus:

To a few of its most devoted students, who have long been aware of the difficulties under which it labours, psychiatry in England is a subject that calls urgently for reform. No one who has [worked on] the continent will...deny that English psychiatry does not at present enjoy there the reputation which it might, and is not accorded that honoured place which is so freely acknowledged...for other branches of English medical science.<sup>42</sup>

The main problem for the more progressive practitioners - those who wished to rid themselves of the taint of the lunatic asylum - was to find effective means of establishing the kind of unquestioned status enjoyed by cardiology, ophthalmology, neurology, pathology, gynaecology, or any one of the multiplicity of medical 'ologies' that had emerged during the latter half of the nineteenth century. To achieve this, there had to be a clear and universally accepted distinction between, on the one hand, prophylactic and therapeutic

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<sup>42</sup> *The Lancet*, 6 April 1912, pp.934-5.  
For discussion of asylums as war hospitals, see Chapter Eight *passim*.



psychiatry as the more modern practitioners wished to see it, and on the other, the asylum system which had, (no doubt unfairly in some instances), inherited the repellent reputation of the mad-house.

It was an unavoidable fact that psychiatry, as preached by the new generation of continental practitioners, was viewed with more than a little suspicion by the British mental health profession. The great majority repudiated what they saw as its erotocentric, dangerous and destabilising ideas. British psychiatry had fallen victim, it would seem, to the hypocritical priggishness of Victorian sexual *mores* and the strictures of the British class system. Despite dissatisfaction with its language and lack of scientific rigour, psychiatry in Britain seemed set for evolutionary, if not revolutionary progress. A thriving professional press actively promulgated the latest theories and therapies through the publication of books, (many of them translations of continental authors), as well as the columns of the specialised journals. Within the pages of *The Lancet*, the *British Medical Journal*, and the *Journal of Mental Science*, there was a lively debate, often amounting to outright controversy, about psychiatry and its proper place within the medical profession.<sup>43</sup> Specifically, pressure was being exerted to establish professional standards of competence, and to require the incorporation of psychiatry into the curricula of the medical schools. In general, there was a distinct movement towards making

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<sup>43</sup> *The Journal of Mental Science* began life as the *Asylum Journal*. Its change of title was an essential element in the developmental process described in this chapter, i.e. adherence to scientific rigour in the assessment of the treatments devised for mental disorders. It also marked a symbolic move away from being concerned solely with asylum affairs.



psychiatry more attractive as a specialism by enhancing the status and rewards attached to its practice.<sup>44</sup>

It was being pointed out, for example, that psychiatry in other countries had long since achieved the status and recognition still absent from the British scene, despite the presence of an active specialist press, and an outpouring of work which, as far as observational skills were concerned, were felt to be the equal of anything appearing elsewhere. This expertise, however, seemed to be confined to the printed word, and was not being translated into international co-operation in the academic or clinical spheres. At international gatherings on psychiatry British participation was dismissed as derisory:

There is held in Munich ...a post-graduate course (Fortbildung) specially for the clinical and pathological study of the subject, a course which is valued so much that it has been attended by as many as 50 or 60 of whom, on an average, one-third are foreigners. We understand, there was one Englishman in the audience.<sup>45</sup>

Despite such criticisms, the evidence - particularly that of the contemporary medical press - suggests that a head of steam was building up behind the campaign for reform. Had the War not intervened, there seems little doubt that some of the more obvious disadvantages from which psychiatry suffered might have received early attention. As it was the medical profession - mental and physical branches alike - was swept up in the crisis. The transfer of many thousands of doctors into military service and the requisitioning of asylums as war hospitals, effectively put paid to any further debate until after the war. As

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<sup>44</sup> Scull, *Museums of Madness*, p.170.

<sup>45</sup> *The Lancet*, 6 April 1912, pp.931-2.

subsequent chapters seek to show, however, the events of the war were to be instrumental in securing at least some of these deferred objectives.



## **PART TWO**

### **ASPECTS OF THE PROBLEM**

## CHAPTER THREE

### 500 MENTAL AND NERVOUS CASE HISTORIES ANALYSED.

#### 3.1 Sources for the study

The mental (as distinct from nervous) casualties of the Great War have received comparatively little historical attention. Writers of the war and immediate post-war periods tended to concentrate on what they regarded as the more interesting and significant aspects of the medical war experience, with the result that functional nervous disorders such as shell shock were given exceptional prominence.<sup>1</sup> In addition, the professional and academic literary output of the last thirty years or so has rested on an extremely narrow statistical foundation, the reasons for which were not drawn out in the literature itself. This paucity of statistical data stems from the fact that very limited research has been carried out on primary sources in the form of medical case histories. Officially, these records were surrendered to the military medical authorities at the conclusion of hostilities and ought to have been available, at least to the official historians, as part of the historical account of the Great War. From the very cessation of hostilities, however, complexity and confusion surrounded these vital records.

As early as 1922 the Southborough Committee, set up by the government to assess the effects and implications of shell shock during the Great War, complained of being unable to obtain any reliable statistics on the condition. At the same time, the committee expressed the hope that the planned Official

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<sup>1</sup> Specific aspects of this imbalance are discussed in Chapter Four.



History of the war would repair the omission in respect of shell shock, and would also contain 'exhaustive information' on the other mental and nervous casualties of the war'.<sup>2</sup> With some reservations, the volume eventually published in 1931 dealt reasonably well with the general run of casualties. As far as mental and nervous casualties were concerned, however, it proved entirely inadequate, and of very limited use in illustrating their relative significance. The chapter on 'Nervous Disorders', for example, opens with the depressing observation that:

...the records are very incomplete, and it has only been possible to compile sample tables indicative of the incidence of nervous disorders...<sup>3</sup>

The passage of a decade since the Southborough Committee's report had evidently done nothing to improve access to the medical records of mental and nervous casualties. The authors expressed their belief that the real lessons of the war lay, not in weighty tables of statistics, but in the 'interesting details of the individual cases' shut away in the archives of the Ministry of Pensions. These, they urged, held the key to the successful future management of the casualties of war. Of all the diseases arising from the conflict, they went on, mental disorders ('psychoses') stood out as causing 'the most ...severe degree of disablement'. The authors' concluding comments reflect their frustration and, in the light of subsequent events, were to prove singularly prophetic:

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<sup>2</sup> *Report of the War Office Committee of Enquiry into "Shell Shock"*, Command 1734, H.M.S.O., (London 1922), p.7.

<sup>3</sup> Mitchell T.J. and Smith G.M., *History of the Great War: Medical Services, Casualties and Statistics*, H.M.S.O. (London 1931), Facsimile reprint : Imperial War Museum and The Battery Press, (Nashville.Tennessee. 1997), p.115.

So, in the aftermath of war...it is the diseases of [the] brain which remain the most conspicuous items in the sum of the State's aggregate liability, whilst the [physical] wounds, despite their greater numbers, have relatively healed.<sup>4</sup>

Whether for reasons of patient confidentiality or because, as a newly-established body, the Ministry of Pensions tended towards excessive caution is not clear. From the cessation of hostilities onwards the Ministry was obliged to respond to many thousands of specific enquiries, for example, from Commonwealth governments regarding their nationals, as well as from Medical Boards in connection with individual claims. As a source of raw data for the production of statistics, however, the records remained wholly inaccessible.

### **3.2 The 'Great Pulping': the fate of the Ministry of Pensions archive.**

Even if the actual production of comprehensive statistics had been found to be impractical, preservation of the documentary raw material would at least have given historians the opportunity of repairing some of the earlier omissions. Having been accessible only to government ministries for more than fifty years, however, in 1975 the future of this mountain of documents came under question. Its primary usefulness in determining entitlement to pensions having been deemed at an end, the authorities apparently saw no point in its preservation. After some further delay, the so-called 'Representative Selection' was made of Medical Case Sheets dealing with the various injuries and diseases of the war, and this was sent to the Public Record Office.

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<sup>4</sup> Mitchell and Smith, *Medical Services, Statistics*, p.350.



The great bulk of the collection, filling 16,254 sacks and weighing 275 tons, was sent for pulping.<sup>5</sup> A tiny fraction escaped this fate, but why some were singled out for preservation and not others is not made clear. Together with the largely nervous cases in the Representative Selection, however, they provide the foundation for the present study. The Public Record Office at Kew holds a range of medical records under a variety of 'class' headings, the most relevant in this case being Class MH ('Ministry of Health') 106. This contains hospital admission and discharge books, medical cards and reports of Medical Boards, as well as what is described in the catalogue references as the 'Representative Selection' of medical case sheets. The Selection covers a wide range of injuries and diseases of the Great War, including mental and nervous disorders. These casenotes had been looked at by R.D.Ritchie in 1986, but no significant use was made of them in his subsequent thesis.<sup>6</sup> The only other notable use made was in another thesis, also focused on shell shock, by P.J.Leese in 1989.<sup>7</sup>

For the purposes of the present study, the 'Representative Selection' has significant limitations. The number of usable cases in the Selection was comparatively small, and unlikely to yield more than 150 relevant examples. A further limitation was that, for unstated reasons, the last mental and nervous cases included in the Selection are dated 23 December 1915 and 6 January 1916

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<sup>5</sup> The P.R.O. has only an anonymous booklet (PRO/MH106/2387) on the chequered history of this archive. The booklet gives no insight into the decision in 1975 to destroy it, other than to note that its 'continued usefulness' was questioned at that time.

<sup>6</sup> Ritchie R.D., 'One History of Shellshock', Unpubl. Ph.D. thesis, University of California, San Diego, (1986).

<sup>7</sup> Leese P.J., 'A Social and Cultural History of Shellshock', Unpubl. Ph.D. thesis, Open University, (1989).

respectively.<sup>8</sup> The Selection is therefore 'representative' only of the mental and nervous disorders of the very earliest period of the war. Some of the effects and implications of that fact are discussed below. From the standpoint of balance alone, however, it will be clear that the Representative Selection is anything but fully representative, and that any previous research was necessarily affected by these limitations.

During the course of research for the present thesis, however, it was discovered that the P.R.O. also holds the admission and discharge registers of the 'County of Middlesex War Hospital' at Napsbury, near St.Albans. Although ostensibly one of many temporary military general hospitals, a major section was in fact devoted to the treatment of neuropsychiatric casualties. Napsbury was one of the 24 hospitals set up under the Asylum War Hospitals Scheme.<sup>9</sup> A substantial collection of medical casenotes corresponding to these registers was also included in the P.R.O. 'Class Lists', but were marked 'Closed for 75 years'. Enquiries established that the embargo dated from 1921 when the last records were added. Representations to the P.R.O. at first met with little success, but persistence was eventually rewarded by the collection being released for research. This study is therefore the first historical work to make use of this important new source.

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<sup>8</sup> Study Case No.154, Ref.PRO/MH106/2102, 6521 Pte.Couland W., 12 Btn. London Regt.

Study Case No.166, Ref.PRO/MH106/2102, 9702 Pte.Talbot R., 10 Btn. Hampshire.Regt.

<sup>9</sup> The Asylum War Hospitals Scheme is discussed in Chapter Eight. Prior to being taken over by the War Office, Napsbury was the Middlesex County Asylum.



The Napsbury Collection consists of the hospital's admission and discharge registers, as well as a separately filed mass of medical case sheets corresponding to those registers. The registers are arranged chronologically, but the medical case sheets are in alphabetical order of patient surname. As the aim of the study was to examine the contemporary medical, cultural and political background of the neuropsychiatric casualties of the Great War, it was decided to concentrate on the actual casenotes themselves. Subsequent references to the 'Napsbury Collection', 'archive' or 'documents', therefore, are to the medical casenotes themselves, or to documents filed with them.

The collection as listed consists of 26 boxes (called 'pieces' by the P.R.O.) of Medical Case Sheets, (Army Form I.1237). The collection covers the period 24 June 1915 when the first military patients were admitted, to 23 May 1919 when military admissions ceased. Each box contains between 2000 and 3000 documents, the great majority dealing with a wide range of physical wounds and diseases. Interspersed irregularly throughout are the casenotes of mental and nervous casualties. For the purposes of this study, the most interesting were the Medical Case Sheets themselves, but documents of many other kinds - hospital transfer certificates, pathological, specialist and other reports - were frequently attached. In some cases, the history included notes actually from the trenches, making it possible to follow the development of that particular case from the front line through to final disposal. Some letters from, to and concerning the patients had also survived. The condition of the documents varied from almost 'as new' typewritten papers, to dilapidated,

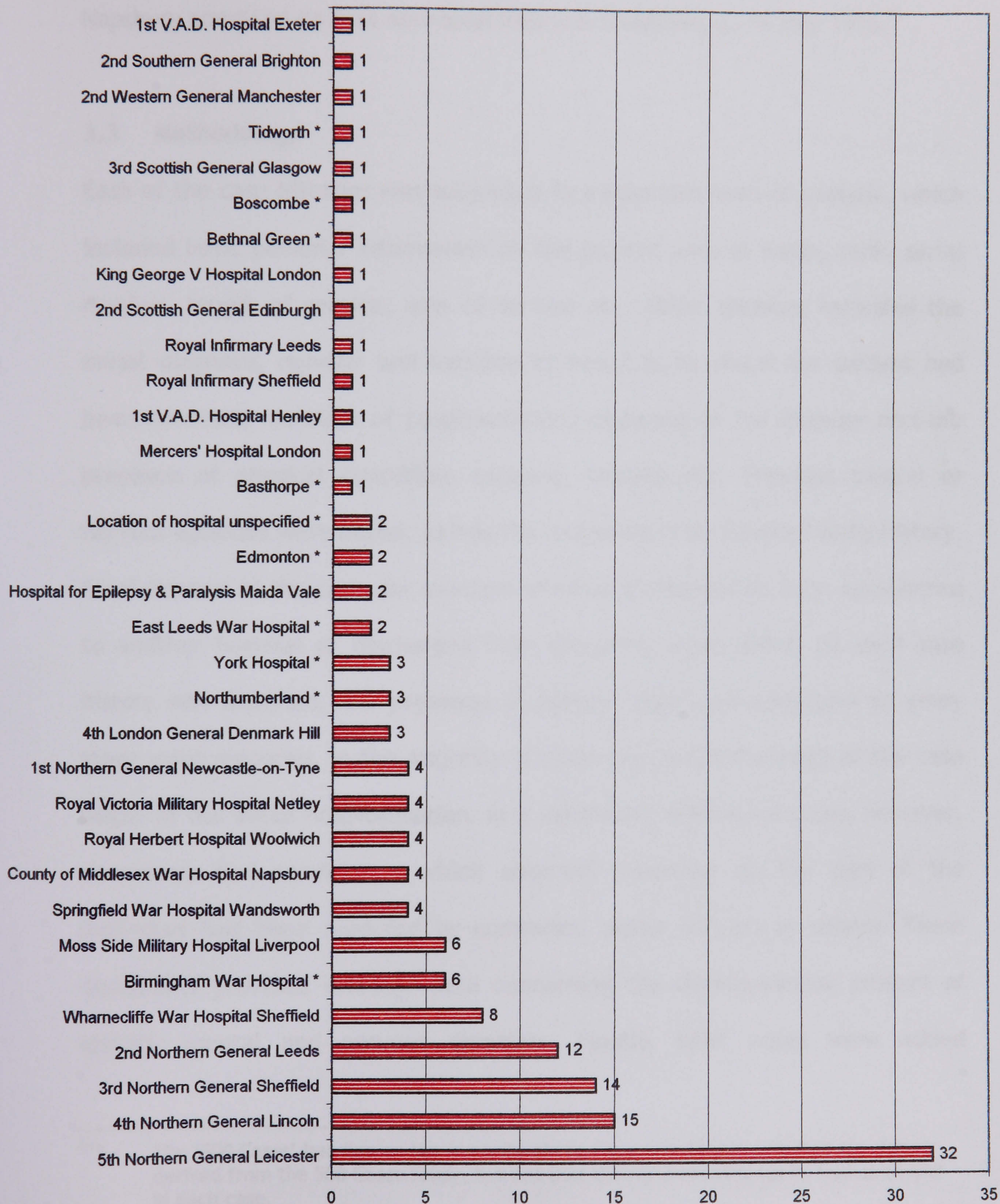
badly darkened and almost illegible manuscripts. Many showed signs of having been stored in seriously invasive damp conditions.

As identification and retrieval proceeded, it became clear that the collection was potentially capable of yielding a considerable number of relevant cases: it was decided, therefore, to expand the study to a total of 500 cases. It also emerged that during its time as a War Hospital, Napsbury had progressively specialised in the care of mental rather than nervous cases. In one sense this admirably served one of the main objectives of the study, which was to correct the bias of previous studies towards shell shock and functional war neuroses. At the same time, it was important to avoid tipping the balance of the study too far in favour of mental casualties. These objectives had to be achieved, as far as possible, within the strict limitations of the available primary sources. It was for this reason that the decision was taken to include appropriate cases from the Representative Selection. In total, the two collections probably number about 100,000 documents, all of which it was necessary to examine in order to make the final choice. Eventually, 600 sets of casenotes were extracted for photocopying and subsequent analysis, with the final 500 being selected for their completeness, and for the statistical and general information they were potentially able to yield.

As a result, the 500 cases making up the study consist of 356 from the Napsbury collection, with 144 from the 'Representative Selection'. Figure 1 shows a breakdown of the relevant section of the Representative Selection, showing the numbers of mental and nervous cases admitted to the hospitals



**Figure 1. P.R.O. 'Representative Selection'**  
**Admissions of mental and nervous casualties to certain UK hospitals:**  
**20 August 1914 to 6 January 1916**



\* No further identification available



concerned.<sup>10</sup> The combined sources provided a satisfactory spread across the range of neuropsychiatric disorders, and use of the 'Representative Selection' filled the chronological gap between the outbreak of war and the point where Napsbury admitted its first neuropsychiatric casualties on 14 May 1915.<sup>11</sup>

### 3.3 Methodology

Each of the case histories was subjected to a standard form of analysis, which included basic personal information on the patient such as name, rank, serial number, length of service, arm of service etc. Other sections recorded the initial diagnosis, number and location of hospitals to which the patient had been admitted, duration of hospitalisation, causation of the disorder and the presence of physical conditions (disease, wounds etc. Previous mental or nervous episodes were noted, as was the existence of a relevant family history. Final disposal of the case, for example whether discharged to duty, transferred to another hospital or discharged from the Army were noted. As each case history was analysed, the presence of specific signs and symptoms at every stage were recorded. In the majority of cases the symptomatology of the case began at the initial hospitalisation. In a significant minority of cases, however, documents had survived in which aberrant behaviour on the part of the individual had been reported by comrades, senior officers or others. These documents provided valuable data concerning the developmental pattern of specific mental and nervous disorders. Finally, brief notes were added

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<sup>10</sup> The '500 Cases' heading on the majority of the Figures indicates only that the data is derived from the 500 Cases Study, but not that the numbers necessarily add up to 500 in each case.

<sup>11</sup> Cooke M. and Bond C.H., *History of the Asylum War Hospitals Scheme*, Command 899, H.M.S.O. (London 1920), pp.46-7.



regarding special aspects of the case such as the identity of medical officers, the relationship of the case to specific military events and so on. Figures 2 and 3 illustrate the format of the analysis. Figures 4 and 5 show the cumulative symptomatology of the 500 cases studied.

The results of these analyses were entered on a specially designed computer spreadsheet utilising Microsoft Windows 98 software. As well as contributing to the statistical database, however, specific cases have been used throughout the thesis to illustrate the aetiology, pathology, symptomatology, treatment and disposal of a range of mental and nervous disorders. The greatest value of medical histories lies in their status as records of first-hand experience. They allow singularly informative insights into the medical and clinical discourse of the Great War, whilst (often graphically) illustrating the personal experience of those who became its casualties.

### **3.4 The use of medical records in contemporary studies and in the Official History**

Both during and after the Great War considerable debate surrounded the causation, diagnosis and treatment of neuropsychiatric casualties. Any volume of *The Lancet* or *The British Medical Journal* of the period contains a wealth of articles, editorials, comment and correspondence on the subject. These and similar sources have been consulted throughout the preparation of this thesis.<sup>12</sup> As a general observation, however, the professional medical press of the Great War period naturally consisted of the output of those physicians - professional military medical officers, as well as civilian practitioners temporarily in uniform

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<sup>12</sup> For details and analysis of this material, see Bibliography, Part Two.

CASE SUMMARY

Archive ref.

Regtl.no. ....Rank.....M / S / N.S.

Surname..... Initial.....

Age.....Age group..... Svce.....

Unit..... Inf. Cav. Art. Svce. Other.....

Disorder code..... Disorder name.....

Hosp. from  to  Total days

No.of hosps.....Names.....

.....

Caus.code.....Descripn.....

Physical wound (n).....Organic dis.(n).....

Treatment: Psych.....Phys.....Both.....None.....

- D1 Furlough

D3 To duty

D5 Dead
- D2 Home

D4 From Army

D6 Convalescent
- Pers.hist.Ment./nerv.

Fam.hist.Ment./nerv.

D7 Asylum/Ment. Inst. (n).....

NOTES

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|------------------------------|-------------------------------|
| S1 Amnesia                   | S44 Giddiness / vertigo       |
| S2 Mute                      | S45 Tinnitus                  |
| S3 Deaf                      | S46 Fits                      |
| S4 Speech dis.(excl. S2)     | S47 Breathing disorder        |
| S5 Head pains                | S48 Pyromania                 |
| S6 Incontinent               | S49 Dull                      |
| S7 Constipated               | S50 Confused                  |
| S8 Anosmia                   | S51 Delus. of persec.         |
| S9 Stupor                    | S52 Delus. of grandeur        |
| S10 Nightmare (excl S29)     | S53 Venereal disease          |
| S11 Tremulous- tongue        | S54 Genl. unspec. nerv.       |
| S12 Tremulous- hands         | S55 Hypersens. - noise        |
| S13 Tremulous- limbs         | S56 Exagg. reactions          |
| S14 Blindness- total         | S57 Sluggish reactions        |
| S15 Vision disord. - other   | S58 Trem. head/face           |
| S16 Suicidal                 | S59 Emotional                 |
| S17 Depressed                | S60 Genl. musc.weakn.         |
| S18 Lachrymose               | S61 Anxious                   |
| S19 Incoherent               | S62 Rombergism                |
| S20 Detached from reality    | S63 Delusions (other)         |
| S21 Imbalanced physically    | S64 Destructive               |
| S22 Hallucinations - visual  | S65 Catal./trance-like states |
| S23 Hallucinations - audit.  | S66 Apathetic                 |
| S24 Hallucinations - olfact. | S67 Exalted                   |
| S25 Excitable                | S68 Dirty habits              |
| S26 Hyperactive              | S69 Childish                  |
| S27 Posture disorder         | S70 Simple                    |
| S28 Gait disorder            | S71 Lethargic                 |
| S29 Sleep dis. (excl. S10)   | S72 Talkative                 |
| S30 Paralysed - face         | S73 Morose                    |
| S31 Paralysed - limbs        | S74 Restless                  |
| S32 Anaesthesia              | S75 Solitary                  |
| S33 Hyperaesthesia           | S76 Contradictory             |
| S34 Violent                  | S77 Masturbation - excessive  |
| S35 Noisy                    | S78 Somnambulism              |
| S36 Disruptive               | S79 Withdrawn                 |
| S37 Homicidal                | S80 Foolish                   |
| S38 Urinary disorder         | S81 Hypochondriacal           |
| S39 Sexual dis.(not VD)      | S82 Aggressive                |
| S40 Tachycardia              | S83 Suspicious                |
| S41 Arrhythmia               | S84 Babinski's sign           |
| S42 Astasia                  | S85 Alcoholic                 |
| S43 Abasia                   |                               |



Fig.4. 500 mental and nervous cases: cumulative list of symptoms noted (ranges 1 - 21 and 22 - 42)

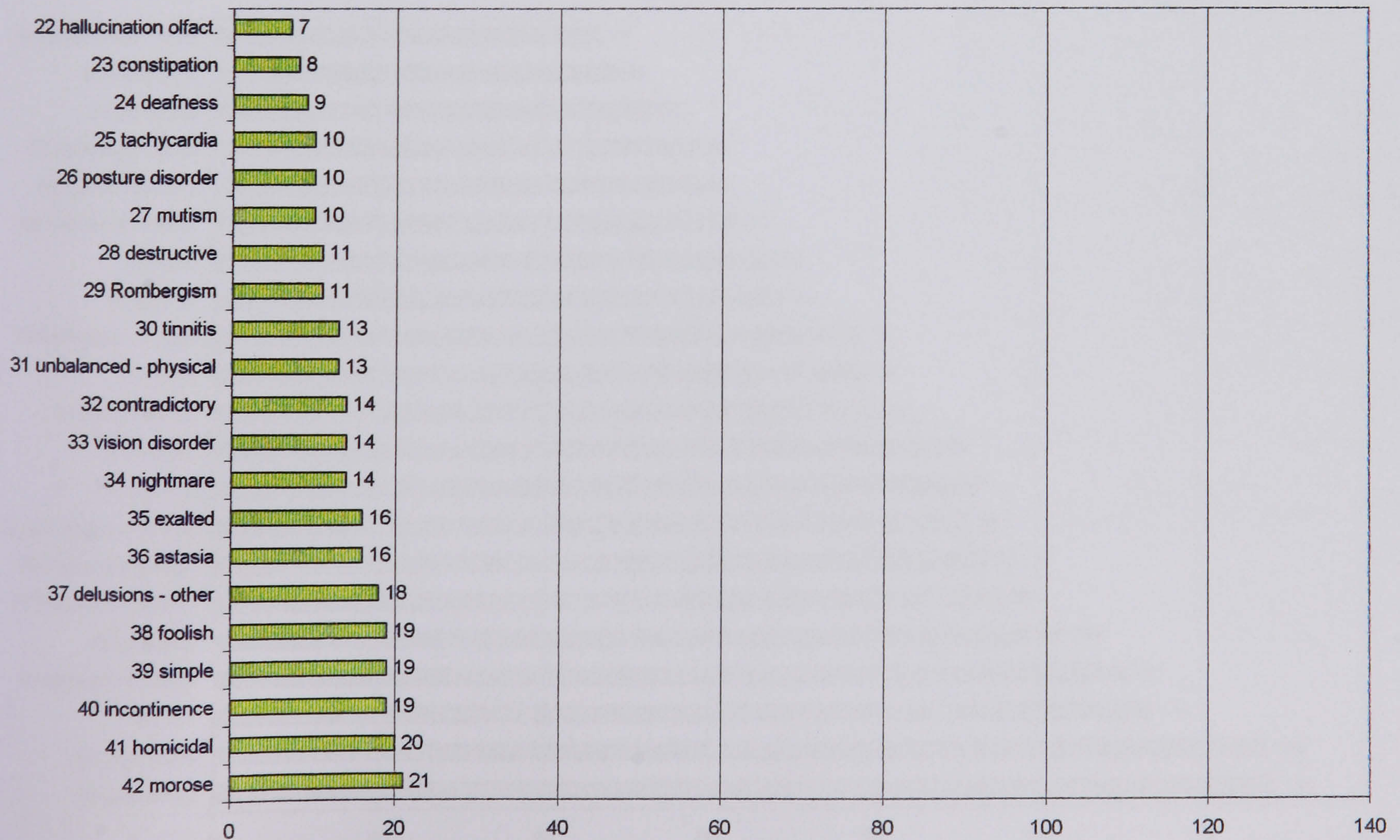
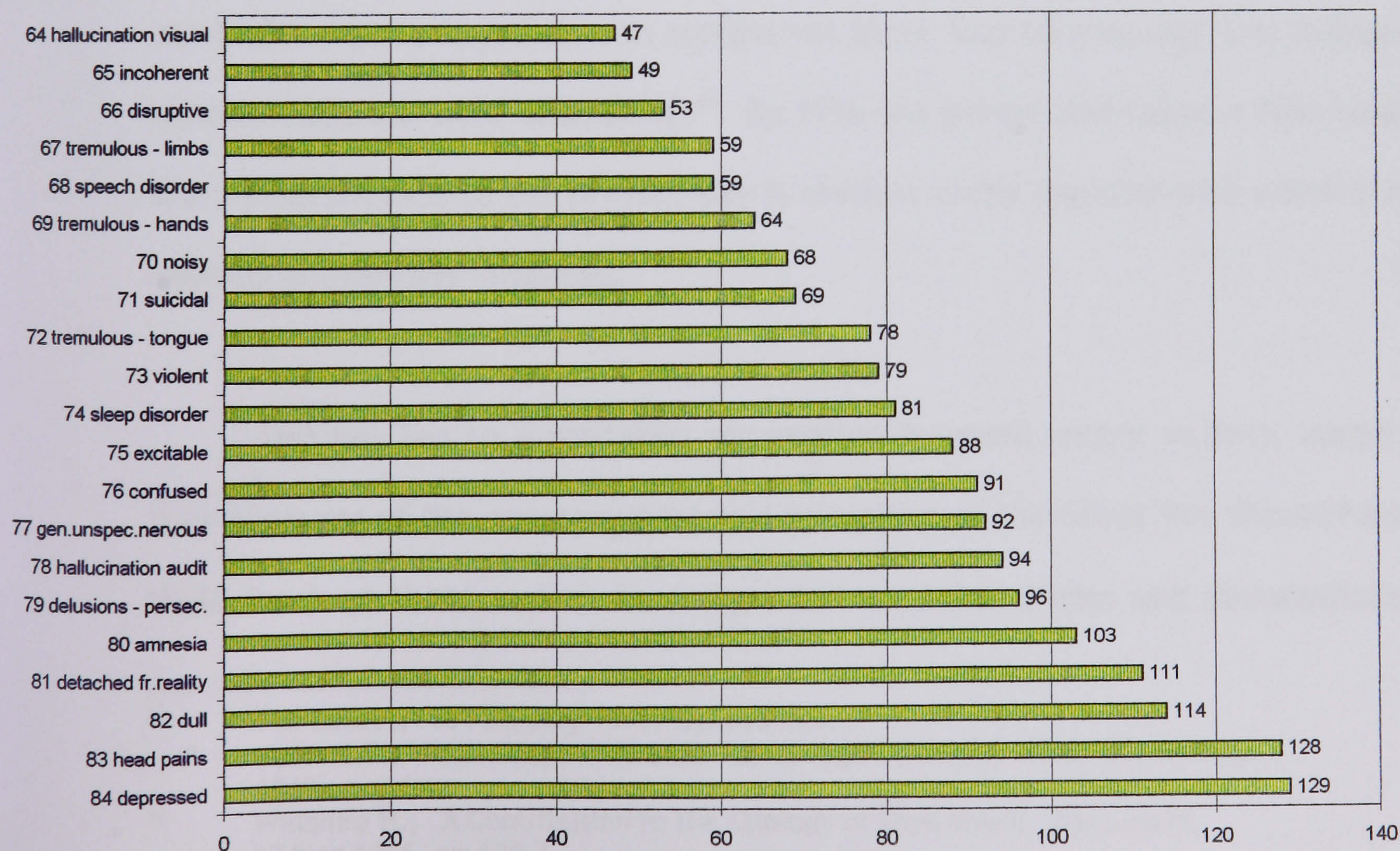
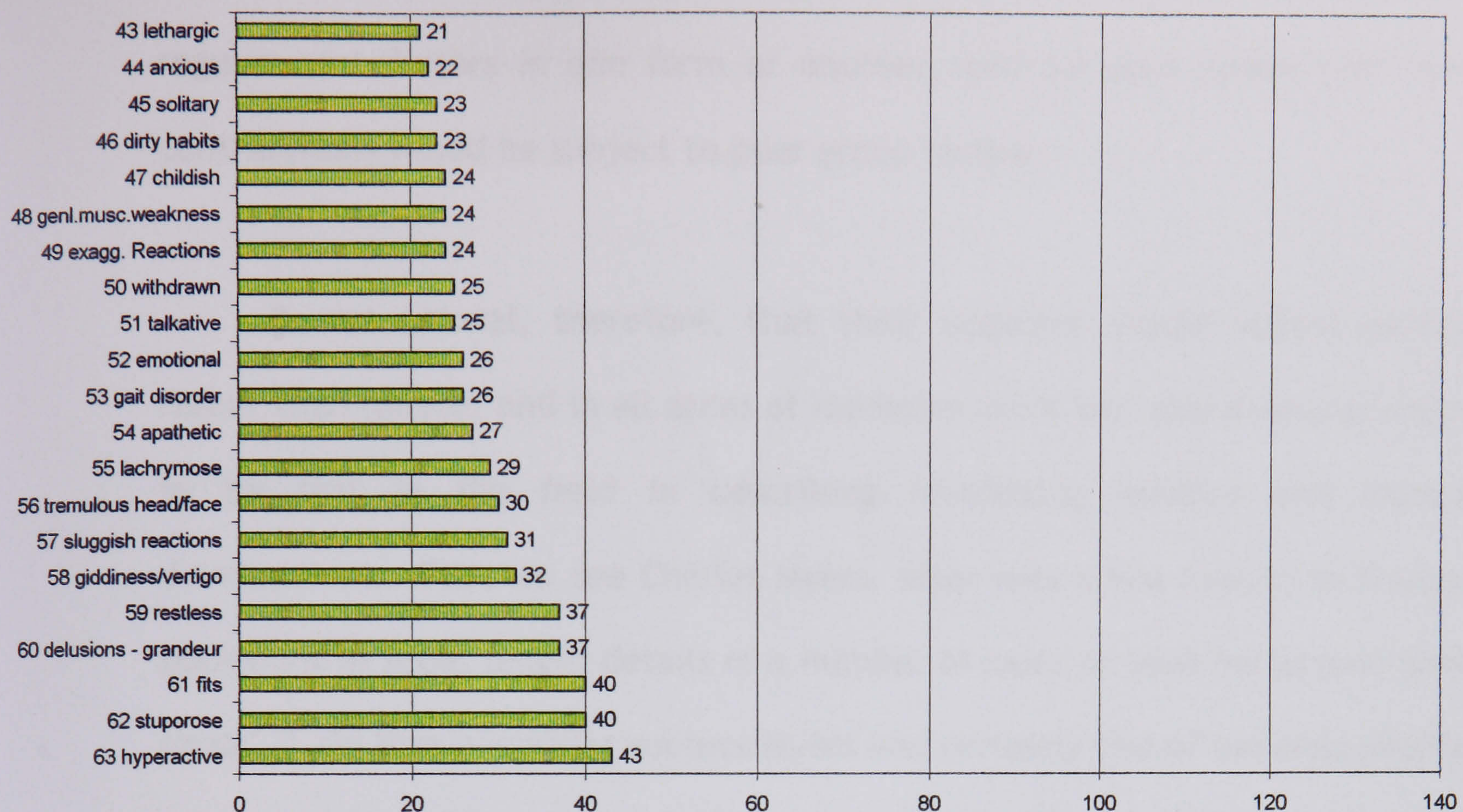




Fig.5. 500 mental and nervous cases: cumulative list of symptoms noted (ranges 43 - 63 &amp; 64 - 84)





- who had both the opportunity and the inclination to go into print. Some were regular contributors in one form or another, and all were aware that their contributions would be subject to peer group review.

It was natural, therefore, that their accounts should reflect success rather than failure, and in all areas of medicine there was also a natural desire to be first in the field in describing interesting medical and clinical developments. Thus we see Charles Myers, after only a few months in France, publishing at great length details of a number of cases of what he termed 'shell shock'.<sup>13</sup> On that particular subject Myers was certainly one of the most prolific writers, with further articles on various aspects of this and related topics appearing throughout the war. Subsequent debate spilled over into Parliament and the popular press. The public imagination, vicariously thrilled by the Gothic drama and mystery, fastened permanently on the phrase. Thinly disguised attacks on Myers, together with complaints about 'bad terminology' and 'dubious clinical histories' were unavailing.<sup>14</sup> By 1916 the phrase had taken a firm hold, and its persistence to the present day is evident in the freedom with which it is applied in everyday language.

This has led to a mistaken assumption by more recent writers, namely that accounts of the neuropsychiatric casualties of the Great War should have shell shock at their centre. As a topic for academic theses and dissertations,

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<sup>13</sup> *The Lancet*, 13 February 1915, pp.316-320.  
Myers C.S., *Shell Shock in France*, Cambridge University Press, (Cambridge 1940), *passim*.

<sup>14</sup> Wiltshire H., 'A Contribution to the Etiology of Shell Shock', *The Lancet*, 17 June 1916, pp.120-2.



and as the subject of a steady stream of books and articles, shell shock has become the iconic disease of the Great War. This preoccupation has distorted historical perceptions to the point where mere mention of the mental and nervous casualties of the Great War is automatically taken as a discussion of shell shock. Confusion and conflation have all too frequently been allowed to blunt the rigour of historical scrutiny, to the almost total exclusion of mental disorders and to the detriment of historical accuracy, balance and understanding.

### **3.5 The statistical database: outcome and discussion.**

The statistical outcome of the study is dictated by the nature of the original sources. If, for example, the Representative Selection had covered the whole period of the war, data drawn from it would undoubtedly have given a more comprehensive view of the whole neuropsychiatric treatment scene in the United Kingdom. Similarly, if Napsbury had dealt with a more inclusive range of nervous disorders, rather than progressively specialising in mental diseases as it did, the perspective would have necessarily been narrower, but the focus would probably have been considerably more intense. Faced with the scarcity of original sources, however, alternative structures were simply unavailable.

Taken at face value, some of the results of the present study call for explanation if unsafe inferences are not to be drawn. For example, the apparent predominance of neurasthenia as a diagnosis is due mainly to two factors. Firstly, conditions in the early part of the war - the chaotic retreat from Mons, the strain of reversing the German advance on Paris, the so-called



'Race to the Sea', as well as the effects of the first winter in the trenches - all these factors naturally gave rise to many more cases of acute exhaustion during late 1914 and the first half of 1915.<sup>15</sup> Also, as the Official History expresses it:

The inadvisability of using the term "neurasthenia" for these cases of severe exhaustion in soldiers was always well realized. It was, however, the only "official" diagnosis available.<sup>16</sup>

In other words, official policy at the time actively encouraged the use of neurasthenia as a diagnosis. As discussed at length in Chapter Four, neurasthenia was the blanket term for a diverse and often imprecise symptomatology, rather than a label for a single disorder. Had records been available from these same hospitals for the whole of the war, it would have been possible to assess more accurately the real significance of neurasthenia. In particular, it might have been possible to judge whether diagnostic skills improved with experience and whether, as Harold Merskey has suggested, the experience of the Great War was directly responsible for the appearance of 'psychiatric services in general hospitals' after the Armistice.<sup>17</sup>

In any event, the study significantly qualifies Simon Wessely's conclusion, namely that many British neurologists 'turned their backs on this now discredited diagnosis' in the years before the Great War.<sup>18</sup> As far as the Representative Selection and the Napsbury archives are concerned, this is

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<sup>15</sup> For details of these events, see bibliographical entries, for example; Edmonds J.E., *History of the Great War*, Vol.1. Liddell Hart B.H., *History of the First World War*, Crutwell C.R.M.F., *History of the Great War 1914 -1918*. Strachan H., *The First World War, Volume 1: To Arms*, Oxford University Press, (Oxford 2001).

<sup>16</sup> Macpherson W.G., et al, (Eds.) *History of the Great War based on Official Documents: Medical Services: Diseases of the War*, (4 vols.), H.M.S.O., (London 1923), p.20. For a full discussion of neurasthenia, see Chapter Four.

<sup>17</sup> Merskey H., 'Post-traumatic Stress Disorder and Shell Shock' in Berrios G. and Porter R., *A History of Clinical Psychiatry*, Athlone, (London 1999), p.492.

<sup>18</sup> Wessely S. 'neurasthenia and Fatigue Syndromes' in Berrios and Porter, *ibid.*, pp.515-6.



simply not the case. The last case of neurasthenia drawn from the Representative Selection, for example, was admitted to Boscombe Military Hospital on 16 January 1916.<sup>19</sup> Thenceforward, all case histories of neurasthenia were taken from the Napsbury records. Admissions of neurasthenic cases naturally declined as Napsbury specialised increasingly in the more severe forms of mental disorder. Nevertheless, they continued at a low but constant level throughout the war. The last case of neurasthenia was admitted to Napsbury on 21 May 1919.<sup>20</sup>

One further important point concerning the Representative Selection must be mentioned, which is that no evidence was found relating to the parameters used by the collators in making their choice. The choice may have been made according to closely defined ratios, in which case the statistical relationship of a particular part to the whole would perhaps have given some indication of the original total. On the other hand, the selection may have been based on nothing more precise than rule of thumb, in which case the Selection is of interest, but offers no reliable guidance to the size of the original archive. According to the P.R.O., the stated aim of the Representative Selection when it was made in 1975 was to reflect the various kinds of injuries and diseases thrown up by the Great War, including mental and nervous conditions.<sup>21</sup> The range of hospitals involved includes special neuropsychiatric centres such as the Moss Side Military Hospital near Liverpool and the Maudsley Extension to the London Hospital. In the early period of the war, however, there was an acute

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<sup>19</sup> Study Case No.145, Ref.PRO/MH106/2102, 9702 Pte.Talbot R., 10 Btn. Hampshire Regt.

<sup>20</sup> Study Case No.498, Ref.PRO/MH106/2223, 52214 Pte.Herbert G., R.E.Labour Coy.

<sup>21</sup> These are held at the P.R.O. in Class MH106, Pieces 2101 and 2102.

shortage of such special centres, with the result that, as Figure One (p.58a) shows, the majority of early cases were sent to one or other of the 23 Territorial General Hospitals set up on mobilization, or to one of the many other war hospitals springing up all over the country. The Territorial General Hospitals had been planned in detail before the war, and were mobilized on 3 August 1914. They were therefore the first to come into effective operation, bearing the brunt of the early wave of casualties of all kinds.

An interesting point to emerge from this analysis is that, during the period August 1914 - December 1915, the 5th Northern General Territorial Hospital at Leicester is recorded as having admitted 30 cases, compared to the next highest total, the 4th Northern General at Lincoln, with a mere 14. Again, this observation is misleading without knowledge of the rationale behind the Representative Selection. It may simply be the case that more Leicester cases were included in the Representative Collection than from other hospitals. Leicester's role as a military hospital has been examined in the present writer's earlier research.<sup>22</sup> Like its 22 counterparts elsewhere in the U.K., the 5th Northern was a general military hospital, not a specialist neuropsychiatric treatment centre like Moss Side at Liverpool or the Springfield War Hospital at Wandsworth. The account left by the hospital's Commanding Officer, Colonel Harrison, makes no reference at all to the treatment of mental or nervous disorders there. Evidence from other sources, however, suggests that one of the 5th Northern's affiliated hospitals, the Gilroes Hospital, was set aside

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<sup>22</sup> Hopkins J.R. 'Leicester's Great War Hospital' (Unpubl. M.A.dissertation) Leicester University (1995).



specifically for the treatment of neurasthenia.<sup>23</sup> As far as the Representative Selection is concerned, Leicester is also distinguished in being one of only nine instances, in the entire 500 case study, in which psychological treatment is referred to, or in which such treatment can be safely inferred from the casenote content. Only two cases refer unequivocally to psychological treatment, and only one specifies the type of therapy employed. These cases are summarised below.

Study Case No.123  
 Archive Reference: PRO/MH106/2101  
 1101 Private Pomroy J.  
 Age: 24  
 Service: 1 year 3 months  
 Unit: 3rd Battalion, Leicestershire Regt.

Private Pomroy was sent to the Dardanelles as part of the British Expeditionary Force in early 1915. At Lemnos on 19 July in the support trenches he collapsed in 'some kind of fit', reportedly the second such episode. Since that time he had been 'weak and nervous and had slept very badly'. He was taken to the beach-head and eventually repatriated to the U.K. via Malta. On 25 September 1915 he was admitted to the 5th Northern General, Leicester, and on 28 September transferred to Gilroes Hospital, Leicester, one of a number of hospitals affiliated to the 5th Northern. At Gilroes he was prescribed potassium bromide and blood tonic. Pomroy stated that his father had suffered with 'nervous debility' for years. He could not account for his own collapse, but thought that 'the heat had a lot to do with it.'

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<sup>23</sup> *The Lancet* 3 April 1920 p.790.



On 10 October 1915 Pomroy was seen by a Dr. Douglas Bryan who gave him 'psychic treatment', with further 'sittings' on 17 and 22 October. The precise nature of these treatments is not made clear. Before the war, Dr. Clement Arthur Douglas Bryan had been in general practice with his father at 44, Humberstone Road, Leicester. Kelly's Directory lists him as 'Lieutenant' Bryan, implying that he was already in the Army. However, he does not appear on the staff lists of either the 5th. Northern, or on those of the nearby Borough Asylum.<sup>24</sup> Despite the evident success of Dr. Bryan's treatment, he was not involved in the treatment of any of the other 29 mental and nervous cases admitted to the 5th. Northern, nor is psychological therapy of any kind mentioned in their casenotes. Three days after the last treatment, Pomroy was reported to be 'very much improved. Looks and feels fit, no nervous symptoms.' He was discharged to furlough on 2 November 1915 after 37 days in hospital, following which he presumably returned to duty.

Study Case No.134  
 Archive Reference: PRO/MH106/2102  
 123 Lance-Corporal Hammersley W.  
 Age: 41  
 Service:12 years  
 Unit: 12 Battalion County of London Regt.

On 23 April 1915 in France, Hammersley was struck by a falling sandbag, and was unconscious 'for a few hours', but stated that the incident did not otherwise upset him much. A few days later he sustained a gunshot wound of the left ankle. He managed to walk to a Dressing Station and was later repatriated to the 'Military General Hospital, Manchester', where the bullet was

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<sup>24</sup> Kelly's Directory (Leicester & Rutland 1914), p.140.



removed.<sup>25</sup> During convalescence he contracted influenza, for which he was admitted to the Royal Herbert Hospital, Woolwich, on 16 October 1915.

On 22 October 1915, Hammersley was reported to 'sleep not more than an hour at [a] time' and to wake at the slightest noise. His left arm was noticeably weaker and smaller than the right. He complained of coarse tremor in both arms. Knee jerks, plantar reflexes and eye movements were normal. Appetite was good. 'Hoards food'. Said his disturbed sleep was because he kept thinking of the "other side", presumably meaning the after-life. He was diagnosed as suffering from chronic anxiety neurosis:

26 October 1915: Suggestion for 3rd. time today. Tremor very nearly gone. He walked about from 9.00 to 10-30am without fatigue this morning. Last night he slept 2½ - 3 hours and again about 3 hours. Says best sleep for months. No hypnotic (drugs). He is greatly improved both physically and mentally. Advise 10 days leave & to report to me when he returns.

N.B. He will relapse to a certainty if sent back to trenches. He should otherwise be fit for other duties.

(Signed)  
James Boyd.

The above are the only two cases in the entire study in which explicit reference is made to psychological therapy. In Pomroy's case the 'psychic' methods employed are not made clear but were obviously effective. In Hammersley's case, both therapy and method are given and were similarly beneficial. Hammersley's case is also of interest in that Dr. Boyd, the attending physician, clearly understood, even at this early stage of the war, the direct connection between the conditions of trench warfare and the incidence of

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<sup>25</sup> Probably the 2nd Western General (Territorial) Hospital, Manchester.



neuropsychiatric disorders. There is also indirect evidence that psychotherapeutic methods were used in six other cases, all of which came under the care of R.G.Rows at Moss Side. Rows's casenotes are otherwise models of their kind but, frustratingly, make no direct reference to the nature of the treatment given in specific cases.<sup>26</sup>

These cases bring into focus one of the most significant findings of the present study, a central aim of which was to identify the nature of the treatment given to mental and nervous casualties. In most of the 500 cases, close examination of each entry for relevant evidence made it possible to follow case histories from the original causational factors, through consecutive hospitalisations to final disposal. With the handful of exceptions described above, this detailed analysis found no evidence of psychological treatment having been given.

### **3.6 The '500 cases' study: relationship to the conflict.**

The casenotes used cover roughly the periods 20 August 1914 - 30 December 1915, and 1 January 1916 - 20 June 1919, with a minor degree of overlap. In general terms, it can be said that the Representative Selection covers the early period of the war, prior to the establishing of special arrangements for the treatment of neuropsychiatric casualties. Napsbury, on the other hand, reflects one aspect of the arrangements made in response to rising numbers of such casualties. As one of the participating institutions in the Asylum War Hospitals Scheme, Napsbury received its first military neuropsychiatric

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<sup>26</sup> See Chapter Ten for discussion of Rows and his work at Moss Side Military Hospital.



patients on 14 May 1915, although general physical casualties were not admitted until a year later.<sup>27</sup> Napsbury was therefore one of the earliest special centres for the reception of mental and nervous casualties, following hard on the heels of the prototype at Moss Side, near Liverpool. According to the Official History, numbers of mental and nervous disorders in the early phases of the conflict were very small. During the latter months of 1914, the account reads:

...several men were evacuated from France to England owing to having been "broken" by their experiences during the retreat from Mons.<sup>28</sup>

The battle of Neuve Chapelle (10-12 March 1915), caused 12,892 British casualties, but there was 'no appearance of [neuropsychiatric] cases to any great extent.' Later that same year, at the battle of Loos, (25 September - 16 October), when casualties totalled 50,380, 'something more serious' was observed, with a definite increase in the numbers of functional hysterical symptoms being recorded.<sup>29</sup> A year later, during the first few weeks of the Somme campaign, (1 July - 18 November 1916) 'several thousand soldiers were...passed out of the battle zone on account of nervous disorders', many being sent back to the U.K.

This 'great influx' of patients reached England at a time when, due largely to the impact of Charles Myers' articles, shell shock had become

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<sup>27</sup> Cooke and Bond, *Asylum War Hospitals*, pp.46-7.

<sup>28</sup> Macpherson, *Medical Services*, Vol.2, p.8.

<sup>29</sup> *ibid.*



'a generally recognised term'.<sup>30</sup> At the Front itself this strange malady had become notorious, so much so that any nervous condition, no matter what its symptoms, was liable to be labelled as shell shock. In the words of the Official History:

When a patient was brought to a neurological centre and was asked of what he complained, he almost invariably answered, "Shellshock, sir." To the soldier's mind it was as much an entity as scarlet fever, with the further addition that, being incurable, shell shock was more to be dreaded.<sup>31</sup>

At Napsbury, specialisation in the more serious mental disorders was already well under way. Between 1 January and 1 July 1916, 40 cases of serious mental disorder were admitted, compared to only 23 nervous cases. Of the latter, 20 were of neurasthenia and 3 of shell shock. During the two weeks immediately following the start of the Somme campaign, however, the number of admissions for shell shock rose sharply. Of the 12 admissions during this comparatively short period, five were for shell shock. Without exception, the patients had been either blown up, or blown up and buried by near explosions. The average age of these patients was 20.8 years, and the average stay in hospital was 35 days. Both of these numbers correspond well to the Official History's assessment, namely, that shell shock as a condition occurred 'chiefly, but not entirely, amongst the younger members of the new armies.'<sup>32</sup> The relatively short stay in hospital also indicates, again according to the Official History, that the treatment of such conditions was relatively simple and recovery rapid. Of

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<sup>30</sup> Myers published articles under the general heading 'A Contribution to the Study of Shell Shock' in *The Lancet*; 13 February 1915, pp.316-20, 8 January 1916, pp.65-9, and 18 March 1916, pp.608-13.

<sup>31</sup> Macpherson, *Medical Services*, Vol.2, p.9. The Southborough Committee reached the opposite conclusion, recording that shell shock became 'a most desirable complaint from which to suffer.' See *Report of the Committee of Enquiry into 'Shell Shock'*, Command 1734, H.M.S.O., (London 1922), p.6.

<sup>32</sup> Macpherson, *Medical Services*, Vol.2, p.8.



the five cases in the 'shell shock cluster', four were discharged to sick leave, and one discharged to duty. Napsbury's Mental Section, although important in itself, was a comparatively small part of the hospital as a whole. For example, during its life as a War Hospital, Napsbury admitted a total of 32,852 casualties of all kinds - sick, wounded, mental and nervous. The great majority of these - 29,337, were general sick and wounded. During the same period, the Mental Section admitted 3515 patients, a mere 10.6% of the hospital's total war effort. In other words, of the hospital's 1700 beds, only 350 were in the Mental Section, a ratio which remained constant throughout the war.<sup>33</sup>

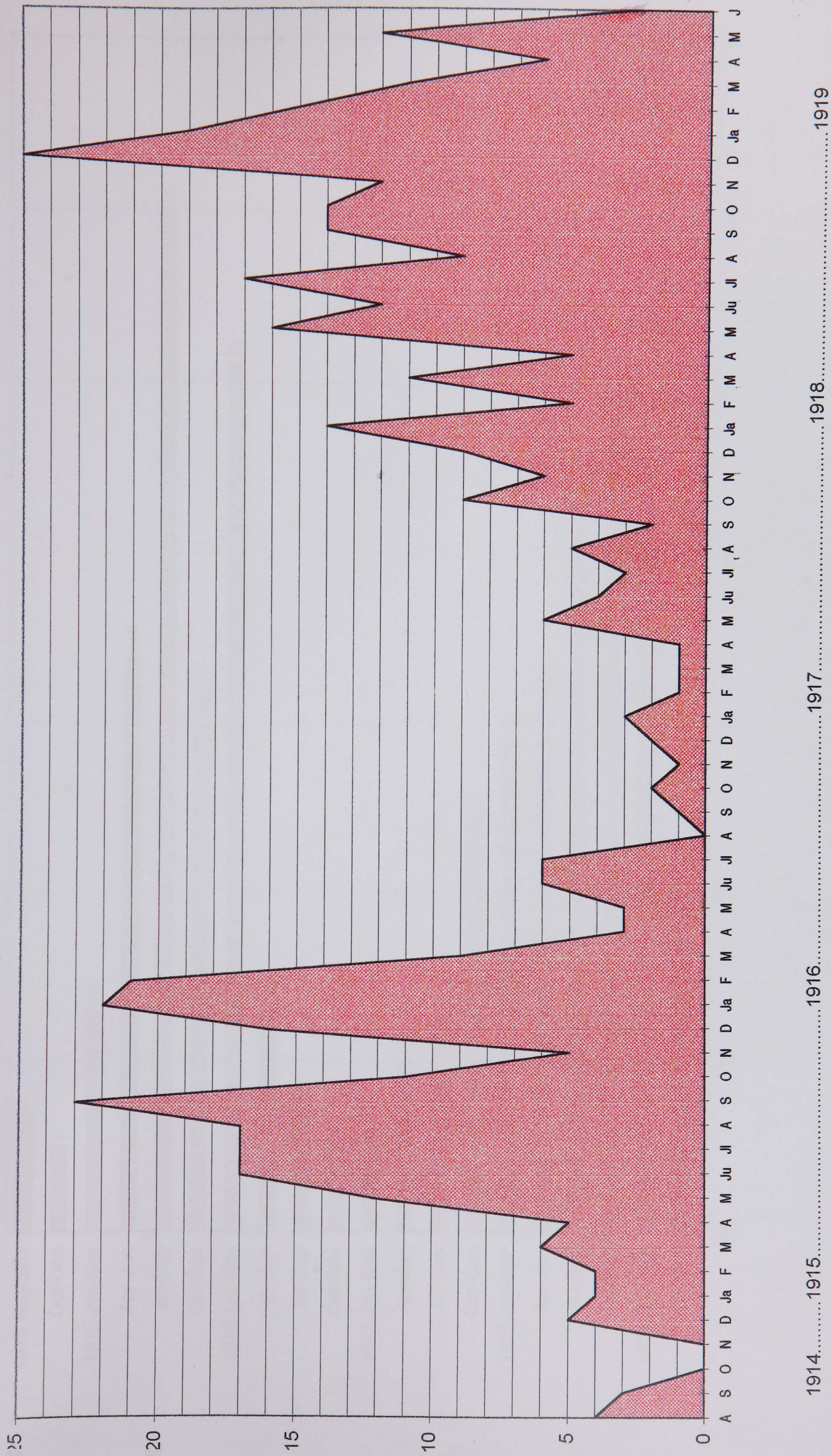
Figure 6 shows in graphical form the monthly admissions of mental and nervous casualties to all hospitals included in the study. Statistics from August 1914 to December 1915 inclusive are essentially those based on the Representative Selection. Statistics from May 1915 onwards may be read essentially as those of Napsbury. Unfortunately, the MS Windows 98 software used here does not allow numbers to be shown in this form of graphical display: Figure 7, therefore, shows these same data numerically, organised in this case as a three-monthly rather than a monthly display. In both displays, however, the chronological progression typical of the overall activity pattern of the Great War is apparent. Starting from the zero baseline of August 1914, casualties can be seen climbing steeply to reflect the disastrous Gallipoli campaign of early to mid-1915 and, from that point onward, a reflection of the cost in casualties of repeated but largely unsuccessful attempts to break the Western Front deadlock.

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<sup>33</sup> Cooke and Bond, *Asylum War Hospitals*, pp.45-7.

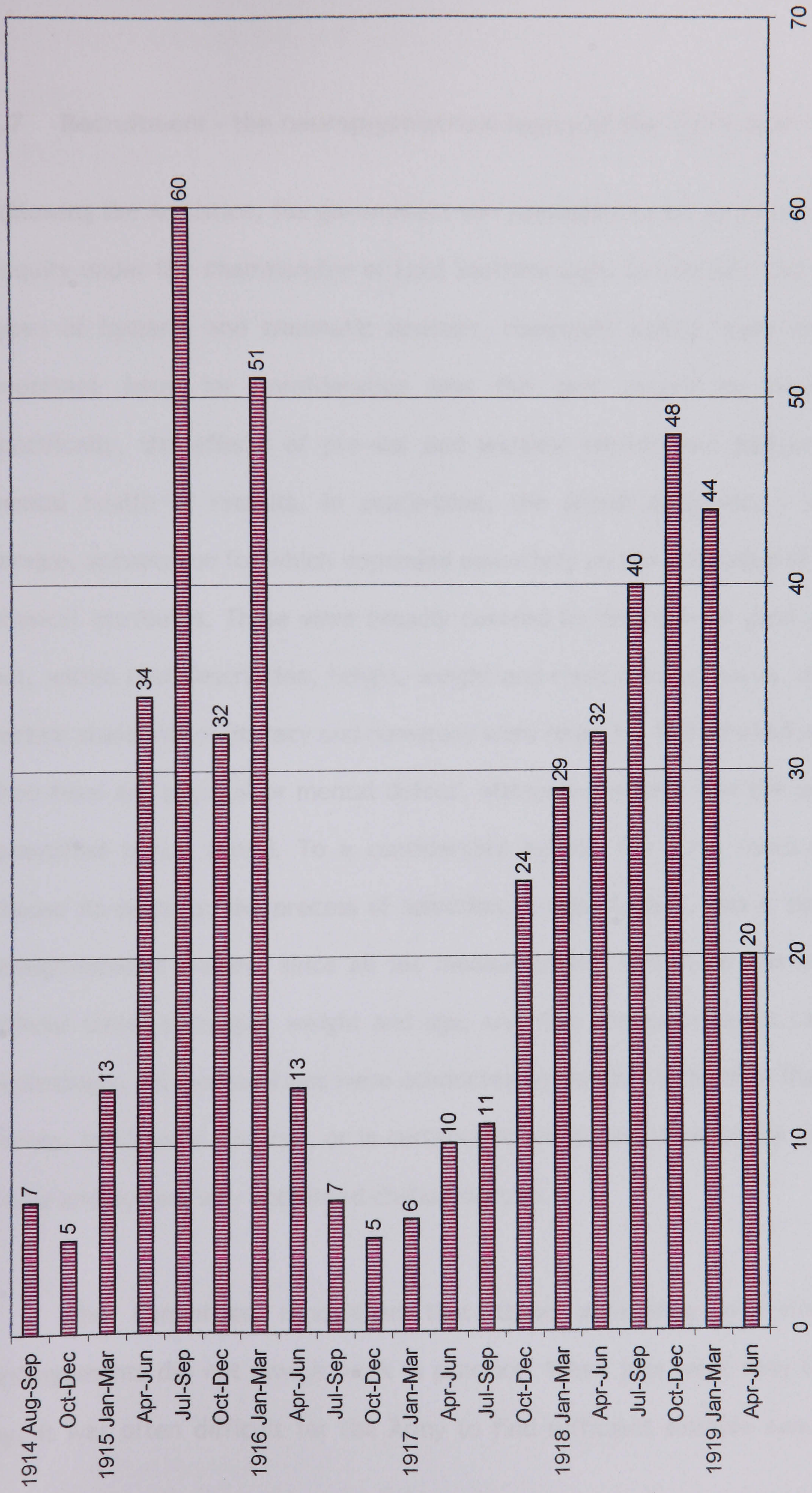


**Figure 6. 500 cases: monthly admissions to study group hospitals, August 1914 - June 1919 incl. (graphical)**





500 cases: (Representative Selection) + Napsbury: recorded admissions Aug 1914-Jun 1919





### **3.7 Recruitment - the neuropsychiatric legacy of the 'Open Door' policy.**

Following the Armistice, the government was persuaded to set up a Committee of Enquiry under the chairmanship of Lord Southborough, to consider 'the different types of hysteria and traumatic neurosis, commonly called "shell shock". An important issue for consideration was the part played by recruitment, specifically, the effects of pre-war and wartime recruitment policies on the mental health of recruits. In peace-time, the British Army was a voluntary service, acceptance for which depended essentially on the possession of minimal physical attributes. These were broadly covered by the term 'of good physique' but, within that description, height, weight and chest measurements, as well as certain standards of literacy and numeracy were required. Recruits had also to be 'free from any physical or mental defect', although precisely how the latter was quantified is not stated. To a considerable extent, the Army could pick and choose its recruits: the process of selection, it was claimed, was a 'simple and straightforward matter', since all the medical officer had to do was to consult official tables of height, weight and age, and then accept or reject candidates accordingly. All examinations were conducted by medical officers of the Regular Forces, the Special Reserve, or in certain circumstances, those of the Territorial Force and by specially appointed civilian doctors.

The Committee recognized that these apparently well-structured arrangements did not always work in practice. When jobs were easy to come by, it was often difficult for the Army to find sufficient suitable candidates.



During recessionary periods, when the prospect of an Army career seemed more attractive, employers tended to retain the healthiest, fittest and most productive men. A natural refuge for the unemployed at such times, the Army had little choice than to lower its standards. Some safeguards were built into the system. Men who, during their first three months' service were deemed 'unlikely to become an efficient soldier' could be discharged without reference to the medical authorities. During his first six months' service, a man whose training had uncovered physical or mental defects which made him unfit to continue, could, after reference to the medical authorities, be similarly discharged.<sup>34</sup>

These were the arrangements in place when war was declared. Between 4 August 1914 and 30 December 1915, 2,452,000 men volunteered for service with the armed forces, completely overwhelming a system designed to cope with only relatively small numbers of candidates:<sup>35</sup>

The result was chaos, intensified by the fact that the regular recruiting staff was mobilised and sent overseas. [...] doctors were called upon to "examine" as many as 200 recruits per diem; the whole tendency was to expedite and reduce to a minimum the medical examination. [...] it is becoming difficult now even to remember the immensity of our unpreparedness for war, and in no department was this...greater than that of recruiting.<sup>36</sup>

Most of the experienced R.A.M.C. medical officers had been sent out with the Expeditionary Forces, leaving the task of processing this vast horde to the small cadre of peace-time examiners, supplemented by doctors who had only the

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<sup>34</sup> Southborough, *Report*, p.161.

<sup>35</sup> Winter D., *Death's Men, Soldiers of the Great War*, Penguin, (London 1979). p.27 (quoting official figures published by H.M.S.O. in 1923).

<sup>36</sup> Southborough, *Report*, p.162.



vaguest notion of the demands of military life. The Southborough Committee again:

In these circumstances, thousands of men were passed "fit" into the Army every week without any medical examination worth the name. No effective means were taken to see that recruiting medical officers were in possession of, still less putting into effect, the standards required.<sup>37</sup>

Concern over the low standards of health in recruits, and warnings about the inevitable consequences of the 'open door' policy quickly appeared in the medical press. A *Lancet* editorial of early 1916 questioned why so many men were breaking down soon after arriving at the Front. Officer candidates, it was pointed out, were subject to a much more rigorous medical examination than the men 'intended for the rank and file', a disparity which it blamed for many of the obviously unfit men being sent to the fighting zones.<sup>38</sup> These concerns arose largely in respect of low physical standards, but the same indiscriminate recruitment policies, it was asserted, were responsible for allowing in many men who later became mental and nervous casualties. Table 1 below shows that a significant proportion of the 500 cases studied had suffered from mental or nervous disorders prior to enlistment in the Army. The degree of disorder varied considerably: at their mildest the patient may have had a history of childhood 'fits' or had suffered undefined 'depression' following illness. At their most severe, however, the patient had been legally certified as insane, and had spent sometimes lengthy periods in an asylum. In all, 162 (32.4%) of the study group recorded histories of this kind.

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<sup>37</sup> Southborough, *Report*, p.162.

<sup>38</sup> *The Lancet*, 13 May 1916, p.1006.



**Table 1.** 500 mental and nervous casualties: Pre-enlistment mental and/or nervous histories.

| Personal history |         | Family history |         |
|------------------|---------|----------------|---------|
| Mental           | Nervous | Mental         | Nervous |
| 38               | 69      | 36             | 19      |

|   |     |
|---|-----|
| Total patients with mental history                | 74  |
| Total patients with nervous history               | 88  |
| Total patients with mental and/or nervous history | 162 |

It must be stressed, however, that the above figures represent only those patients whose pre-enlistment histories were actually recorded. Case histories taken from the period before treatment facilities were properly organised tend to be less well documented. Many of the casenotes consist of only one or two Medical Case Sheets, with nothing to indicate that enquiries of this kind were made. In cases where a pre-enlistment mental or nervous history had been established, enquiries were often made with the patient's family. In view of the widespread fear of 'asylum stigma', however, concealment of a negative history - even in an age of much greater deference to authority - cannot be ruled out.<sup>39</sup>

Even at a very late stage in the conflict, psychologically and neurologically unfit candidates were being taken into the Army. The following case illustrates the readiness with which mentally and neurologically unfit men were recruited. The case also underlines the often complex symptomatology, and the need for expert medical assessment at the time of recruitment.

<sup>39</sup> For discussion of so-called 'asylum stigma' in respect of military neuropsychiatric casualties, see Chapter Nine.



Study Case No.286  
Archive Reference: PRO/MH106/2222  
159554 Gunner Harris J.  
Age: 30  
Service: 9 months  
Unit: Royal Garrison Artillery

On 3 January 1918 while serving in France, Gunner Harris was admitted to No. 26 General Hospital at Etaples, diagnosed as suffering from 'paranoia'. He was an educated man, a dental practitioner of sorts, although his qualifications seem to have been somewhat questionable. His notes state that he was 'registered in the Isle of Man'. He was 'attested' in 1915 but exempted for reasons that are not made clear. He eventually enlisted in May 1917, primarily because he had been jeered at several times in public for not being in uniform. He said he had been under fire since being in France, but said it had not affected him unduly. On admission he complained of being victimised by the officers and N.C.O.s of his unit because they thought he was 'too grand'. He was also under the delusion that he had been 'secretly ruined' by an unknown woman in England, and that his food, drink and cigarettes were being drugged. His memory was deficient, his speech incoherent, and at times he lapsed into long introspective silences, and was 'apt to become emotional'. He also exhibited psychasthenic (obsessive behavioural) symptoms, spending a great deal of time 'sweeping under his bed'. Another case sheet, dated 5 January 1918 and signed by a different medical officer, (possibly a mental specialist) and headed 'Dementia', contains only the following statement:



This man is very insane...full of delusions of persecution and suspicion, with ideas of reference.<sup>40</sup> He gives me the impression of being a D.P.<sup>41</sup> No trouble here, so far, but I think him very uncertain.

H.Yellowlees

Captain R.A.M.C.

Harris was sent back to the U.K. and admitted to 'D' Block, Netley, on 16 January 1918. There, he said he had always been nervous, that he had had a nervous breakdown and neurasthenia just before enlistment, and that he suffered from sleeplessness, depression and head pains. Major Read, who examined him, found that Harris answered questions 'readily and rationally and detected no psychotic symptoms. He found Harris 'a most superior, educated man with a highly conscientious mind.' He was correctly oriented and his memory was good. He slept 'poorly' but was said to be 'otherwise...his usual self.' His physical condition and appetite were good. Deep reflexes were somewhat diminished, but he exhibited no nervous habits or tremor. In short, Major Read might well have been examining a quite different man from the one admitted to Etaples only 11 days before. Apparently almost recovered, therefore, and despite living in Hampstead, Harris was sent to Dykebar War Hospital near Paisley, and admitted there on 24 January 1918. 42

At Dykebar, Harris gave a history which differed markedly from any he had previously volunteered. His nervous breakdown, neurasthenia, depression,

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<sup>40</sup> An extreme form of 'taking things the wrong way' (see glossary).

<sup>41</sup> Dementia praecox (see glossary).

<sup>42</sup> Dykebar (previously Renfrew District Asylum) provided 850 beds for mental patients only. See: Salmon T.W., 'The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army', Typescript: produced for internal circulation, National Committee for Mental Hygiene, New York 1917, Appendix 3, p.13. Wellcome Institute, R.A.M.C. Collection.



sleeplessness and the rest of his symptoms were played down. He stated that he had had 'no previous mental attack' and claimed to have enjoyed good health prior to enlistment. He also said he had served in the Sussex Yeomanry between 1905 and 1907. Harris's manner was described as 'shy and reticent'. He now accepted that his fears about food and cigarettes being drugged had been imaginary, but clung to his delusion that he was under some kind of malign influence exerted by a woman in England. Harris's story was now also more complex. He claimed to have had sexual contact with this woman before leaving England and to have been persuaded to marry her 'lest she should have become pregnant through him'. He stated that the pregnancy had not actually transpired, but that the woman had hypnotised him into believing that it had:

...probably after drinking whisky drugged by her & that he has felt himself under this hypnotic influence all the time he was in France.

After further discussion, Lieut. Anderson, the attending medical officer, recorded that it was 'not easy to determine how much of the idea (of persecution) remains.' He concluded that Harris was still very depressed and possibly suicidal. Harris remained at Dykebar without improvement. He retained his persecutory delusions, and now interpreted past and more recent events as a 'combined attempt to make him go insane'. He was transferred to Napsbury, and admitted there on 12 August 1918. Replying to the hospital's standard enquiry form, Harris's father confirmed that his son had suffered some sort of mental breakdown in December 1916, and that his delusions concerning a predatory woman, hypnotism and marriage began around that time. Harris remained at Napsbury, showing no improvement, until 13 June 1919, when he was discharged from the Army and sent home. His discharge was almost



certainly prompted by the fact that Napsbury was rapidly contracting at the time, closing as a War Hospital on 25 July 1919.

Harris's case is one of many identified in the course of the study in which the patient had not only been discharged in what was clearly a mentally disordered condition, but had equally clearly been psychologically unfit at enlistment. This arose directly from the fact that few general practitioners were capable of identifying the signs and symptoms of neuropsychiatric illness. Particularly in the early stages of the war, this was also true of most Army medical officers. Harris, like many others, was also put under pressure by 'bellicose enthusiasm' exemplified by social phenomena such as the 'White Feather' campaign, and by officially sanctioned, and often aggressive, exhortations through posters and the press.<sup>43</sup> The meanings of the various categories are given below.

#### **(a) 'Discharged to furlough'**

'Furlough' - nowadays American rather than British English usage - was the term routinely used by the authorities at the time for authorised absence. It was normally granted following hospitalisation and prior to returning to duty, the period granted varying from 14 to 30 days.

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<sup>43</sup> For the reaction of front-line troops to the 'White Feather' campaign, see: Pope S. and Wheal E.-A., *Dictionary of the First World War*, Macmillan, (London 1995). p.507.



**(b) 'Discharged to home'.**

This destination was recorded in a number of ways; 'Home', 'Home for discharge', 'Discharged to his home'. Where the survival of Medical Board Reports showed conclusively that the patient had in fact been discharged from the Army, such cases are included in (d) below.

**(c) 'Discharged to duty'.**

A destination more frequently met with in the largely nervous cases of the Representative Selection than in the mental cases dealt with at Napsbury. 36 (59.0%) of the 61 cases marked 'discharged to duty' were included in the Representative Selection which, as noted earlier, accounted for only 145 (29.0%) of the 500 cases studied.

**(d) 'Discharged from the Army'**

This category accounted for 181 (36.2%) of the cases studied. Patients sent to asylums and mental hospitals were in every case discharged from the Army. If those (99), together with deaths in hospital (11) and those discharged 'To Home' (30) are included, the total permanent wastage through mental and nervous illness in the 500 sample is 321 (64.2%).

**(e) 'Discharged dead'**

The 11 cases in which the patient died while in hospital were, with a single exception, suffering from the more severe forms of mental illness. The symptomatology of these cases included progressive deterioration of physical condition, usually as a consequence of chronic refusal of nourishment,



interference with wounds, or apathetic immobility leading to pulmonary disease.

**(f) 'Discharged to convalescence'.**

The majority of discharges to convalescence were from nervous cases in the Representative Selection. The only four discharges to convalescence from Napsbury were the rare cases of shell shock admitted there. No mental patients were disposed of in this way.

**(g) 'Discharged to asylum'.**

In 85 instances casenotes were marked with the name of the receiving institution. The sparseness of surviving correspondence suggests, however, that the process of transferring patients from military hospitals to public lunatic asylums was very much less formal than the strictly controlled medico-legal process required by the 1890 lunacy legislation. Some casenotes were marked 'Certified and transferred to...' or similar. As far as administrative procedures were concerned, however, nothing more formal than an exchange of letters seems to have been involved. This does not mean, of course, that more formal and detailed records were not made, simply that they do not survive in the medical casenotes with which this thesis is concerned.

**(h) 'Discharged to mental hospital'.**

As explained more fully in Chapter Eight, the designation 'mental hospital' as opposed to 'asylum' was slowly gaining ground at the start of the Great War. Their legal status remained unchanged. Both were governed by the provisions of



the 1890 Lunacy Act, and both operated under the *aegis* of the Board of Control. For practical purposes, therefore, discharges to asylums and mental hospitals may be consolidated. Altogether, 99 (19.7%) of the 500 cases were disposed of to these institutions.

**(i) 'Transferred to other hospital'.**

Of the four cases transferred, three were from the early period of the war, and were comparatively mild cases of shell shock. Uniquely, only one case was transferred from Napsbury, a case of neurasthenia transferred after improving.

**(j) 'Discharged - no record'.**

Lack of a confirmed final destination was largely due to failure on the part of hospitals in the early period of the war to correctly complete Medical Case Sheets. The most probable cause was unfamiliarity on the part of 'hostilities only' medical staff with military administrative procedures.<sup>44</sup> 40 (67.7%) of the incomplete Medical Case Sheets came from the early war period and from cases in the Representative Selection. As a general observation, the problem was not helped by the largely unstructured format of the Form I.1237 itself. Apart from the standard personal details - name, rank, unit, etc., the form was completely blank, allowing the attending medical officer more or less complete freedom as to content.

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<sup>44</sup> Lieut.-Colonel Harrison, Commanding Officer of the 5th Northern General Territorial Hospital at Leicester, recorded specific complaints about the inability or disinclination of auxiliary and temporary hospitals to comply with standard military administrative procedures. See: Harrison L.K., 'History of the 5th. Northern General Military Hospital, Leicester.' (Unpubl. typescript 1919) Leics. County Record Office, Ref. LM/8/11/TS.



### **3.8 Distribution of mental and nervous casualties by service branch.**

Previous studies have focused on shell shock, and on the infantry branch of the British Army to which shell shock was largely assumed to have been restricted. Confined to their trenches, the 'P.B.I.' - the 'Poor Bloody Infantry' - is popularly portrayed as cowering helplessly while their own artillery pounded the enemy. Any satisfaction they may have derived from the thought of so many tons of metal and high explosive being hurled at the Germans, was qualified by the knowledge that their turn for a similar pounding would inevitably follow.

Giving evidence to the post-war Southborough Committee, W.H.R. Rivers used the term 'manipulative activity' to describe Man's instinctive reaction to danger. This instinct - often summarised as the 'fight or flight' instinct - arose directly from the deeper and more primitive instinct of self-preservation. Briefly, the options were to attack the threat, to run away, or to hide. Frustration of this 'manipulative activity', Rivers argued, led to emotional conflict, stress and neuropsychiatric disorders. In the trenches, however, running away risked death before a firing squad. Attacking the enemy across 'No Man's Land' was highly dangerous under the most favourable conditions. The only course left open to the infantryman was to seek what shelter he could, while the artillery fought their duels overhead. This, as Rivers pointed out, was in itself a highly stressful situation to be in, with the prospect of a direct hit always imminent:



...what did produce fear was being between two barrages - a barrage in front and one behind and nothing to be done.<sup>45</sup>

Writing after the war, Frederick Mott described the psychological conflict which he believed particularly affected the officer class. Combining with and intensifying the emotional conflict set up by the frustration of the natural 'fight or flight' instinct, the officer was subject to the 'continuous mental conflict' of having to appear fearless and dependable in front of his subordinates. Perhaps the most important function of the infantry officer was to lead his men 'over the top', and to take them forward by force of example, often into a veritable hail of bullets. Whilst every natural instinct clamoured for him to dive for cover, every environmental lesson of class, family, education, duty and patriotism urged him to stand erect and advance on the enemy.<sup>46</sup>

This is the 'classic' picture of military activity on the Western Front. The Official History of the medical services speaks of 'prolonged fighting and heavy bombardments' as the two most important aetiological factors in the causation of neuropsychiatric disorders, to the extent that other factors could be regarded as 'almost negligible.' Since it was the infantry who were subjected to the worst effects of both, it follows that it was they who suffered most in neuropsychiatric terms. However, this study has highlighted other aspects of the neuropsychiatric history of the Great War, notably the numbers of mental and nervous casualties experienced in other branches of the Army, as well as the complex nature of the problem. The Official History's view of the fighting

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<sup>45</sup> Southborough, *Report*, p.57.

<sup>46</sup> For discussion of the special position of the officer class in relation to mental and nervous disorders, see Chapter Four.



implies that it was the major battles such as the Somme that caused most neuropsychiatric casualties. This is undoubtedly true, but the present study also suggests that bombardments and traumatic burials were far from being the whole story. Figure 8 shows that, in almost half of the 326 instances in which the causation was recorded, the patient's condition could not be attributed to a specific external event or events. For example, 65 cases (19.9%) were said to be due to an acute breakdown, and 85 (26.0%) to breakdown over an extended period. Explosion and traumatic burial - the popularly supposed major causes of Great War neuropsychiatric disorders - in fact accounted for only 37 (11.3%) of the total. Concentrating on the aetiological background of the infantry experience, therefore, fails to explain how and why the artillery, or the service branches sustained their share of neuropsychiatric casualties. Behind the numbers themselves, however, lie factors which merit consideration if unsafe inferences are not to be drawn.

**Table 2.**

**500 Cases: Admissions of neuropsychiatric casualties to United Kingdom Hospitals, 20 August 1914 - 20 June 1919. Analysed by Army service branches.**

| Branch of Service | No. of cases | % of total cases |
|-------------------|--------------|------------------|
| Infantry          | 288          | 57.6             |
| Service*          | 134          | 26.8             |
| Artillery         | 59           | 11.8             |
| Other**           | 15           | 3.0              |
| Cavalry           | 4            | 0.8              |
| Total             | 500          | 100%             |

\*includes R.A.M.C., R.A.O.C., R.E., Labour Corps, etc.

\*\* Includes R.F.C, Officer Cadet (1) in training, etc.



500 cases (326 patients) - Classification / number / percentage of causational event

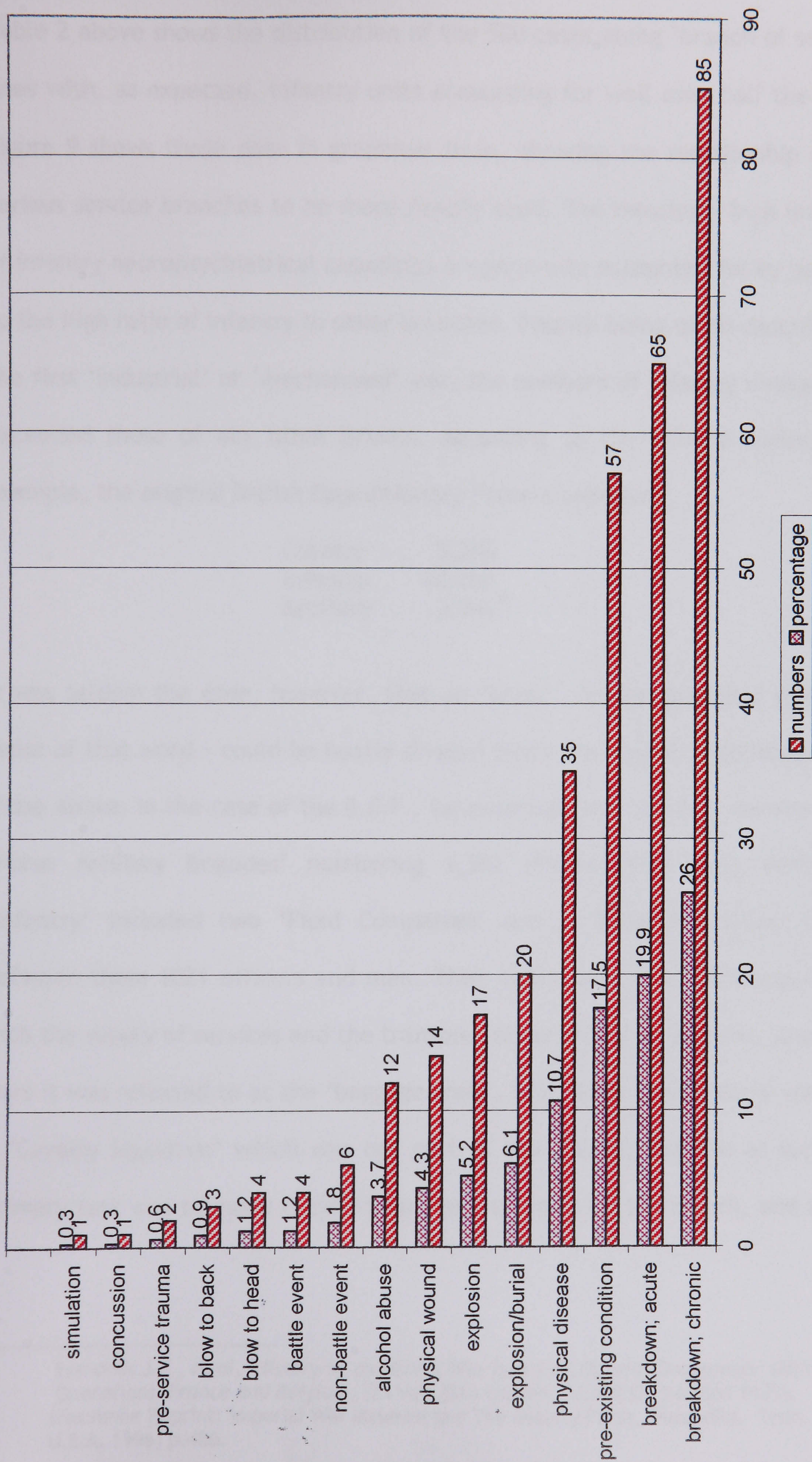




Table 2 above shows the distribution of the 500 cases along 'branch of service' lines with, as expected, infantry units accounting for well over half the total. Figure 9 shows these data in graphical form, allowing the relationship of the various service branches to be more readily seen. The relatively high numbers of infantry neuropsychiatric casualties are generally accounted for by pointing to the high ratio of infantry to other branches. Despite being often described as the first 'industrial' or 'mechanised' war, the numbers of infantry engaged far exceeded those of any other branch. According to the Official History, for example, the original British Expeditionary Force comprised;

|           |                     |
|-----------|---------------------|
| Cavalry   | 9,269               |
| Infantry  | 12,165              |
| Artillery | 3,042 <sup>47</sup> |

It was seldom the case, however, that an 'army' - in the generally accepted sense of that word - could be neatly divided into a few major branches such as those above. In the case of the B.E.F., for example, the 'cavalry' included two 'Horse Artillery Brigades' numbering 1,362 officers and men, while the 'infantry' included two 'Field Companies' and a 'Divisional Train' having between them 1021 officers and men. Their tasks were essentially connected with the supply of services and the transport of necessary equipment. In earlier wars it was referred to as the 'baggage train'. With the infantry there was also a 'Cavalry Squadron' which was not part of the Cavalry Division as such. Its primary task was to move rapidly to protect columns on the march, and to act

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<sup>47</sup> Edmonds J.E., et al, *History of the Great War based on Official Documents: Military Operations France and Belgium*, (21 vols.) 3rd Edition, H.M.S.O. (London 1933). (Facsimile Reprint: Imperial War Museum and The Battery Press, Nashville, Tenn. U.S.A. 1996) p.486.



500 cases - numbers of mental and nervous cases (by arm of service) 1914-1918





as scouts and a forward protective screen.<sup>48</sup> Regrettably, none of the many sources consulted draw distinctions between the various branches of the British Army when recording neuropsychiatric casualties. Consequently, It is not possible to make any direct comparisons between the data generated by the present study and any valid data elsewhere. The kind of causational explanations offered by W.H.R.Rivers are persuasive in respect of the infantry, and have been generally accepted by successive writers. They are less helpful, however, in attempting to explain mental and nervous disorders in other branches of the Army such as the artillery itself.

It calls for little imagination to appreciate that the combat stresses referred to acted in quite different ways on artillery units than on the infantry. For one thing, the enforced immobility described by Rivers did not generally apply to artillery units. The light guns of the Royal Horse Artillery were highly mobile when conditions allowed, and were noted for their 'dash and *elan*'. The medium guns of the Royal Field Artillery, and particularly the heavy guns and howitzers of the Royal Garrison Artillery, were capable of inflicting substantial blows on the enemy, They were, in Malcolm Brown's words:

...the siege cannon of the Western Front war; they, rather than the rifle or, deadly as it was, the machine gun, were to be responsible for the great majority of the casualties.<sup>49</sup>

Although far from immune to enemy attack, and in many ways more exposed to the enemy's reciprocal bombardments, the artillery - at least following

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<sup>48</sup> Edmonds, *Military Operations*, p.486. A single infantry brigade of 4000 men, for example, together with its 'impedimenta' occupied three and a half miles (5.63 km) of road space.

<sup>49</sup> Brown M., *The Imperial War Museum Book of the Western Front*, Sidgwick and Jackson, (London 1993), p.59.



entrenchment - fought their duels at a distance. The action, particularly of the big guns, also conveyed a sense of power and technical perfection which others could not fail to sense. Infantry Lieutenant John Stamford of the 7th Leinster Regiment, newly arrived in France, recorded his impressions on first seeing a battery of big guns in action:

It was a lovely picture; the gun crews stripped and sweating, each crew working like a machine, the swing and smack of the breech-block as clean and sweet as a kiss, and then a six-foot stream of crimson flame from the muzzle, a thunderclap of sound, and away tore the shell over the hills to Boche trenches 5000 yards away.<sup>50</sup>

As far as the causational environment for mental and nervous disorders is concerned, this extract illustrates vividly the major contrasts between the respective situations of the artillery and the infantry. Above all else, the artillery possessed the means of striking back at the enemy in an immediate and telling fashion. The infantry's opportunities for contact with the enemy mainly took the form of frontal attacks, night patrols and bombing raids.<sup>51</sup> Such episodes could be satisfying, a chance to release pent-up anger and to avenge the death of comrades. However, their declared aim of keeping the enemy 'on the hop' was often achieved at a disproportionate cost in casualties.

Bombing raids in particular were often regarded by junior officers as a form of competition. The poet Siegfried Sassoon had a reputation as an audacious exponent of the art of the bombing raid, exploits for which he was awarded the Military Cross. Fearful anticipation of the frontal attack, on the

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<sup>50</sup> Close on three miles. For a comprehensive but concise summary of the philosophy of Great War artillery combat, see: Macksey K., *The Penguin Encyclopaedia of Weapons and Military Technology*, Penguin, (London 1993), esp. pp.47-8.

<sup>51</sup> *ibid.*, pp.473-4.



other hand, was frequently cited as a major contributory factor in the causation of mental and nervous disorders. They were often costly in terms of life and limb, and were therefore more dreaded than welcomed. Regrettably, lack of sufficient statistical data prevents a detailed study of the comparative incidence of mental and nervous disorders in the artillery and infantry branches. Since the basis on which the Representative Selection was made is not known, it is not possible to assess how closely it correlates with the total neuropsychiatric experience of the war.

Table 3.

Admissions to Napsbury War Hospital 1 January 1916 to 20 June 1919. Analysis of patients by Army service branches.

| Branch of service | No. of cases | % of total cases |
|-------------------|--------------|------------------|
|                   |              |                  |
| Infantry          | 173 (288)    | 49.8 (57.6)      |
| Service           | 113 (134)    | 32.5 (26.8)      |
| Artillery         | 45 (59)      | 12.9 (11.8)      |
| Other             | 14 (15)      | 4.0 (3.0)        |
| Cavalry           | 2 (4)        | 0.5 (0.8)        |
|                   |              |                  |
| Total             | 347          | 100%             |

The numbers in brackets are taken from Table 2 on p.86 above, and represent the same division of mental and nervous casualties along branch of service lines. The open and bracketed numbers are essentially those from the whole study and from Napsbury respectively. They are therefore comparable only in the sense of service branch ratios, and not chronologically. Even taking all these modifying factors into account, however, the ratios between the various service branches seem to have remained remarkably consistent throughout the war, a reflection perhaps of the essentially static nature of the conflict. The



closeness of the correlation is all the more noteworthy in view of the narrowness of the statistical base, and taking into account the fact that these tables represent only admissions of mental and nervous casualties and not the whole patient population. An interesting, and possibly enlightening exercise for the future might be a study along similar lines, comparing the ratios of physical injuries and diseases with those of mental and nervous disorders. For this purpose, the admission and discharge registers of Napsbury War Hospital, referred to at the start of this chapter, would be ideally suited.

A brief note needs to be added here concerning the role of the cavalry. At the start of the war, cavalry units were expected to operate as they had in previous conflicts. After entrenchment, however, they became almost wholly redundant. Many cavalry units were 'dismounted' and fought as infantry for the remainder of the conflict. This, and their highly mobile role in the early months of the conflict, meant that cavalry units as such scarcely featured in the neuropsychiatric casualty lists.



## CHAPTER FOUR

### NEURASTHENIA - FROM MIDDLE CLASS *ENNUI* TO COMBAT FATIGUE SYNDROME.

#### 4.1 Background and rationale.

No investigation into the mental and nervous casualties of the Great War can progress far without encountering neurasthenia. The condition was diagnosed in thousands of soldiers - officers and other ranks alike - in British military hospitals, both in the United Kingdom and in expeditionary forces and garrisons abroad. It was diagnosed in 119 (23.8%) of the 500 neuropsychiatric cases analysed in the course of the present study, and accounts for 56.1% of the 212 cases of nervous disorder of all types found in the study group. An example of its universality as a diagnosis is the fact that, of the 207 officers admitted to Craiglockhart hospital between 27 October 1916 and 10 November 1917, no less than 163 (78.7%) were diagnosed as suffering from neurasthenia. Figure 10 shows the relationship of neurasthenia to the other nervous disorders recorded in the study.<sup>1</sup>

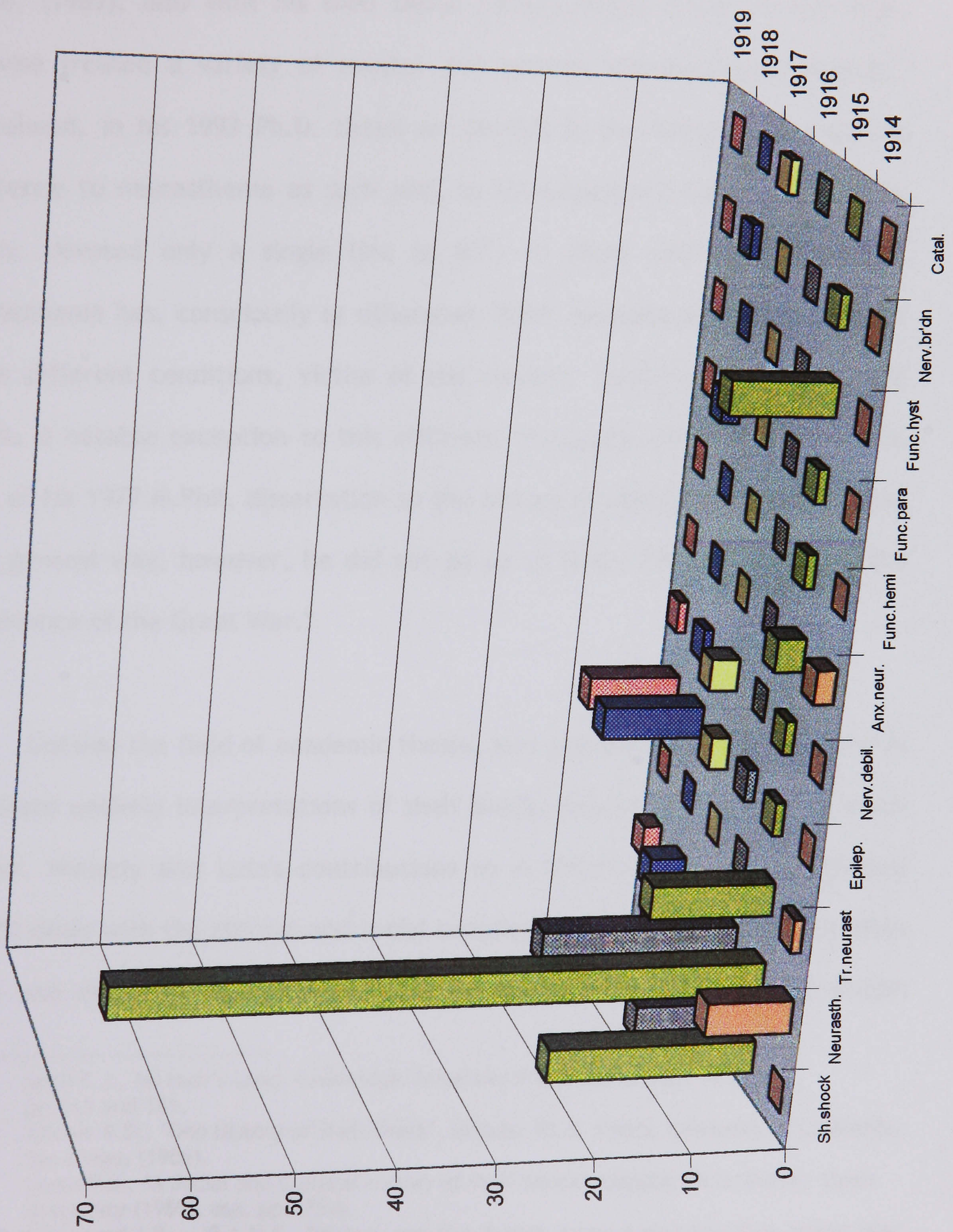
The literature on neurasthenia fills thousands of pages in books, monographs, articles and editorials before, during, and after the Great War. Despite its prevalence, and its significance as a causational and exacerbatory factor in both mental and nervous disorders, the condition has been given only perfunctory, and almost invariably confused and inaccurate treatment, in much of the literature dealing with Great War psychiatry. Eric Leed, in his much-quoted *No Man's Land* (1979), compounded neurasthenia and other unrelated disorders in a complex psycho-political synthesis, without further investigating

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<sup>1</sup> See Chapter Three for further analysis of these numbers.



500 cases: Comparative incidence of nervous (only) disorders 1914-1919





the nature of the condition itself.<sup>2</sup> In support of his particular shell shock thesis, Ritchie (1986), emphasised the importance of shell shock by conflating the neurasthenic (fatigue) and shell shock (functional hysterical) syndromes.<sup>3</sup> Leese, (1989), also with his shell shock colours nailed firmly to the mast, likewise treated a variety of mental and nervous disorders synonymously.<sup>4</sup> Whitehead, in his 1993 Ph.D. thesis on doctors in the Great War, made no reference to neurasthenia as such and, in his subsequent book based on his thesis, devoted only a single line to it.<sup>5</sup> In these and other instances, neurasthenia has, consciously or otherwise, been confused and conflated with quite different conditions, victim of the modern preoccupation with shell shock. A notable exception to this criticism, P.J.Lynch devoted a substantial part of his 1977 M.Phil. dissertation to the history of neurasthenia. Other than in a general way, however, he did not go on to relate his conclusions to the experience of the Great War.<sup>6</sup>

Outside the field of academic theses, and unaffected by the urge to find yet more unlikely interpretations of shell shock, neurasthenia has fared much better. Wessely and Lutz's contributions to *A History of Clinical Psychiatry* (1995) deals with the clinical and social complexities respectively with enviable style and erudition. The treatment of neurasthenia in *150 Years of British*

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<sup>2</sup> Leed E.J., *No man's Land*, Cambridge University Press, (Cambridge 1979) pp.163 and 181.

<sup>3</sup> Ritchie R.D., 'One History of Shell Shock', Unpubl. Ph.D. thesis, University of California, San Diego, (1986).

<sup>4</sup> Leese P.J., 'A Social and Cultural History of Shell Shock', Unpubl. Ph.D. thesis, Open University (1989), esp. pp.375-6.

<sup>5</sup> Whitehead I.R., 'R.A.M.C. Doctors and the British Army during the First World War', Unpubl. Ph.D. thesis, Leeds University, (1993).

Whitehead I.R., *Doctors in the Great War*, Leo Cooper, (London 1999) p.241.

<sup>6</sup> Lynch P.J., 'The Exploitation of Courage', Unpubl. M.Phil. thesis. University College London, (1977).



*Psychiatry* (1996), necessarily sacrifices comprehensiveness in the interests of sharper focus. Nevertheless, the widely separated entries in that publication, taken together, provide a reasonably clear view of the condition within its historical framework.<sup>7</sup> Laudable as they most certainly are, these approaches face the difficult task of dealing with the entire historiography of neurasthenia, and are therefore limited in the amount of space they are able to devote specifically to the place of neurasthenia in the medical history of the Great War. As part of the historical synthesis of modern psychiatry, however, they nevertheless provide the essential matrix within which neurasthenia, as it manifested itself during the conflict, can be located. In this chapter, evidence drawn from a number of sources, including newly available primary sources, will, it is hoped, go some way towards relocating neurasthenia within the overall context of Great War neuropsychiatric medicine. In the process, some of the more harmful distortions that have clouded earlier academic approaches are corrected.

#### 4.2 Neurasthenia: medical and social historiography.

As its name implies, neurasthenia has at its centre the concept of 'nervous exhaustion', a synonym frequently used in the many hundreds of books and articles written about this now almost forgotten disorder.<sup>8</sup> Neurasthenia was ostensibly a disorder of the nervous system, 'without organic lesion'. It was characterised by loss of nervous tone, lack of interest in the events of daily

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<sup>7</sup> Freeman H. and Berrios G.E. (Eds.) *150 years of British Psychiatry: Volume 2; The Aftermath*, Athlone, (London 1996) *passim*.

<sup>8</sup> See for example, Cobb I.G., *A Manual of Neurasthenia: (Nervous Exhaustion)*, Bailliere, Tindall and Cox, (London 1920). The bibliography in this work alone extends to 61 books and articles on neurasthenia. Authors include Beard, Weir Mitchell, Ballet, Dubois, Adler, Forel, Freud, Jung, Hart, McDougall and Kraepelin.



life, physical enfeeblement, chronic fatigue, penetrating lassitude, rapid exhaustion of energy, and the wide dissemination of these and similar symptoms throughout the nervous system.

Writing in November 1912, Drs. A.T.Schofield and R.Murray Leslie deplored the complexities that had grown up around the nomenclature of nervous diseases generally. Most doctors faced with the task of diagnosing such a disorder, they complained, were left 'perfectly bewildered amidst the weird assemblage of psychical and physical symptoms'. The medical nosologies listed a dozen different forms of 'asthenia' most of which, they complained, the average doctor had never seen, and would not recognise if he did. Some authorities held that neurasthenia was merely a convenient invention: Eichhorst, Dubois and others, the writers noted, 'deny that neurasthenia is a corporeal malady at all, and regard it as purely mental'. For their part, Schofield and Leslie were convinced that:

Neurasthenia may be, but is not always or even mostly, hereditary; and its exciting causes are nerve poisons of all sorts - malnutrition, fatigue, and overstrain - all of which are clearly of a physical nature and effect.<sup>9</sup>

The outcome of such contradictions and uncertainties, they believed, was that doctors took refuge in generalities such as neurasthenia. The sheer number of such diagnoses further solidified its position, with the result that it

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<sup>9</sup> *The British Medical Journal*, 23 November 1912, p.1458.



had become, in the words of Dr. Collins, Professor of Mental Diseases in New York, 'a clinical Colossus in the shape of a sphinx.'<sup>10</sup>

As an encouragement to their bewildered colleagues, Schofield and Leslie claimed to have detected signs that, as a diagnosis, neurasthenia was falling out of favour. Five years later, however, the question of neurasthenia's legitimacy as a medical entity, and the difficulty of setting limits to its symptomatology, was still surrounded by controversy.

In late 1917, when Lieut.-Colonel F.W.(later Sir Frederick) Mott, at the time the leading neurologist at the Maudsley Hospital in London, addressed a meeting of the Harveian Society. Although previously a confirmed physicalist as far as the war neuroses were concerned, Mott had by this time accepted some of the arguments of the 'psychological' school, and had recognised the essentially mental basis of neurasthenia as a war-related disorder. As far as definition was concerned, Mott preferred that of the French neurologist Dejerine;

Neurasthenia consists of the ensemble of phenomena which result from the *non-adaptation* of the individual to a *continuous emotive* cause and the *struggle of the individual* for this adaptation.<sup>11</sup>

He also shared the view, widely held among neurologists, that sustaining a physical wound conferred some sort of immunity from mental illness. The war had demonstrated 'conclusively' that soldiers could sustain severe injuries of the head, spine and peripheral nervous system, without showing any signs of

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<sup>10</sup> *The British Medical Journal*, 23 November 1912, p.1458.

<sup>11</sup> *The Lancet*, 26 January 1918, p.127. (Original emphases).



neurasthenia. In looking for the disorder, Mott insisted, 'we should not go to the surgical wards'.<sup>12</sup>

Work done under his direction at the 4th London (Territorial) General Hospital (of which the Maudsley was a part), Mott went on, proved 'conclusively' that the most significant factor in the genesis of neurasthenia was an 'inborn or acquired tendency to emotivity.' The work to which Mott referred was in fact carried out by an American psychiatrist, Professor Julian Wolfsohn, who at that time was attached to the Maudsley as a Captain in the United States Medical Reserve Corps. Wolfsohn's research seemed to support the contention that those sustaining physical wounds tended not to develop mental or nervous symptoms. Wolfsohn's study, however, was not, as Mott implies, aimed at neurasthenia alone, but on the wider subject of neuropsychiatric casualties generally.<sup>13</sup>

Neurasthenia, Mott continued, was to be found in 'the majority of cases [of] so-called "shell shock".' The neurasthenia associated with these cases resulted largely from the frustration of the self-preserving 'flight' instinct, coupled with the sustained fear of death or mutilation, the irrefutable evidence for which lay on every hand in the form of dead and mutilated comrades. These conditions, Mott suggested, brought about the 'continuous emotive' situation required by Dejerine's definition. The individual's futile struggle to adapt to these emotionally overwhelming events, often over protracted periods, played

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<sup>12</sup> *The Lancet*, 26 January 1918, p.127.

<sup>13</sup> Wolfsohn J.M. 'The Predisposing Factors of War Psycho-neuroses', *The Lancet*, 2 February 1918, pp.177-9.



a 'dominant part' in the causation of neurasthenia. The 'dodging reflex and the startling reflex' in response to sudden movement or noise, commonly observed in those suffering from post-shell shock neurasthenia, Mott concluded, confirmed their origin as 'instinctive self-conservative reactions' to the patients' traumatic experiences.<sup>14</sup>

It must be immediately apparent that much of the symptomatology of neurasthenia was not only intrinsically subjective, but lent itself to exaggeration on the part of patients, and to wide interpretation by the physician. The term itself dates from 1869, when George Beard, a neurologist with a fashionable New York practice, claimed to have been the first to introduce it in the *Boston Medical and Surgical Journal*. Dispute over authorship of the term, Simon Wessely believes, 'mirrored the wider confrontation between neurology and psychiatry at that time'.<sup>15</sup>

It also reflected contemporary concerns regarding the effects of industrialization, the cohesion of society in general and family life in particular, a pervasive sense of unease concerning the 'strain of modern living', and a growing conviction that society was paying too high a price for the benefits of 'progress'. Debate over the diagnosis of neurasthenia, its aetiology, symptomatology, pathology and treatment spread rapidly from America to Europe, especially to France and Germany. By the turn of the century, it was being used to explain the failure of French students to perform well in

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<sup>14</sup> *The Lancet*, 26 January 1918, p.128.

<sup>15</sup> A rival claim by Van Deusen in Kalamazoo, Michigan, in the same year did not prevail, and Beard is generally given the credit.



examinations, decadent art, conspicuous consumption in dress and the prevalence of adultery. In its heyday, neurasthenia was the *maladie de la mode*, the subject of widespread and often acrimonious debate between medical professionals from a dozen countries; the illness from which all polite society wished to suffer. Lutz sums it up thus;

From its lowly beginnings in the 1860s...the disease grew in status and stature until it was invited into all the best homes of the industrial nations. By the end of the century, few families in the upper echelons of society in Europe and America had been unaffected by neurasthenia in at least one of its myriad symptomatic forms.<sup>16</sup>

#### 4.3 Modern perceptions and misconceptions.

Only now, when the term has largely disappeared from the medical nosologies, is it possible to draw anything like a finite map of the condition. This is particularly so in the context of the Great War, in which neurasthenia assumed a wide range of disguises. In the Harveian address referred to above, F.W. Mott was in no doubt that the term had been widely and deliberately misapplied.

...no term employed in medical science has been more loosely and inappropriately used than the term neurasthenia. It has been employed to cloak ignorance, to help deception, and to aid fraud.<sup>17</sup>

One argument advanced in the following pages is that, with regard to neuropsychiatric casualties in the officer class, neurasthenia was employed as a camouflage for more serious mental disorders. Again, Mott is clear on the subject, stating bluntly that 'to avoid certification and to satisfy the scruples ...

<sup>16</sup> Lutz T., 'Neurasthenia and Fatigue Syndromes' in *A History of Clinical Psychiatry*, Berrios G. and Porter R., (Eds.), Athlone, (London 1999), p.533.

<sup>17</sup> *The Lancet*, 26 January 1918, p.127.



of friends' almost every form of insanity had at one time or another been deliberately misdiagnosed as neurasthenia.

These complicating factors inevitably render an assessment of neurasthenia during the Great War that much more problematic. Conversely, the evidence implicit in the '500 cases' study helps materially in correcting some of the more recent misconceptions. On the evidence of Schofield, Leslie, Mott and others, it seems clear that, as war approached, neurasthenia was already recognised as a clinical convenience. There is no reason to suppose, therefore, that it was not employed as such at Craiglockhart.

Reference has already been made to an unfortunate tendency in modern writers to conflate neurasthenia with other quite separate and distinct conditions. In a typically individualistic attempt to impose some kind of chronological matrix on the many disparate and fragmented treatments of shell shock, Shephard, for example, contends that;

...what Charles Myers, F.W.Mott or William Rivers said or wrote in 1915 is not the same as what they said, wrote - or did - in 1918; a soldier who claimed to have been blown up by a shell would have been believed immediately in 1914 but not in 1917; a man shot for cowardice would have been spared in 1918; a condition once labelled 'neurasthenia' had, by the end of the war, become 'anxiety neurosis'...<sup>18</sup>

As a generalisation, some of Shephard's statement may be allowed to pass unchallenged. As far as neurasthenia progressively being replaced by 'anxiety neurosis' is concerned, however, the evidence of the present study does not

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<sup>18</sup> Shephard B., 'The early treatment of Mental Disorders', in Freeman and Berrios, *150 Years of British Psychiatry*, Vol. 2, p.435.



bear this out. On the contrary, neurasthenia continued to be diagnosed throughout the war. The first case in the '500 cases' study was admitted to the 2nd. Northern General (Territorial) Hospital at Leeds on 20 August 1914, and the last in the sample to Napsbury War Hospital on 21 May 1919.<sup>19</sup> As to whether 'anxiety neurosis' replaced neurasthenia as the war progressed, this statement could only be quantified if a much wider range of relevant hospital records had survived and had been analysed. In the present study, the earliest recorded admission for anxiety neurosis was in fact on 3 February 1915, to the Moss Side Military Hospital at Maghull, Liverpool, and the last on 22 October 1915, to the Royal Herbert Hospital at Woolwich.<sup>20</sup> Only five cases of anxiety neurosis were recorded, all of them in the Representative Selection. As far as the present study is concerned, this is only to be expected, since the majority of the cases under examination are from the Napsbury War Hospital, which tended to specialise in mental, rather than nervous disorders.

The symptomatology of neurasthenia was described in detail by alienists, psychiatrists, psychologists, neurologists and general practitioners of every stripe and hue. Its very heterogeneity and ambiguity invited interpretation and re-interpretation, until neurasthenia could be, and was, extended in all directions to fill the gaps left by almost every other condition known to the medical profession. For medical practitioners in the decades before the Great War, the Protean nature of neurasthenia offered a number of advantages.

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<sup>19</sup> Study Case No.5, Ref. PRO/MH106/2101, 1715 Pte. Mitchel J.,  
6 Bttn. W.Yorks. Regt.

<sup>20</sup> Study Case No.498, Ref. PRO/MH106/2223, Private Herbert G., Labour Coy.



Writers on nervous disorders could rely, if not on an unquestioning acceptance of neurasthenia, then at least on a broad recognition of its credentials as a medical entity. This in turn was born of an understanding absorbed through the constant flow of debate, discussion, interpretation and controversy surrounding the subject. Crucially for the modern investigator, this understanding was also informed by the daily experiences of the time, through the natural discourse between doctor, patient and society at large. The fact that modern writers cannot participate in that discourse renders an examination of neurasthenia in the context of the Great War that much more problematic. It may be for this reason that modern writers on the neuroses and psychoses of the Great War have shown a singular disinclination to tackle neurasthenia as an issue. To make sense of a condition which was part of the everyday diagnostic vernacular of the medical profession during the war years, but which is now virtually unknown, it is necessary to acquire a secure contextual working knowledge of neurasthenia.

The place of neurasthenia in the medical nosologies has largely been taken by 'chronic fatigue syndrome', a disorder which, like neurasthenia, wears a coat of many colours, and engenders similar arguments for and against its legitimacy. As a medical, clinical and social entity, neurasthenia was predicated on a number of fundamental assumptions, from which it can be extricated only with difficulty. In their attempts to demonstrate understanding of this inherently diffuse condition, writers on neurasthenia resorted freely to metaphor and euphemism, attaching the discourse of neurasthenia and the neurasthenic temperament to any difficult social, political or medical issue that



happened to be at hand. To the medical profession of the mid-to-late nineteenth century, and to the leisured classes in which neurasthenia first flourished, such ambiguities were of little real consequence, adding as they did to the essential mystery and solemnity of the condition, and injecting a desirable degree of flexibility into the patient/doctor dialogue. As Lutz puts it;

Throughout its career as a disease, ideas and metaphors of nervous debility, nervous excitability, and nervous bankruptcy appeared in discussions of economics, politics, religion, art, literature, ethics, sex, work, class - in fact in any place writers focused on the relationship of individuals to the general social process. In its heyday...neurasthenic discourse became a prime language for the articulation of social, moral and cultural debates.<sup>21</sup>

Lutz also maintains that neurasthenia progressively 'trickled down' to become familiar to lower social strata, although whether 'trades, laborers and farmers' engaged in anything like the 'neurasthenic discourse' beloved of the leisured classes must be open to question. For the bank clerk or shopkeeper, the relationship of his nerves to the moral or cultural exteriority of the times was probably less important than that he was offered an explanation for what were otherwise inexplicable symptoms. To be able to attach an officially sanctioned label to one's complaint personalised it, and at the same time empowered the patient as interpreter of his illness to family, friends and lay society at large.

But this view of neurasthenia as a medico-social construct is misleading. It was not simply a convenient cloak with which physicians could conceal their indecision, nor was it only a vague symptomatological hinterland wherein hypochondriacs could indulge their particular preoccupations. A term as all-

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<sup>21</sup> Lutz, in Berrios and Porter, *A History of Clinical Psychiatry*, p.533.



encompassing as neurasthenia helped to arbitrate in what Ritchie in 1986 engagingly described as the discourse surrounding the 'ownership' of disease; the relative roles of physician and patient in the negotiations concerning recovery. In these negotiations, he argued that;

Throughout the war the pattern of "shellshock's" ownership was an approximate wartime copy of the pre-war ownership, in joint trust, of neurasthenia.<sup>22</sup>

Ritchie, like other writers on the neuropsychiatric casualties of the Great War, found it convenient to conflate shell shock, neurasthenia and war neuroses generally. The complex nature of neurasthenia, he suggested, was a positive factor in that it afforded both physician and patient considerable latitude in the 'negotiations' which, he contended, governed the relationship between the shell shocked soldier and the physician in charge of the case. Both, he argued, were legitimate 'proprietors' of the complaint, and both 'negotiated' on behalf of their particular interest. Neurasthenia flourished in that wide, ill-defined territory that lay between the concerns of psychology, psychiatry, neurology and general medicine. Its very lack of concrete identification, Ritchie admits, was often a distinct advantage. Ritchie's is perhaps the most obvious example of how, in the search for novel interpretations, neurasthenia has been illegitimately employed in order to underpin less than secure arguments concerning the primacy of shell shock.

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<sup>22</sup> Ritchie, 'One History of Shell Shock'. p.5.



#### 4.4 Incidence, prevalence and class distinction

Although concerned with shell shock as it is with other neuropsychiatric conditions, the present thesis emphasises the identification and interpretation of new primary sources, in the form of medical casenotes, as a means of throwing new light on the wider issues. However, the significance of neurasthenia as a constituent factor in the historical synthesis of mental and nervous disorders of the Great War, lies in demonstrating that the number of cases of neurasthenia was very high. This thesis contends that this was in fact the case, for a number of reasons.

In the early part of the war this was due primarily to the fluid and uncertain nature of the prevailing combat conditions. Long forced marches to meet the enemy, the shock of coming to grips with a numerically superior foe, the demoralising effect of a succession of defeats, followed by the long retreat from Mons, imposed almost insupportable strains on the newly-arrived British Expeditionary Force. The Official History - an account not given to hyperbole - describes 'men and horses utterly exhausted', recounting how two retreating infantry brigades were forbidden to take the customary hourly rest periods;

...for fear that if the whole division were once halted and the men sat or lay down, they would never be got moving again.<sup>23</sup>

Despite what the Official History of the Army Medical Services claims to have been the 'excellent physique...perfect training and...splendid *esprit de corps*' of the men of the B.E.F., few could endure such conditions and remain

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<sup>23</sup> Edmonds J.E. *et al*, *History of the Great War based on Official Documents, Military Operations in France and Flanders 1914*, Facsimile reprint, The Imperial War Museum and the Battery Press, Nashville, Tenn. U.S.A. (1996), pp.214-5.



unaffected.<sup>24</sup> Carried along for days and weeks by an atmosphere of confusion and imminent danger, starved of food and unable to rest for more than an hour or two for fear of being overtaken, thousands fell victim to what might be called 'classic' neurasthenia - exhaustion beyond utter exhaustion, drained of every last scintilla of energy, craving nothing but sleep and yet more sleep.

When at last the combined Allied armies succeeded in first halting, then partly reversing, the German advance, the highly professional but comparatively small British force had been severely depleted, and was in a condition where it could do little more than hold the line until help arrived. The constant threat of a renewed German offensive, however, meant that reinforcements had to be recruited, trained, and moved to the front line as quickly as possible.

Subsequent recruitment policies, however, starting with the enlistment of the 'Kitchener Armies' of 1915, and followed by the introduction of conscription a year later, emphasised quantity at the expense of quality, encouraging the admission of many thousands of unsuitable candidates. More to the point of the present work, many of these had negative mental and nervous histories. These men, as the following pages will seek to demonstrate, were strongly predisposed to breakdown. Aided by the official policy of the R.A.M.C., which limited the number of diagnoses that could be applied, the all-inclusive nature of the neurasthenic syndrome encouraged its use in a wide variety of cases. Examples given in the following pages illustrate this propensity.

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<sup>24</sup> Macpherson W.G. *et al.*, (Eds.) *History of the Great War based on Official Documents: Medical Services: Diseases of the War*, Vol. 2, H.M.S.O., (London 1923), p.1.



Neurasthenia was as prevalent in troops of the home forces as it was in those in the fighting zones, occurring frequently in men who had never left the U.K. In that respect, neurasthenia differed fundamentally from the more dramatic hysterical disorders, another reason why the conflation of neurasthenia and shell shock, criticised in earlier pages, cannot be justified. Neurasthenia within the British Army in wartime differed crucially from that of the peace-time civilian population, not least in its propensity to develop from relatively mild neurological states into much more serious mental disorders. Through the availability of new data, these important but hitherto neglected *sequelae* of neurasthenia are addressed. Finally, neurasthenia is significant through its misuse as a camouflage for the mental and nervous casualties in the officer corps, a deception prompted by class, social and disciplinary considerations not previously addressed.

To the hard-pressed doctors of the early period of the Great War, neurasthenia met an immediate need for a diagnostic matrix into which a wide variety of fugitive symptoms could be fitted. It provided a clinical position from which it was possible to later move without undue pangs of conscience or without risking professional embarrassment. From the standpoint of the medical officer with little or no experience of psychological or neurological medicine, neurasthenia was a safe diagnosis, although its limitations as a diagnosis were clearly well known.



Having established that neurasthenia was a significant factor, the supplementary questions must be; how significant was neurasthenia, and to what extent did it affect the ability of the British Army to prosecute the war? The official volume of statistics devotes only a brief chapter to the subject, but, even so, it would be natural to turn to that source for details. As with mental and nervous disorders generally, the modern enquirer faces disappointment. Ominously, the chapter opens with an admission that ;

There is unfortunately little information regarding the wastage due to nervous disorders in France other than for the period August to December 1914 and for 1915.<sup>25</sup>

The information referred to is contained in the tables reproduced below. N.B. Table numbers in open text are thesis references: table numbers in brackets are those in the original.

**Table 2. (Table 17) Admissions and Disposal of Cases of Nervous Disorders in Army Areas for the weeks ending 30.3.18 and 13.4.18, and from 8.6.18 to 7.12.18.<sup>26</sup>**

| Diagnosis                               | Disposal   | Officers   | O.R.        | Total       | Offs.% | O.R.% | Total |
|---|------------|------------|-------------|-------------|--------|-------|-------|
| Neurasthenia or other nervous complaint | To duty    | 27         | 2064        | 2091        | 5.53   | 26.91 | 25.63 |
| "                                       | To base    | 324        | 2761        | 3085        | 66.39  | 36    | 37.82 |
| Shell-shock (wound)                     | To duty    | 5          | 191         | 196         | 1.02   | 2.49  | 2.4   |
| "                                       | To base    | 33         | 452         | 485         | 6.76   | 5.89  | 5.95  |
| No appreciable disease                  | To duty    | 10         | 522         | 532         | 2.05   | 6.81  | 6.52  |
| Not yet diagnosed (nervous)             | To base    | 66         | 1305        | 1371        | 13.52  | 17.02 | 16.81 |
|   | Not stated | 23         | 374         | 397         | 4.71   | 4.88  | 4.87  |
| <b>Total admissions</b>                 |            | <b>488</b> | <b>7669</b> | <b>8157</b> |        |       |       |

<sup>25</sup> Mitchell T. and Smith G., *History of the Great War based on Official Documents: Medical Services, Casualties and Medical Statistics*. Facsimile reprint, The Imperial War Museum and The Battery Press, (London and Nashville, Tenn., 1997), p.114.

<sup>26</sup> Mitchell and Smith, Table 17, p.115.



**Table 3. (Table 18).- Diagnosis and Final Disposal of "N.Y.D.(N.)" Cases sent from Armies to the Base, June to December, 1917.<sup>27</sup>**

| Diagnosis               | Disposal   | Officers   | O.R.        | Total       | Offs.% | O.R.% | Total |
|-------------------------|------------|------------|-------------|-------------|--------|-------|-------|
| Neurasthenia            | To duty    | 25         | 384         | 409         | 16.13  | 15.72 | 15.74 |
| "                       | To UK      | 53         | 139         | 192         | 34.19  | 5.69  | 7.39  |
| Shell-shock (wound)     | To duty    | 21         | 1184        | 1205        | 13.55  | 48.47 | 46.38 |
| "                       | To UK      | 39         | 449         | 488         | 25.16  | 18.38 | 18.78 |
| No appreciable disease  | To duty    | 0          | 1           | 1           | 0      | 0.04  | 0.04  |
| Other casualty          | To duty    | 7          | 191         | 198         | 4.52   | 7.82  | 7.62  |
| "                       | To UK      | 8          | 89          | 97          | 5.16   | 3.64  | 3.73  |
|                         | Died       | 0          | 2           | 2           | 0      | 0.08  | 0.08  |
|                         | Not stated | 2          | 4           | 6           | 1.29   | 0.16  | 0.23  |
| <b>Total admissions</b> |            | <b>155</b> | <b>2443</b> | <b>2598</b> |        |       |       |

**Table 4. (Table 19).- Proportion of Nervous Disorders to Sick and Wounded Admitted.<sup>28</sup>**

| Nervous disorders |      |       | Sick and wounded |         |         | Proportion of nervous disorders |          |          |
|-------------------|------|-------|------------------|---------|---------|---------------------------------|----------|----------|
|                   |      |       |                  |         |         | To sick and wounded admitted    |          |          |
| Officers          | O.R. | Total | Officers         | O.R.    | Total   | Officers                        | O.R.     | Total    |
| 488               | 7669 | 8157  | 40336            | 1116858 | 1157194 | 1:82.64                         | 1:145.63 | 1:141.87 |
| 155               | 2443 | 2598  | 35708            | 1051009 | 1086717 | 1:230.37                        | 1:430.21 | 1:418.28 |

Even these 'very incomplete' data lend support to the argument advanced here. Table 17, for example, shows that during 26 (non-consecutive) weeks in 1918, a total of 5,176 cases of 'neurasthenia or other nervous complaint' were admitted to hospital from Army areas on the Continent. The fact that neurasthenia is the only named 'nervous complaint' suggests that it probably accounted for the majority of these cases. Of that number, 2,091 (40.39%) were 'discharged to duty' after treatment on the Continent, the remaining 3,085 (59.6%) being sent to the U.K. for treatment.

<sup>27</sup> Mitchell and Smith, Table 18, p.116.

<sup>28</sup> *Ibid.*, Table 19, p.116.



The absence of the relevant records, however, makes it impossible to follow these cases through to their final disposal. A further 2,300 undiagnosed nervous cases were also admitted to hospital during this period, 532 (23.1%) being 'discharged to duty' and 1768 (76.8%) repatriated to the U.K. Bearing in mind the eminently elastic nature of neurasthenia as a diagnosis, it is difficult to understand why any nervous cases should be left undiagnosed. On these data alone, however, it is clear that neurasthenia posed a significant problem for the military medical authorities throughout the war. These figures do not include cases specifically listed in Table 17 as 'shell shock', of which there were 681 in the same 26 week period, (estimated as 1362 for the whole of 1918). They exclude cases of neurasthenia and other nervous disorders arising in the United Kingdom, and also in garrison and expeditionary forces other than in France and Belgium. The incidence of neurasthenia in the 'home forces' is discussed in a later paragraph.

Table 18 shows that during the last seven months of 1917, 601 diagnosed cases of neurasthenia were sent from the 'N.Y.D.N.' centres in the forward areas in France and Belgium, and admitted to hospitals at the base. Of these, 409 (67.9%) were 'discharged to duty', the remaining 192 (31%) being sent back to the U.K.<sup>29</sup> The N.Y.D.N. centres did not begin receiving patients until the middle of 1917: it is legitimate to suppose, therefore, that had they been in operation for the whole of 1917, they may well have processed a number of cases of neurasthenia *pro rata* to the above, and that the total for 1917 would

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<sup>29</sup> The official statistics give no indication of length of stay in hospital, an important indicator of the severity of any condition.



have been in the region of 1,030.<sup>30</sup> Again, this is inherently an underestimation. Analysis of the '500 cases' demonstrates conclusively that, contrary to the policy described in the Official History, the N.Y.D.N. centres did not in fact process all the cases of mental and nervous disorder arising in the continental Army areas. Of the 7 cases of neurasthenia admitted to Napsbury after June 1917 when the N.Y.D.N policy came into effect, none makes any reference to having been treated at such a centre. As far as distribution over time is concerned, Figure 10 on p.92a above shows that, as expected, the majority of cases of neurasthenia are concentrated in 1914-1915. In assessing them, however, it is important to bear the following points in mind.

Firstly, the sample is drawn from two sources; the so-called 'Representative Selection' of cases of wounds and diseases and, secondly, from the very recently released medical records of the Napsbury War Hospital, St. Albans, both held at the Public Record Office, Kew. The 'Representative Selection', as its name implies, was drawn from a wide range of hospitals, but is incomplete, covering only the period August 1914 to December 1915. Although the Napsbury archive is complete in itself, Napsbury was a general War Hospital with an important 'Mental Section', but did not specialise in the treatment of neuropsychiatric disorders.

Sources for the Representative Selection included Territorial General Hospitals, War Hospitals and specialist neurological centres such as Maida Vale and the Maudsley Hospital. If the name of the archive is any guide, the

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<sup>30</sup> For discussion of the conception and operation of the 'N.Y.D.N.' centres, see Chapters Six and Seven respectively.



selection was designed to reflect the range of conditions met with throughout the war. No evidence has been found as to what proportion of the original archive these documents represent. They may represent 1 in 10 of the original archive, or 1 in 1000, or the proportion may have been decided on a wholly arbitrary basis. Whatever the true case, the Representative Selection as it stands cannot be taken as a reliable guide to the actual numbers of cases. The value of the two sets of records lies more in the unique insight they provide into the circumstances of the cases, and the social, cultural, medical and clinical environment of their treatment.

Adding the figures in Tables 2 and 3 together, and comparing them to the total number of admissions to hospital from all causes in the same Army Areas during the same periods, gives some indication of the 'wastage' caused by nervous disorders generally. Applying the official ratio of 1:560.15 as a modifying factor to the relationship between 'neurasthenia and other nervous complaint', and total admissions to hospital from all causes, a figure of 10,755 is obtained.

During the whole of the Great War, taking into account all theatres of activity and 'home forces' in the United Kingdom, British and Dominion forces suffered a total of 11,096,338 casualties, 5,900,876 of which were classified as 'non-battle' casualties.<sup>31</sup> Excluding altogether the 'battle' casualties, and applying the same ratio of 1:560.15 to the 'non-battle' cases alone, an

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<sup>31</sup> Mitchell and Smith, *Medical Services, Statistics*, p.12.



estimated total of 1,053,445 cases of nervous disorder of all kinds for the whole period of hostilities is obtained.

What proportion of these were in fact cases of neurasthenia can only be guessed at. As the above has shown, however, the official history clearly regarded neurasthenia as a major constituent of the overall 'nervous complaint' group of diseases, and the evidence of the Representative Selection suggests that neurasthenia accounted for a very substantial proportion of total admissions to hospital. F.W.Burton-Fanning, an expert on the subject whose war-time work is examined later, spoke of the 'astounding prevalence' of neurasthenia in new recruits, and the consequent 'enormous loss of manpower'.<sup>32</sup> One popular history of the Great War, published in the later post-war years, speaks of 'vast numbers of men suffering from (neuroses)', maintaining that all these 'nervous diseases (neuroses) and abnormal mental states (psychoses)' could all be 'compendiously comprised under the heading of neurasthenia'.<sup>33</sup> Although this is a gross misrepresentation of the facts, the following cases show that neurasthenia frequently developed into more serious conditions. For all of these reasons, there can be little doubt that neurasthenia posed a serious threat to the fighting capabilities of the British Army.

#### 4.5 Neurasthenia as a precursory factor in serious mental disorders.

Apart from its obvious prevalence as a complex and diffuse neurological syndrome in its own right, neurasthenia acted in many instances as a precursor

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<sup>32</sup> *The Lancet*, 16 June 1917, p.907.

<sup>33</sup> Hammerton J. (Ed.), *A Popular History of the Great War*, 6 vols., Geo.Newnes, (London 1925), vol.6, pp.283-4.



to more serious disorders and, in some cases, led to chronic mental and physical disintegration and death. The following cases have been selected to illustrate the wide range of conditions to which a diagnosis of neurasthenia could be attached, as well as the generally negative approach to treatment adopted by the military medical authorities. In these cases, as in the majority of cases studied, there is no evidence of psychologically-based treatment being used, nor indeed any other positive therapies being employed other than 'bed and bromide'.

Study case No. 85  
 Archive Ref. PRO/MH106/2234  
 1197 Sapper Wild W.  
 Age: 32  
 Service: 1 year  
 Unit: Royal Engineers.  
 Total hospital stay: 39 days.

22 July 1915. Admitted to the 3rd Northern (Territorial) General Hospital, Sheffield, diagnosed as suffering from neurasthenia. Wild displayed few overt symptoms, and those noted - for example dyspnoea and tachycardia were subjective and reported by him, but not observed on examination.<sup>34</sup> He also complained of diffuse chest pain and 'a kind of a soreness' over the rib bones. Again, examination showed his heart and lungs to be normal, and he gave no history of rheumatic fever. After being prescribed drill and convalescence, Wild was 'Boarded' and discharged on 30 August 1915 as permanently unfit.

At the other end of the neurasthenic scale were those cases arising from physiological conditions such as the case summarised below;

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<sup>34</sup>

See glossary.



Study Case No. 169  
 Archive Ref. PRO/ MH106/ 2224  
 8912 Private Leigh H.  
 Age: 27  
 Service: 7yrs.  
 Unit: 1st. Battalion Royal Berkshire Regt.  
 Total hospital stay: 207 days

On 17 December 1915 Leigh was admitted to Reading Military Hospital suffering from gonorrhoea. He had been on leave from France, and had reported sick on the expiration of his leave. About a week later he began to exhibit mental symptoms. He developed delusions of persecution, claiming that unidentified persons were lurking outside the window talking about him. He became morose and suspicious, complaining that his food was being poisoned. His state of mind is graphically reflected in a letter written by him while at Reading, a copy of which was sent to the Assistant Director of Medical Services (A.D.M.S.) at the main depot on Salisbury Plain, requesting advice as to the appropriate disposal of the case.

On that morning I dashed out at Bert the Orderly. I heard my mother crying outside the winder I could not concentrate my thoughts on another object as been the cause of this owing to my trying to prevent the pain rising to the open part of the body and now I can fancy the pain are rising to my head I shall go mad too day...<sup>35</sup>

The letter contains much more in similar vein, together with expressions of guilt concerning a 'wet dream' he had , and his intention of confessing this to Bert (the orderly) and to 'Bill Potter and Mark' - presumably his comrades.<sup>36</sup>

Possessing 'no facilities for the proper observation of this case' the officer in

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<sup>35</sup> Although the letter is typed, the inclusion of spelling and grammatical errors show that it has been copied *verbatim* from Leigh's original.

<sup>36</sup> Expressions of guilt concerning sexual incidents, particularly of what was commonly referred to as 'self abuse', were frequently encountered in the cases studied.



charge at Reading was understandably anxious to get rid of what promised to become a difficult case.

On instructions from the A.D.M.S., Leigh was transferred to the 'Mental Observation Ward' of the Tidworth Military Hospital. There, the initial diagnosis was 'Delusional Insanity'; this was later deleted and 'Mania' substituted. Later still this too was replaced by 'Neurasthenia'. It will be clear by this stage that, as a diagnosis, neurasthenia could mean all things to all men. At its widest possible interpretation, however, Tidworth's diagnosis is quite incomprehensible. It is totally at odds both with the symptoms presented at Leigh's initial examination at Reading, and also with his subsequent behaviour.

On 2 February 1916 Leigh's medical case sheet recorded that he had;

...no idea of deference or responsibility, answers questions abruptly; during his service with the Expeditionary Force in France he contracted Gonorrhoea for which he is getting the usual remedies.

For reasons left unstated Leigh remained at Tidworth for only ten days, after which he was transferred to Napsbury and admitted there on 12 February 1916.

On admission, he was said to be 'confused', with intermittent amnesia, and was unable to give a sensible account of himself. His manner was 'dazed and dreamy', his attention constantly wandering and occasionally smiling fatuously.

The case sheet went on;

He is apparently influenced by auditory hallucinations: he says that he hears voices day and night. He does not appear to realise where he is : & he says that he is not concerned about the future or about his people. He is unoccupied rationally.



On 15 April 1916, Leigh's objective and subjective symptoms remained much as they had been since first being admitted to Reading, although he had not since been violent, noisy, restless or excitable. Despite this, he was described as being 'in a maniacal state'. He showed no improvement, and was transferred to the Berkshire County Asylum at Wallingford on 12 July 1916.

Although it is the case that diagnoses were altered, for example on admission to a new hospital, this was mostly to take account of deterioration in the patient's condition. In Leigh's case, altering the diagnosis to neurasthenia in the face of such manifest and persistent mental symptoms is inexplicable. Equally puzzling is the decision of the A.D.M.S. to send him to Tidworth, only to have him almost immediately passed on to Napsbury.

Study Case No. 68

Archive ref. PRO/MH106/2101/56605

3225 Rifleman Rose T.

Age: 26

Service: 7 years

Unit: 4th Battalion, Rifle Brigade.

First hospitalised: Between 24 May and 24 June 1915\*.

Diagnosis: Neurasthenia with Irritability.

\*Already under treatment for gunshot wound of right thigh when mental symptoms supervened.

Total hospital stay: (estimated) 282 days.

On 24 June 1915 Rfm. Rose was admitted to the Mental Section of the County of Middlesex War Hospital, Napsbury, St. Albans. On admission he was noisy, violent, excitable and incoherent, complaining of auditory hallucinations. Rose had gone to France in January 1915, sustaining a gunshot wound of the right thigh on 24 May. He was transferred to the U.K. and was initially admitted to the Victoria Hospital, Chelsea. (No casenotes transferred to Napsbury). There,



he was said to have been 'doing well' until the middle of June 1915, when he began to complain of head pains and disordered sleep. Between 24 June and 3 August 1915 Rose's mental condition began to deteriorate. He became restless, excited and self-destructive, 'knocking his head against the wall' and frequently removing the dressings from his wounds. He then became quiescent, 'lying quietly in bed...although confused (he) is much more rational than before.' On 9 August 1915 he was said to be...'dull and silent...only drinks and refuses his food'...lying in bed and taking little interest in his surroundings.'

During the ensuing months, Rose's condition varied between being intensely self-satisfied and deluded, '...he laughs at himself and appears to hear imaginary voices', and being preoccupied and detached. By early April 1916, however, he had become dull and slow of speech, tremulous and withdrawn. One of the scars on his thigh had opened. He remained in much the same mental state until 22 April 1916, when he was discharged from the Army, 'certified (and) removed to Hatton Asylum'.

In its civilian guise, neurasthenia was not generally regarded as a disabling condition, a view challenged by Leigh's and Rose's experiences. The propensity of neurasthenia to develop from the mildest of symptoms, to the extremes of disturbed behaviour, is demonstrated in the final example below.

Study Case No.433  
 Archive ref. PRO/MH106/2217  
 20767 Private Cox T.  
 Age: 26  
 Service: 1 year 4 months  
 Unit: Pay Corps



Diagnosis: Neurasthenia

Total hospital stay (estimated) 165 days

Private Cox was serving in France when he was first hospitalised at No.8 Stationary Hospital, Wimereux (Mental Division). The precise date is not known, but it seems that he had been attending this hospital as an out-patient for some time and was admitted when his condition worsened. Cox had been an accountant in civilian life. He had apparently been treated for neurasthenia at some time, but gave no indication of the severity of the illness, nor any details of the treatment he had received. He complained of head pains, depression and sleeplessness. He also said he had 'lost confidence' in himself, became tired on the slightest exertion, and could not concentrate. He was prescribed a 'light liberal diet of milk, eggs, fish etc.' On 16 September 1918 he was said to have made 'little improvement' since admission and was more depressed. He was transferred to the U.K. and admitted to the Mental Division of the Welsh Metropolitan War Hospital (previously the Cardiff City Asylum) on 16 September 1918.

Very few of the casenotes in the '500 Case Study' originate at the Welsh Metropolitan. Before the war this institution enjoyed something of a progressive reputation in the treatment of mental disorders. The Medical Superintendent, Edwin Goodall, who became Commanding Officer of the institution in its War Hospital guise, had taken a prominent part in the movement for reform of the conditions of service of asylum medical officers in the immediate pre-war years. With Sir George Savage, Goodall had also written standard texts on



mental disorders.<sup>37</sup> Casenotes from the Welsh Metropolitan take a very different form from other military hospitals. Instead of a largely unstructured blank form, Army Form I.1237, on which the examining medical officer entered a more or less comprehensive series of notes, the Welsh Metropolitan reprinted the form to pose 62 formal physiological, neurological and psychological questions, which, if properly completed, gave a detailed picture of the patient's condition on admission.

On these criteria, Private Cox displayed no symptoms other than those previously noted in France. He was said to be 'small and thin. Very depressed and frightened looking.' At this stage the diagnosis was altered to 'Melancholia'. On 24 September 1918 Cox was said to be 'Not so depressed' and to be '...feeling a little better.' A week later he was 'Improving slowly.' A month later, however, he was said to be 'Getting worse. Very miserable & emotional. Always weeping. Does not wish to eat.' After a further month there had been no improvement. Cox insisted that he was 'suffering for his past sins', although their nature was not specified and no investigation seems to have been attempted. Despite special diets and dietary supplements (cod liver oil and malt) he continued to lose weight. By 1 January 1919 he was having to be spoon fed. On 17 January Cox was transferred to Napsbury War Hospital. There his condition continued to deteriorate. He developed a habitual cough with pulmonary rales and expectoration. On 22 February 1919 the notes read; 'Patient generally getting weaker - takes his food badly.' And on 26 February

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<sup>37</sup> For details of this, and of Goodall's involvement in the controversy surrounding the use of asylums as War Hospitals, see Chapters Two and Nine respectively.



1919; 'Patient sinking. Died at 3.40 pm today. Patient's father present when he died. Cause of death - Phthisis.'<sup>38</sup>

There appears to have been no investigation into how Cox contracted tuberculosis. It is possible that he already had the disease, and that the general emaciation resulting from his continued refusal to take food masked the symptoms, particularly the loss of flesh normally associated with this condition. Cox's pre-war medical history and his position in the Pay Corps suggest strongly that his illness may have been of long standing.

#### 4.6 Neurasthenia and shell shock.

The cases analysed above give some idea of the essentially ambiguous nature of neurasthenia, as well as the range of symptoms to which the name could be attached. An editorial in *The Lancet* in March 1916, gave a useful summary of these characteristics.

In medicine there is a neutral zone, a no-man's land...which really defies definition. This zone... shelters many among the sad examples of nervous trouble sent home from the front, and it is only by the accumulation of facts that we can hope for definitions of permanent value. The term "neurasthenia" applied to many of these cases has been of great service in allaying public anxiety. It is commonly associated with the idea of a tedious, troublesome malady in which there is fair ground for hope of recovery under favourable conditions.<sup>39</sup>

There are a number of interesting points in this statement which bear on the arguments being advanced here. The first is the admission that, as a diagnosis, neurasthenia was being deliberately misused as a means of disguising the real condition of men being returned from the Front, deflecting public concern over

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<sup>38</sup> See glossary.

<sup>39</sup> *The Lancet*, 18 March 1916, p.627.



cases which might otherwise be labelled as more severe mental disorders. In its tacit approval of such deceit, the editorial throws light on contemporary attitudes to mental illness within the medical profession, and on the complacency that sparked off the controversy surrounding the Army's policy and practice on the treatment of mental casualties.<sup>40</sup>

The *Lancet* went on to suggest, (rather oddly in view of the above), that neurasthenia, being of 'such limited application in medicine' could not be used to cover the hysterical symptoms for which the term 'shell shock' had been coined. It was true that some functional hysterical symptoms - mutism, visual disturbances, amnesia, cutaneous anaesthesias and so on - had been observed to a limited extent in neurasthenics in civil practice, but on nothing like the scale seen since the outbreak of the war. More to the point was the fact that these symptoms had appeared in large numbers in otherwise 'healthy young males', pointing to the existence of a quite different 'immediate exciting cause' from that of neurasthenia. However, the editorial went on, simply attaching the label of 'shell shock' to it, as Charles Myers had done, indicated this immediate cause without explaining the mechanism by means of which the damage was done. Similarly, Frederick Mott's hypothesis, centred as it was on the assumption of 'some structural or pathological change in the central nervous system' failed to explain precisely how exposure to the effects of high explosives acted on the human organism. Much research was needed, the editorial concluded, before these questions could be fully answered.<sup>41</sup>

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<sup>40</sup> For discussion of the controversy, see Chapter Nine.

<sup>41</sup> *The Lancet*, 18 March 1916, p.627.



As the war progressed, experience with neurasthenic patients allowed more detailed studies of the condition to be carried out *en masse*, something that had not been possible in civilian practice. None of this, however, seems to have allowed the medical profession to gain a real understanding of neurasthenia, or to formulate anything approaching an effective therapeutic strategy. Many practitioners seemed incapable of differentiating between the neurasthenia they had dealt with in their civilian practices, and the neurasthenia they faced in the wards of military hospitals.

The problem was complicated by the fact that, once in uniform, military medical officers were subject to pressures other than professional ethics. From the military point of view, the first priority was to weed out shirkers and malingerers and send them back to duty. Secondly, those classed as 'genuinely' ill had to be treated by the most efficacious means to hand, and likewise sent back to duty as soon as possible. These pressures were intensified by the medical officer's own sense of patriotism and the need to assist the war effort, as well as his responsibility as a member of the professional classes, to see that his patients also discharged their patriotic duty. Only when these criteria had been satisfied could the medical officer allow his ethical sensibilities anything like the freedom they had enjoyed before the war. The responsibilities weighing on Army medical officers, particularly those away from the fighting zones, were in that sense much greater and more complex than they had been before the war.



Writing in June 1917, Dr. F.W.Burton-Fanning, in a report to the Medical Research Committee published in *The Lancet*, set out his own views of the place of neurasthenia in the overall medical discourse of the war. At the same time, he offered an unusually revealing glimpse of contemporary social *mores* as they impinged on the treatment of nervous disorders in the British Army at this time. Additionally, Burton-Fanning provided some useful medical and clinical comparisons between his experience of neurasthenia in civilian life, and that of his ten months as a R.A.M.C. medical officer. The report was largely concerned with his experiences at the 1st Eastern General Hospital at Cambridge, where he dealt mostly with neurasthenia, 'as a cause of going sick amongst our newly recruited soldiers'.

I use the term in its widest sense to include disorders of the nervous system which are believed to have no organic basis. No experience that I had gained in civil practice was...more important than the recognition of the fact that neurasthenia in some shape or form is by far the most common of the ailments for which the doctor is consulted....<sup>42</sup>

Despite the high incidence of neurasthenia he had dealt with in his civilian practice, Burton-Fanning was wholly unprepared for the numbers he found in the Army. During the ten months he had charge of medical wards at the 1st Eastern General, he had dealt with 2240 cases of all kinds; 640 from overseas and 1600 from troops of the home forces. Of the 'home forces' troops, 509 (31.8%) had been diagnosed as suffering from neurasthenia. None were suffering from any form of organic disease. Burton-Fanning's view of neurasthenia can best be summarised by the phrase, 'it's all in the mind'. He

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<sup>42</sup> *The Lancet*, 16 June 1917, p.907.



was convinced that, in the majority of cases, the cause of the condition was a congenital predisposition to nervousness, a 'neuropathic taint' which usually became evident in early childhood. He had found neurasthenia to be widely distributed throughout the population, affecting all social classes.

For the employed classes at least, Burton-Fanning did not normally consider neurasthenia to be disabling. Like chronic constipation, it was something with which sufferers had to contend, whilst getting on with life as best they could. In the Army, however, medical care was free. For those of a certain temperament the prospect of hardship and danger was something to be avoided, and the realisation dawned that their disability could be turned to positive advantage. This fact Burton-Fanning had encountered with some surprise and predictable disapproval. These patients, he noted;

...have spent far more time in hospitals and convalescent homes than with their units. They are passed from one institution to another, they presently return to their battalions, where they immediately report sick again and are readmitted to hospital. Such a patient was asked: "How long have you been in the Army?" he replied, "Three weeks, sir." "How many times have you been on parade?" "Every day, sir - sick parade."<sup>43</sup>

The fact that, in civilian life, most working-class neurasthenics did not take to their beds ought not to have surprised a physician of Burton-Fanning's experience. The nature of neurasthenia was such that protracted treatment was often required, and few, if any, of the employed classes could afford to leave their jobs for more than a few days or weeks. Similarly, hospitals were unlikely to allow beds to be taken up by patients with the 'tedious, troublesome

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<sup>43</sup> *The Lancet*, 16 June 1917, p.907.



malady' described by Burton-Fanning.

In the Army the situation was quite different. For troops in the fighting zones, neurasthenia, whether in the form of extreme exhaustion, general 'nervousness', depression, 'funk' or whatever, could be enough to justify a spell out of the line. In the home forces it could be the first line of protest by men resentful of being conscripted. The diffuse nature of the symptoms, and the variety of complaints that could be brought under the heading of neurasthenia, made it a gift to the malingerer and the 'scrimshanker'.

On the other hand, neurasthenic symptoms might reflect genuine illness by men totally unfitted for Army life in any capacity. In any case, medical treatment was free for the asking, the only qualification being the 'sick parade' each morning. Once past the Unit Medical Officer, the whole of the military medical services lay open to exploitation by the dodger, services eager to care for the genuine sufferer and, in general, poorly equipped to deal with the accomplished and determined malingerer.

A 'large proportion' of neurasthenic patients accepted that the basis of their disability was of nervous origin. Many, however, held firmly to the belief that something organic lay at the heart of their trouble. Many produced a dog-eared 'treasured note which certified that they suffered from some physical malady.' Most were suspiciously familiar with the symptoms of their supposed ailments, and were quick to express the view that they ought never to have been called up. Burton-Fanning clearly believed that patients who were



'suspiciously familiar' with the symptoms of their own illness were potential malingerers and not to be trusted. Like Frederick Mott, he was in no doubt that the basis of the neurasthenic's ailment lay in a chronic neuropathic predisposition. From his earliest years, he maintained, the typical sufferer began to 'evinced the characteristics of the nervous temperament', unable to adapt himself to the 'rough and tumble of school life', inclined to be timid, bookish and sedentary. Uncorrected by faulty upbringing, these tendencies, if not already evident, lay dormant, liable to emerge when prompted by challenging or stressful events. Few of his patients, Burton-Fanning observed condescendingly;

...had enjoyed the traditional advantages of our old public schools  
 ... introspective habits have not been corrected, and they have  
 not been told that their only rule is to play the man.<sup>44</sup>

He was unaware of, or chose to ignore, the situation at Craiglockhart War Hospital near Edinburgh where, as noted above, hundreds of officer patients - the majority educated at his admired 'old public schools' were being diagnosed as suffering from neurasthenia. Here again neurasthenia was deliberately misused to conceal the weaknesses of the governing class. To avoid court-martial, Siegfried Sassoon, whose anti-war declaration had brought him into conflict with authority, was sent to Craiglockhart on the falsified testimony of his friend Robert Graves.<sup>45</sup> W.H.R.Rivers, whose work at Craiglockhart and

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<sup>44</sup> *The Lancet*, 16 June 1917, p.907.

<sup>45</sup> The best accounts of this episode are to be found in Graves R. *Goodbye to All That*, Jonathan Cape, (London 1929), pp.162-3, and in Seymour M., *Robert Graves: Life on the Edge*, Transworld, (London 1995), *passim*. Siegfried Sassoon is widely recorded as suffering from shell shock. The Craiglockhart hospital Admission and Discharge Book, however, list his complaint as neurasthenia. Both Graves' and Seymour's accounts make it clear that the Army authorities were reluctantly persuaded to 'Board' and hospitalise Sassoon in order to divert attention from his anti-war utterances.



elsewhere is discussed in Chapter Eleven, was involved in this affair and, also in 1917, helped to cover up the scandal surrounding George Harcourt Johnstone, with whom Graves was suspected of having a homosexual relationship while they were both at Charterhouse.<sup>46</sup>

The literature of neurasthenia mirrors directly both the universality and the complexity of the subject, each writer not only having a different view of the aetiology and pathology of the malady, but also of the correct approach to treatment. The 'neutral zone' to which Burton-Fanning referred represented a *terra incognita* on which anyone with a claim to medical knowledge of any kind might plant his flag. We have noted in the preceding paragraphs Burton-Fanning's belief in the efficacy of the public school system as a prophylactic factor.

His recommended therapy for the neurasthenic temperament appeared to be a combination of laddish bonhomie and quasi-Freudian analysis - a kind of scout-camp psycho-therapy aimed, to use his words - at removing from the mind 'whatever is the disturbing influence'. Quite how that was to be achieved is not explained. Having admitted that 'all social classes are affected' and that his officers' ward had 'as large a proportion of neurasthenics as any other', Burton-Fanning nevertheless adhered to his belief that the environment of the English public school, in which 'character and manliness are developed side by

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<sup>46</sup> Shephard B., 'The Early Treatment of Mental Disorders: R.G. Rows and Maghull 1914-1918', in *150 Years of British Psychiatry, Vol. 2: The Aftermath*, Athlone, (London 1996), p.434.



side with learning, seems to prevent neurasthenia.'<sup>47</sup> The surviving records of the Craiglockhart officers' hospital emphatically refute any such claims. Not only that, but to suggest that only the products of public schools were capable of behaving well under fire is fatuous nonsense. The misuse of neurasthenia as a diagnosis in the officer class, and the claims of intrinsic officer 'manliness' will be examined at length in later pages.

#### **4.7 Division and deception: protecting the position of the officer class.**

The symptoms of neurasthenia included fatigue, irritability, headache, dizziness, anxiety and intolerance of noise, often with intestinal and genito-urinary dysfunction.<sup>48</sup> All these could be present in varying degrees, depending on the initial and aggravating causes, and on the physique and psychological disposition of the individual. Writing in 1913, H.Campbell Thomson, Physician in Nervous Diseases at both the Middlesex Hospital and at the Hospital for Epilepsy and Paralysis at Maida Vale observed;

One has always to remember that disease is modified by the individuality of the person in whom it exists, and nowhere is the influence of individuality of more importance than in diseases complicated by mental disturbance - a fact which has been especially emphasised by some of the more recent psychological work. It is the individuality of every case that must be worked out regardless of the particular name given to it.<sup>49</sup>

Since the condition had its roots in such a wide variety of causes, and since the symptoms were so disparate and diffuse, it was inevitable that neurasthenia became something of a portmanteau term, as much abused as it was used. More

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<sup>47</sup> *The Lancet*, 16 June 1917, p.910.

<sup>48</sup> For an extended list of the symptoms associated with neurasthenia, see Chapter Seven, esp.pp. 230-2.

<sup>49</sup> *The Journal of Mental Science*, Vol. 59, October 1913, pp.582-3.



to the point of the present thesis, however, it was frequently used as a disguise for more serious mental conditions, where a more explicit diagnosis might have had unacceptable social, disciplinary or political implications.

As a fighting force, the effectiveness of the British Army depended crucially on the maintenance of what Army law referred to as 'good order and military discipline', the military equivalent of 'the Queen's peace'. Anything that threatened this fundamental principle was proscribed by one or more of the multiplicity of rules and regulations that formed the body of military law. Sanctions ranged from a few days 'fatigues' or 'confined to barracks', to imprisonment and even death. In 1915, the first full year of war, permanent losses in British troops through death, wounds and disease in France and Flanders alone totalled 4,359 officers and 77,464 other ranks.<sup>50</sup> More importantly, the respective percentage losses from the total fighting strength were 17.26 for officers, and 9.79 for other ranks. Scouring the universities and public schools could not keep pace with losses on this scale, with the result that the Army was forced to look outside its traditional selection pool. By the time the Armistice was declared, it was estimated that only one third of the officers then in uniform had come from the Officer Training Corps, the remainder having been promoted from the ranks in the field.<sup>51</sup>

Officers drawn from the traditional sources could count on being regarded as 'proper' officers irrespective of age and experience. It was well

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<sup>50</sup> Mitchell and Smith, *Medical Services, Statistics*, p.135. (These numbers do not include 'Imperial and Dominion' forces).

<sup>51</sup> Winter D. *Death's Men*, Penguin, (London 1979), p.64.



known, for example, that young, inexperienced officers needed a good sergeant on whom they could rely for advice and guidance, until their own experience had widened sufficiently for them to avoid the most obvious pitfalls. Officers newly commissioned from the ranks were carefully kept away from their former comrades, in the hope that the essential mystique that had traditionally surrounded the officer class should not be too deeply penetrated. A social *faux pas* committed in the officer's mess was one thing, but his behaviour in the field had to be that of a 'real' officer. Doctors commissioned in response to the exigencies of the war, whose intimacy with horses extended no further than carefully avoiding their droppings in the street, quickly assumed all the accoutrements of the cavalry officer. What were known as '*a la suite*' medical officers, with temporary commissions and no military experience of any kind, paraded the wards of War Hospitals resplendent in breeches and gleaming riding boots.<sup>52</sup> If to this was added the universally recognised badge of the officer corps, the 'Sam Browne' belt, the neophyte was identified as a sword-bearer rather than a spear-carrier, and the transformation was complete.<sup>53</sup>

The final touch, the outward sign of inward grace which set the seal on the transformation, was that even the most junior officers were provided with servants. These 'batmen' had to fetch and carry for 'their' officer, take first pick of the available food supplies, clean their clothes, polish their boots, and generally provide the unmistakable attribute which set officers above the

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<sup>52</sup> For evidence of the scant regard in which temporary medical officers were held, see Harrison L.K. 'History of the 5th Northern General Military Hospital, Leicester', Unpubl. Typescript, (1919), Leics. C.R.O., Ref.LM /8/TS.

<sup>53</sup> W.H.R.Rivers, whose work at Craiglockhart officers' hospital is discussed in Chapter Eleven, provides unwitting testimony (at pp.6-7) to the vital symbolism, and importance to the families of officer casualties, of this particular item of equipment.



common soldiery. By these means, even the most unpromising material could be transformed, making this new breed of officers heirs to the traditions of the ruling class and to all the knightly virtues.

The end product was remarkable...when the public-school officers were killed, working-class replacements were just as good and soon acquired the same mannerisms.<sup>54</sup>

As the previously rigid social distinctions blurred and shifted under the pressure of wartime exigencies, however, it became increasingly important for the signs and symbols of superiority to be preserved wherever possible. For officers to be seen as vulnerable to psychological pressure would, it was feared, strike at the heart of the traditional military ethos, seriously undermining the claims of the officer class to their historically sanctioned role as leaders. Thus, it was felt necessary to play down the significance of mental and nervous casualties within the officer class, by excluding or minimising references to insanity, mental illness, derangement or other terms reminiscent of the unsound mind. When the fact that officers were being sent back from the front suffering from mental and nervous disorders became public knowledge, the added responsibility which officers bore for the safety of their men was constantly referred to as the prime cause.

Officer patients were carefully segregated from those of the 'rank and file'. When, as the result of an appeal by Viscount Knutsford, special hospitals for officers were opened in London, the emphasis was on 'nervous' rather than 'mental'. The atmosphere, *The Lancet* reported, was that of;

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<sup>54</sup> For an excellent summary of the psychology of the 'ranker to officer' transition, both from the Army's and the individual's points of view, see Winter, *Death's Men*, esp. pp.63-70.



...a well-ordered private house and in no way that of an institution [...] (There is) nothing to attract or distract the attention of the tired men, to whom complete and absolute rest of body and mind is the first essential of recovery. In such a quiet haven fatigue as a rule rapidly passes off and convalescence begins.<sup>55</sup>

In the case of officer patients, the hospital records, sparse as they are, suggest that diagnoses of mental disorder in officer patients were avoided, because of the obvious problems of morale and discipline they would have posed. The Craiglockhart admission and discharge books apparently confirm that officers admitted there suffered from neurasthenia and very little else. Any challenge to that assumption would need to be based on a detailed analysis of the corresponding medical casenotes, for which the contemporary scholar must continue to search. P.J.Leese, who examined all four of the Craiglockhart admission and discharge books, also regarded the diagnoses as open to serious question;

...Army doctors adapted the terminology of the ...complaints with which they were more familiar...'neurasthenia' more successfully implied a justifiable nerve complaint [...] the diagnosis entered for each of the 1,560 cases treated in over two years was 'neurasthenia'.<sup>56</sup>

Leese also looked at the small number of surviving casenotes of the Lennel officers' convalescent hospital in Scotland, commenting that the severity of some of the disorders was disguised by 'vague diagnosis' and the employment

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<sup>55</sup> *The Lancet*, 20 November 1915, p.1155.

<sup>56</sup> Leese, 'A Social and Cultural History of Shellshock', pp.65-6.



of euphemisms such as 'clouding of consciousness'.

#### **4.8 Neuropsychiatric casualties and social class.**

According to the Official History, war neurosis for the other ranks more frequently took the form of "functional" disorders, while officers (as the Craiglockhart records apparently demonstrate) generally suffered from neurasthenia. The reason for this peculiarity was said to be that the common soldier bore no responsibility beyond that of obeying orders. His limited horizons allowed him to take a phlegmatic, optimistic and often seemingly uncaring attitude to danger. Unconsciously, however, his primitive 'fight or flight' instincts revolted against being forced to remain immobile under incessant bombardment and the constant threat of death. Powerless to retaliate, his reaction was 'to retreat from an intolerable reality into illness'. Hence the development of unconscious conflict and the consequent functional disorders.

The type of warfare practised during the Somme battles of 1916 provided ideal conditions for the development of these disorders. The "artillery preparation" called for an "artillery reply" from the opposing side. This duel frequently lasted several hours or days, during which time the nerves of all were kept on edge.<sup>57</sup>

These factors obviously affected officers as well as men, but were, it was asserted, amplified by additional responsibilities. Firstly, there was the need for officers to behave in such a way as to satisfy their own sense of honour, patriotism and 'doing the right thing'. Secondly, there was the responsibility for setting a good example to the men in their charge, to conceal all signs of fear,

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<sup>57</sup> Macpherson, *Medical Services, Diseases*, p.16.



and to display the leadership without which the business of fighting the war could not be carried on. The unremitting strain of having to maintain this outward show of fearlessness, combined with the knowledge that their acts and omissions could cost the lives of men with whom they shared the dangers and hardships of battle, imposed strains under which many officers broke down.<sup>58</sup>

Another aspect of war neurosis, not necessarily confined to officers but arguably more likely in their particular role, was the question of psychological compensation for fear. Having had drummed into them at school that 'the only rule was to play the man', young officers in the incipient stages of mental or nervous illness were liable to indulge in deliberate acts of bravado. The motivation for these glaringly risky acts was two-fold. They were a reaction to the individual's own sense of dwindling fortitude - a desperate attempt to counteract feelings of impending mental dissolution. This same sense of looming disaster, after being more or less internalised, eventually gave rise to the sense that others - particularly those to whom he was supposed to represent imperturbable leadership - would discern his inner fears and despise him. Acts of reckless 'bravery' in pressing home attacks, or instances of individual 'courage' in the face of the enemy were equally liable, Forsyth contends, to be (usually vain) attempts to delay the inevitable.

[The officer] now goes in constant anxiety of his feelings to those around him, whether by acts of commission or omission. He envies them their calm demeanour without ever suspecting that it may be as deliberately assumed as his own, and that they are envying him his own apparent composure. [...] In order to convey an

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<sup>58</sup> For a clear exposition of the psychological factors involved in these conditions, see Forsyth D., 'Functional Nerve Disease and the Shock of Battle', *The Lancet*, 25 December 1915, pp.1399-1403.



impression of indifference to danger he begins deliberately to expose himself to unnecessary risks.<sup>59</sup>

This neat division of nervous casualties into 'officers/neurasthenia, other ranks/hysteria' is not supported by the evidence of the present study. As noted above, neurasthenic conditions in the other ranks accounted for more than 20% of the 500 cases analysed. As a diagnosis, neurasthenia was much more acceptable, not only to the officer corps and those treating them, but also to the class from which most officers were drawn. 'Neurasthenia' implied a disorder of the nervous system rather than the mind, avoiding any disturbing connotations of mental degeneracy. Emphasis could therefore be put on the physical rather than the mental aspects of the disorder, a clinical sleight-of-hand assisted by the broadness and generality of the symptomatology of neurasthenia itself. What young officers needed, it could be argued, was not psychiatric help, but rest and relaxation away from the responsibilities of the fighting, decent food, and the society of companions of a similar social background.

The poet Robert Graves, having suffered what Miranda Seymour describes as a 'nervous breakdown' after being wounded in 1916, was sent to one such hospital. Seymour, too, recognised the atmosphere of euphemism that had grown up around the issue of officer mental casualties;



Convalescent home' had become a wartime euphemism for a psychiatric hospital, of which many officers besides Graves were in dire need. In June (1917)...he was sent to Osborne House on the Isle of Wight [which had] been turned into one of these informal asylums. Here...his chief entertainment was a rag society which he had started with a journalist inmate. The type of jokes they enjoyed suggests that he was going through a period of hysteria. One was to construct a model of a drowned sailor and prop it up on the beach to frighten fishermen.<sup>60</sup>

Such comments demonstrate a misunderstanding of what hysteria as a functional nervous disorder really was. Rather than being symptomatic of a neuropsychiatric disorder, pranks of this juvenile silliness strongly support Peter Parker's contention, namely, that many young officers regarded the War as something of a lark, a game in which, like their games at Eton, Harrow or Rugby it was important to win, but even more important to have 'played the game' to the best of one's ability. Letters from Old Boys which found their way into school magazines, for the most part suggested that life at the Front was rather like life at school - rough but surprisingly enjoyable.<sup>61</sup>

Seymour's description of the atmosphere prevailing at 'informal asylums' like Osborne (once a favourite residence of Queen Victoria and Prince Albert) emphasises the quite extraordinary latitude extended to officers who became mental or nervous casualties. As 'a refuge from the madness of his friends' Graves spent a good deal of time at nearby Quarr Abbey, where he had been given the run of the 'magnificent' library where he could immerse himself in reading poetry. Not surprisingly perhaps, no evidence has come to light to confirm that this constituted official policy, although sources such as Graves,

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<sup>60</sup> Seymour M., *Robert Graves: Life on the Edge*, Doubleday, (London 1995) pp.63-4.

<sup>61</sup> Parker P., *The Old Lie*, Constable, (London 1987), p.201.



Sassoon (and more recently Seymour's and Barker's treatments of their experiences) suggest strongly that there was in effect class-inspired collusion to divert attention from mental casualties within the officer corps. The subject clearly warrants more detailed research, but whatever the true situation, the kind of class-based explanation put forward by Burton-Fanning is clearly untenable. If, as he maintained, the values instilled by the public school system tended to prevent neurasthenia, then the wholesale diagnosis of the condition in officer patients at Craiglockhart is rendered inexplicable, other than as camouflage for a situation the authorities wished to conceal. The force of this argument is strengthened by the progressive promotion from the ranks of other than public school candidates. Burton-Fanning suggests that a major factor that protected officers from the worst effects of war conditions was the moral fibre inculcated by their public school education. This leaves unanswered the question of how non-public school officers survived without the benefit of this supposed psychological armour.

An interesting aspect of the '500 cases' study has been the opportunities it has presented for comparing the recorded diagnoses of mental and nervous disorders with the actual symptoms presented by the patient and the signs observed by the medical officers. As the examples of diagnosed neurasthenia given above demonstrate, wide divergence can be observed. Unfortunately, the absence of officer medical case sheets rules out a similar kind of comparison in the case of officer patients. This thesis has earlier drawn attention to the admission and discharge books of the officer's hospital at Craiglockhart, and to the fact that the overwhelming majority of patients there were diagnosed as



suffering from neurasthenia.<sup>62</sup> The implication is clear enough. If, as the Official History maintains, the diagnosis of neurasthenia was widely misapplied, then the credibility of the Craiglockhart records must be open to serious question. The suspicion that neurasthenia was used to disguise other and more serious mental and nervous disorders, is not lessened by the fact that those who had the task of compiling the 'Representative Selection' of medical case sheets, chose to exclude, or were under instruction to exclude, any medical casenotes referring to officer patients.

Finally, despite the fact that the overwhelming majority of officers treated at Craiglockhart ostensibly suffered from neurasthenia, the chapter of the Official History purporting to deal with the disorder refers to 'soldiers' throughout, making no mention of officer patients. The symptoms presented by the 'neurasthenic group' are set out in considerable detail. In view of the ubiquitous nature of the condition (particularly in the officer class) it is probably worth reproducing this 'official' definition in full.

Neurasthenic Group. - Under this term are included patients who presented anxiety and psychasthenic symptoms. The inadvisability of using the term "neurasthenia" for these cases of severe exhaustion in soldiers was always well realized. It was, however, the only "official" diagnosis available. The outstanding feature of the soldier's "nervous breakdown" was the rapid improvement which occurred under the simplest forms of treatment. It was therefore unfortunate that in a disorder in which it was of the utmost importance to avoid suggesting symptoms to the patient, it should have been the practice to use a diagnosis which immediately brought to his mind the intractable forms of the neurasthenia of civil life.<sup>63</sup>

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<sup>62</sup> Archive reference: PRO/MH106/1887-1908. Craiglockhart Admission and Discharge Registers.

<sup>63</sup> Macpherson, *Medical Services, Diseases*, p.20.



There is a good deal of muddled thinking in this statement. In the first place, the present study shows conclusively that neurasthenia was far from being the only diagnosis applied. From the very early days of the War, as far as the other ranks were concerned, medical officers seemed to have no difficulty in making diagnoses such as 'anxiety neurosis' (3.2.15), 'mental instability' (15.2.15), 'melancholia' (28.3.15) and 'functional hysteria' (1.5.15). It is also highly questionable as to whether most ordinary soldiers would be familiar with neurasthenia. If Burton-Fanning is right, the working classes rarely, if ever, became incapacitated by neurasthenia, if only because their economic situation did not allow them to succumb to any but the most obvious illnesses. Neurasthenia, however 'tiresome' and 'troublesome' it may have been, was a luxury the working classes could not afford. There was clearly more risk of exacerbating a given situation by suggesting these symptoms to young, impressionable officers whose lives, for the most part, included medical care whenever it was needed. To think otherwise is to accept Burton-Fanning's ludicrous assertion, that attendance at a public school conferred some sort of immunity from the neuropsychiatric effects of war. Also, if the Official History is to be believed, neurasthenia was all too frequently entered as a diagnosis, not as the outcome of examination and observation of signs and symptoms, but because the official nosology provided no acceptable alternative.

If this is the case, much of the statistical data on neurasthenia contained in the Official History, based as it is on this entirely artificial premise



becomes, if not entirely worthless, then certainly of questionable value as a historical record. An added motive, therefore, for present historians to explore other avenues in pursuit of reliable statistical evidence.<sup>64</sup>

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<sup>64</sup> For an extended note on the post-war *sequelae* of neurasthenia, see Stone M. 'Shellshock and the psychologists' in Bynum W.F., Porter R. and Shepherd M., *The Anatomy of Madness*, Vol.3, Tavistock, (London 1985), p.267.



## CHAPTER FIVE

### COHESION AND DISSOLUTION IN THE 'COMRADELY GROUP' - THE NEUROPSYCHIATRICAL CASUALTY AS OUTSIDER.

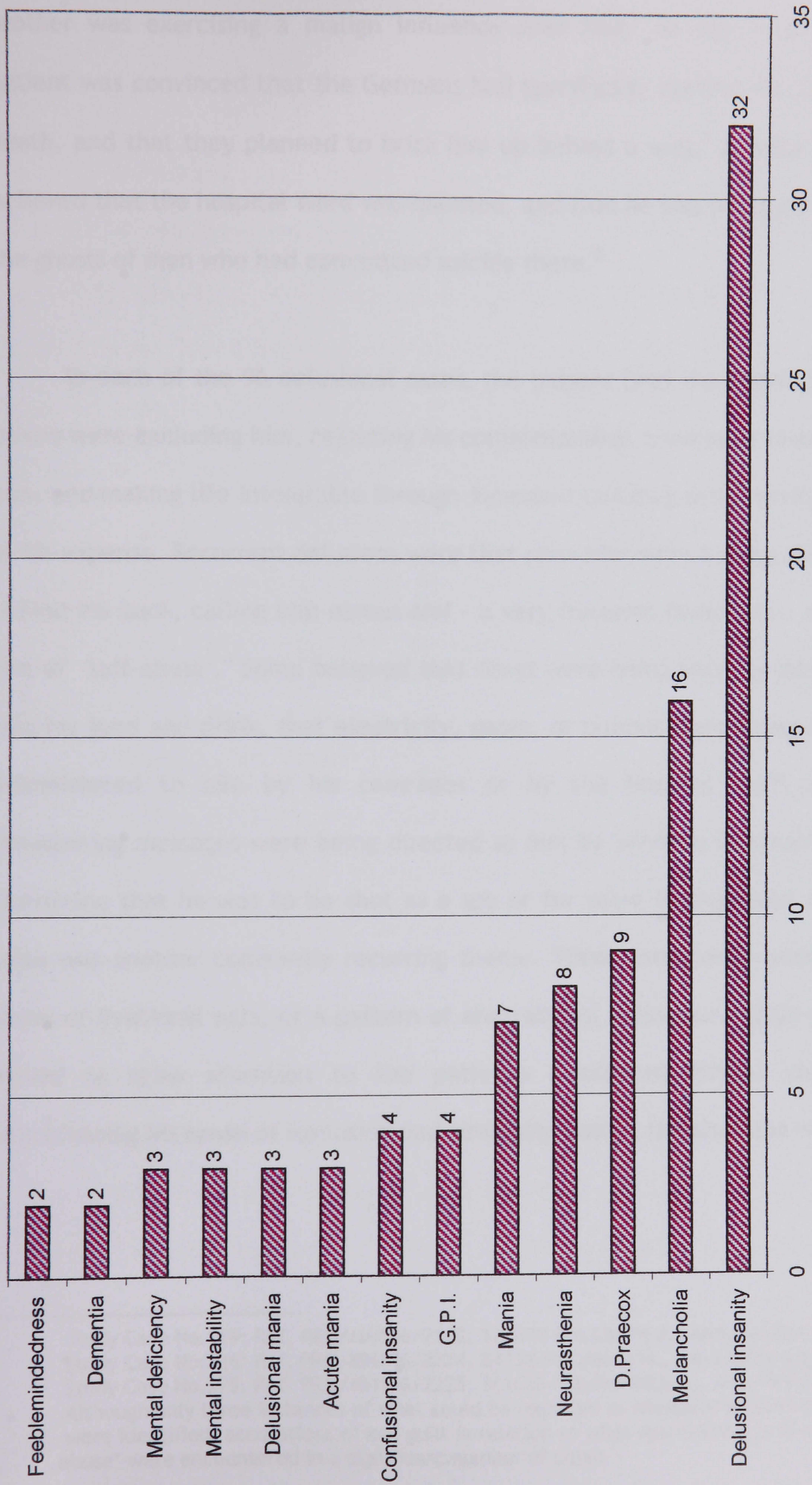
#### 5.1 Background.

Of the 500 neuropsychiatric casualties whose case histories were analysed in detail in Chapter Three, 151 (30.2%) exhibited what were routinely recorded at the time as 'delusional' symptoms. Of these, 96 (63.5%) were of the persecutory type, 37 (24.5%) were delusions of grandeur and 18 (11.9%) were delusional symptoms of other types. As might be expected, delusional symptoms tended to be more a feature of mental than of nervous disorders, although neurasthenic cases exhibiting delusions of persecution featured prominently in the 96 cases. Figures Three and Four show the numbers of such symptoms noted in relation to the overall range of symptoms found in the study group. Figure 11 shows the various categories of mental and nervous disorder, with the numbers of cases exhibiting 'persecutory delusional' symptoms in each of the categories.

In modern psychiatry, 'delusion' is defined as 'a belief...maintained in spite of argument, data and refutation which should (reasonably) be sufficient to destroy it'. Delusions of persecution are defined as 'delusions of the paranoid type' in which the individual feels victimised. In the early years of the twentieth century, however, the terms 'paranoid' and 'paranoia', were not routinely employed, 'delusional' and 'delusional insanity' being the most commonly used terms. Cases in the 'persecutory' sample range from a case of delusional insanity in which the patient believed that a non-existent twin



500 cases: Mental and nervous disorders exhibiting persecutory delusions.





brother was exercising a malign influence over him,<sup>1</sup> to one in which the patient was convinced that the Germans had specifically marked him down for death, and that they planned to brick him up behind a wall.<sup>2</sup> Another patient believed that the hospital ward was haunted, and that he was being pursued by the ghosts of men who had committed suicide there.<sup>3</sup>

In each of the 96 delusional cases, the patient held the conviction that others were excluding him, rejecting his companionship, combining to endanger him, and making life intolerable through incessant taunting and practical jokes at his expense. Recurrent delusions were that comrades were talking about him behind his back, calling him names and - a very frequent complaint - accusing him of 'self-abuse'.<sup>4</sup> Some believed that drugs were being secretly introduced into his food and drink, that electricity, gases, or poisons were being covertly administered to him by his comrades or by the hospital staff, or that threatening messages were being directed at him by 'wireless telegraphy'. The conviction that he was to be shot as a spy or for some infringement of Army rules was another constantly recurring theme. These convictions prompted a series of irrational acts, or a pattern of aberrational behaviour, which in itself served to draw attention to the patient's disordered mental condition, exacerbating his sense of exclusion and generally making the situation worse.

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<sup>1</sup> Study Case No.119: Ref. PRO/MH106/2102, 103398 Pte.Clarke J., Army Service Corps.

<sup>2</sup> Study Case No.326: Ref. PRO/MH106/2224, 84238 Pte.Jarvis M., 141 Labour Coy.

<sup>3</sup> Study Case No.375: Ref. PRO/MH106/2225, 361636 Pte.Kendrick A., Army Service Corps.

<sup>4</sup> Although only three instances of what could be regarded as excessive masturbation were identified, accusations of and guilt in relation to what was commonly termed 'self abuse' were encountered in a significant number of cases.



## 5.2 Powerful fragility: the paradoxical nature of the 'comradely group'.

The main hypotheses advanced in this chapter are, firstly, that the hierarchical structure of the Army necessitated the formation of what are called here 'comradely groups' - small groups of men bound together by common circumstances. The binding agent might be shared danger, as in the fighting zones, or it might be a common sense of injustice and oppression where, for example, a group of men suffered under a particularly harsh disciplinary regime. In *Firing Line* (1986) Richard Holmes draws attention to the strongly reciprocal, interdependent nature of the relationships existing within the primary fighting groups, and their pre-eminence as the foundation of military organisations:

Although the full flowering of group cohesion is to be seen in the regiment, whose corporate identity is often reinforced by distinctive uniforms and insignia, its roots lie deeply in the smallest of military groups. The importance of the primary group of up to ten, whose members were in regular face-to-face contact, was recognised long before psychologists or sociologists turned their attention to the question of group behaviour.<sup>5</sup>

Holmes is, of course, speaking primarily of men in combat situations, where relationships evolve in a vivid and sharply focused way through shared perils and hardships. The intensely hierarchical nature of the Army's organisational structure, it is argued here, also created a similar need for mutual aid and comfort in the men who carried supplies, cooked the food, tended the sick and wounded and buried the dead. For lack of a suitable phrase in the literature, the term 'comradely group' is coined in this thesis to refer to the natural

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<sup>5</sup> Holmes R. *Firing Line*, Jonathan Cape, (London 1985) p.293.



interest grouping at the lowest level of the military hierarchy, and in all categories of military activity.

The second, and equally important element in the argument put forward here is that by its nature, the comradely group required of its members certain social and cultural behavioural standards. These were typically connected with solidarity in the face of external authority, mutual trust and regard, and the maintenance of tacitly agreed standards regarding interpersonal relationships. Persistent failure to adhere to those standards rendered the individual liable to sanctions in the form of exclusion. In the Army, it is suggested, the consequences of exclusion from the comradely group were potentially much more serious than they might be in an analogous social grouping in civilian life.

Those who faced the enemy directly possessed a natural focus for their cohesion, and for the exclusivity they displayed towards the wider world. Basic military training, however, through which all recruits had to pass, left no soldier untouched, and was the Army's naturally evolved way of identifying potentially useful, as well as potentially disruptive elements in its midst. By definition, the central purpose of military training is to instil into individuals a sense of comradeship, an acceptance of needs and aspirations higher and deeper than their own; to which they and the organisation as a whole must be subordinate if it is to be effective. In Holmes's words, the purpose of training is:

...to inculcate the military ethos in recruits, and to ensure that the individual values which prevail in most civilian societies are replaced by the group spirit and group loyalties which underlie all military organisations.<sup>6</sup>

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<sup>6</sup> Holmes, *Firing Line*, p.96.



In the comradely group, as in the family or the wider society from which its members were drawn, aberrational behaviour was difficult to conceal. 'In the Army' one medical officer observed 'a very slight variation from the normal in conduct quickly attracts attention'.<sup>7</sup> Unacceptable social standards such as petty thieving, lack of personal hygiene, or voluntary collaboration with authority could introduce potentially destructive tensions. The supervision of mental illness was liable to cause the individual to behave in ways that were culturally and sociologically threatening. As the result, the individual ceased to be acceptable as a member of the group, his comrades' behaviour towards him became exclusive rather than inclusive, and the individual became an outsider.

Through the presentation of statistical data, combined with detailed analyses of relevant case histories, this chapter sets out evidence in support of these arguments. At the same time, contemporary attitudes of the mental casualty, the Army, the comradely group and the wider society towards mental illness are explored.

### **5.3. Them and us: the forces that formed the 'comradely group'.**

Situated as he was at the bottom of a rigidly maintained hierarchy, the private soldier relied heavily on the comradely group for mutual aid, support and solace, sharing as they did mutual interests and common miseries. Necessarily on the defensive against superiors whose primary function, all too often,

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<sup>7</sup> Chambers W.D., 'Mental wards with the British Expeditionary Force: A review of Ten Months' Experience' *The Journal of Mental Science*, Vol.64, July 1919, p.154. See also Eager R., 'The Early Treatment of Mental Disorders', *The Lancet*, 20 September 1919, pp. 558-563.



seemed to be that of making life difficult for those at the bottom of the heap.

Denis Winter sums it up in this way:

'Man' to a staff officer was [...] like a chess piece - 'Send...men to 'A' and tell them to hold it at all costs'.

'Man' to a quartermaster was an envelope of skin consuming food, needing a billet.

'Man' to a subaltern out of the line was a shadowy figure...

(To) the N.C.O. 'Man'... was a being tending constantly towards evil...<sup>8</sup>

Officers were responsible for the welfare of their men as well as for exercising authority, and many earned respect and even affection for that and for other admirable qualities. In the combat situation they shared the dangers and privations of their men, and in that situation much of the hierarchical structure lapsed. In the line, Winter records. 'saluting and social distance gave way to survival'.<sup>9</sup>

Away from the fighting, however, the Army's special class structure reasserted itself. Officers did not routinely eat with the men or share their tables at the local *estaminet*. Most importantly, they did not share the heaviest burdens of the private soldier, his loss of individuality and sense of worth, his forced subservience to irksome and often pointless routines, nor his liability to punishment if he transgressed. The private soldier was left in no doubt that any

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<sup>8</sup> Winter D., *Death's Men*, Penguin, (London 1978) p.51.

<sup>9</sup> *Ibid.*, p.61.



form of resistance was not only futile, but was liable to harsh and often humiliating punishment.<sup>10</sup>

Private John Herbert (Jack) Calow of Leicester was initially rejected for military service in 1914 because of slightly defective vision in his right eye. Later accepted as a medical orderly by the R.A.M.C. he served at the 5th Northern General Military Hospital in Leicester from early 1915. As a spirited youngster of 19, he described the resentment felt by himself and his comrades when forced to carry out domestic tasks such as scrubbing floors, work which in civilian life was reserved for women. He also vividly recalled the arrogance of local doctors, temporarily commissioned in the R.A.M.C., and their insistence on every minor point of military etiquette. Questioned about the relationship between officers and men at the hospital, Jack's response was brief and uncompromising - 'They treated us like dirt'.<sup>11</sup>

When, in October 1917, the shortage of manpower forced the transfer of Jack and many of his comrades from the hospital into the Infantry and into the trenches, his reaction was, firstly, that the years of experience with the R.A.M.C. had been wasted. Secondly, he and his comrades were treated as little better than dumb animals, subject to every whim of the 'top brass', and left in no doubt that they were wholly expendable.

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<sup>10</sup> Winter, *Death's Men*, p.61.

<sup>11</sup> Personal recollections of ex-Private John Herbert (Jack) Calow, R.A.M.C., (later the Leicestershire Regt.). Recorded interview with the author (1995).



With a resentment undimmed by the passage of nearly eighty years, Jack recalled marching for several hours through torrential rain on the way to billets. Nearing exhaustion, and knowing they would need a fire to 'brew up' when they arrived, some of the men in the column had gathered bundles of wood when passing through a ruined and abandoned village, and were keeping it as dry as they could beneath their gas capes. A senior officer who happened to be riding by halted the column, forcing the men to reveal their burdens. Launching a violent tirade, he condemned what he described as 'looting'. The entire column - those with firewood and those without - was forced to march back for several miles through the downpour, and were made to replace every scrap of wood on the mounds of rain-soaked rubble. Having indulged his taste for petty tyranny, the officer rode away.<sup>12</sup>

It was natural for men to mistrust a system that perpetuated such patent injustices, and to take refuge in the defensive and protective society of those with whom they shared common values. Ordinary soldiers literally closed ranks, forging the strongest bonds they could as a bulwark against oppression, intimidation and fear. These 'comradely groups' provided a forum within which their individual and collective grievances could be voiced without fear of betrayal, providing also a substitute for the loss of family ties and the supportive social environment of civilian life. Denis Winter is in no doubt concerning the importance of what in this thesis is termed the 'comradely group':

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<sup>12</sup> Personal recollections: ex-Private Calow.



United by a common jargon, by shared secrets and experiences, by common discomfort and grievances, by deep fears and common laughter, by shared prejudice against...common authority...men belonged to platoon or section as to no other aspect of their war life.<sup>13</sup>

Holmes, Winter and others offer a compelling weight of evidence concerning the strength of the bonds forged within the comradely group. If that evidence is accepted, it follows that the severing of those bonds, or expulsion from the security of the group, was liable to release powerful negative forces, capable of acting disruptively on the individual personalities making up the group. In the trenches, there was literally nowhere else to go, and little or no opportunity for the individual soldier to find alternative social interaction. The soldier was fastened into the comradely group, with only a limited number of ways in which he could legitimately be detached from it.

#### **5.4. Self-inflicted wounds and other escape routes.**

Legitimate passports out of the privations of the trenches included death, wounds, sickness, or exigencies of the service such as disbandment of the unit or promotion out of it. Death was of course always possible, though few soldiers actively courted it. In the Great War, it was considered desirable to sustain certain kinds of wound - the 'Blighty one' that would guarantee repatriation to the U.K., but would not involve mutilation or permanent disability. There were, however, many cases where soldiers resorted to the most desperate measures to get out of the fighting. Lieut. Neville Woodruffe, 1st. Battalion, Irish Guards, was killed in action on 6 December 1914. In letters to his mother, he paints a vivid picture of the strains to which all sides were exposed, as well as the

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<sup>13</sup> Winter, *Death's Men*, p.56.



extremes to which both officers and men were driven. Woodroffe admitted that the 'self-inflicted' wound had not only made its appearance at this early stage of the War, but that it was recognised as 'a traditional means of opting out of the fighting', even in elite regiments such as the Guards. Woodruffe comments ironically that two of his men had been admitted to hospital having blown off their fingers ostensibly cleaning their rifles.<sup>14</sup> As a legitimate reason for leaving the comradely group, disease had to be accepted, if only because of its prevalence. What were termed 'non-battle' casualties - sickness and accidental injury - exceeded 'battle' casualties by more than a million on the Western Front alone. During the disastrous Gallipoli expedition of April 1915 to January 1916, British losses alone totalled 213,980, with 'non-battle' casualties accounting for no less than 145,154. It seems hardly necessary to mention that becoming a casualty through disease carried none of the distinction of an honourable wound.<sup>15</sup>

As a cause of rejection from the comradely group, the cases analysed below show how, from the viewpoint of the sufferer, the persecutory delusions associated with certain forms of mental illness could lead to the dissolution of comradely bonds. The process was, of course, not one-sided, and it must have been the case that excluding the mental casualty had some reciprocal effect on the other members of the group. However, the present work is concerned primarily with the situation of the neuropsychiatric casualty.

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<sup>14</sup> Winter, *Death's Men*, p.35.

<sup>15</sup> Honourable wounds earned the recipient a gold 'wound stripe', worn diagonally on the lower tunic sleeve. Refusal of the stripe for certain categories of neuropsychiatric injury was the cause of much resentment.



In the trenches, the nature and function of comradeship can be readily understood. It is less easy to visualise the bonds of the comradely group functioning in situations away from the actual fighting - in base camps, in training depots or in hospitals. Nevertheless, if we accept the existence of the comradely group as a military phenomenon, we must by logical extension accept the existence of some kind of social adhesive, the function of which was to bind groups of all kinds together, allowing them to function as an integral part of the army as a whole. To deny that is to postulate an army composed entirely of individuals, having no unifying disciplinary code, no relationship one with another, lacking common purpose, and pursuing self-identified and unilaterally satisfied goals. Such an 'army' would be a contradiction in terms.

Put simply, what is true for the infantry must also be true for the cavalry, for the tank crews and for the artillery. What is true for these 'early contact' units must also be true - not as strongly, and probably acting in different ways - for the Army's hewers of wood and drawers of water. If this is denied, arguing, for example, that the influence of the comradely bond stops, as it were, at the entrance to the front-line trench, or at the extreme range of the enemy's guns, then by inference, the support units have no interest in the prosecution of the conflict at all. In order to maximise their contribution to the overall war effort, support and service units must share in some way and to some degree in the comradely ethos. Such units and functions had no option but to find ways, not simply of justifying their existence and validating their contribution, but also of establishing a self-fulfilling measurement of worth, a little citadel of pride within which they could also take refuge from the



condescension of the more glamorous units. Of necessity, they needed their own version of the comradely group, their own route to a satisfactory self-image and, by extension, a sufficiently strong motivation for maintaining their contribution to the overall war effort.

Services as mundane as sanitary or mobile bath units were self-evidently necessary - even vital - to the welfare of the Army as a whole: without them dirt, vermin and disease would flourish unchecked as they had done in previous wars, and the fighting efficiency of the Army would inevitably have suffered. Such patent truths are widely known, wholly accepted and largely ignored when the victory laurels come to be awarded. Units such as these must therefore look inward for mutual aid, support and comfort, and it may well be that the bonds of the comradely group give rise to a more powerful reaction when severed in these circumstances than in early contact units.

W.H.R.Rivers argued that paranoia, together with its characteristic symptoms of persecutory delusion, was a common means by which the individual strove to reconcile conflicts, 'between instinctive tendencies and the forces by which they are normally controlled'.<sup>16</sup> Paranoia, Rivers observed, often seemed to have its roots in a 'state of inferiority, real or supposed', in which the individual attempts to rationalise his mental conflicts by devising an elaborate scenario to run alongside the real conditions of his life, into which he is able to weave the details of his delusions. This process, Rivers argued, was:

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<sup>16</sup> Rivers W.H.R., *Instinct and the Unconscious*, Cambridge University Press, (Cambridge 1920) p.144.



...partly to explain his inferiority, partly to still the conflicts to which certain forms of inferiority render their subjects peculiarly liable.<sup>17</sup>

### 5.5. The 'comradely group' away from the trenches.

The precise nature of the personal relationships that existed in the many different kinds of units within the British Army during the Great War is too complex a question to be dealt with here. However, drawing on the data generated by the present study it is possible to say, for example, that of the 94 cases admitted to hospital exhibiting delusions of persecution within the semiology of their neurosis or psychosis, 34 patients (36.1%) were serving in units supportive of the early contact units. But to infer that these individuals were in any sense less courageous or praiseworthy than those in the early contact units would be mistaken. It is only necessary to think of stretcher-bearers of the R.A.M.C. to readily dismiss such a conclusion.

In the early contact units - the Guards, the Rifle Brigade, the Dragoons and a host of similarly prestigious units, regimental pride, battle honours, medals and 'mentions in dispatches' were the natural harvest of endeavour. On the other hand, casualties were far higher, replacements had constantly to be assimilated, and the bonds of the comradely group were necessarily formed and re-formed again and again. In the rear areas and support units, the bonds of common interest, shared hardships and sense of being unfavourably contrasted with the early contact units, necessarily caused comradely bonds to form in different ways and for different reasons. Though different, relationships formed

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<sup>17</sup> Rivers, *Instinct and the Unconscious*, p.144.



in this way may have been more strongly attached to the psyche of those concerned. More to the point of the present study, the evidence suggests that their severing may have been more psychologically disruptive in the excluded individual than in the early contact units.

Like the majority of Army officers, Rivers believed that the existence of a strong and pervasive *esprit de corps* amounted to a great deal more than simply a talisman to which men might turn for reassurance and inspiration. At the same time, Rivers recognised that the nature of soldiering, (and consequently the nature of the relationship between soldiers and their units) had also undergone much modification as the result of expansion during the Great War:

...but these changes have only modified the process (of creating *esprit de corps*) and have not changed its essential character. [...] the spirit embodied in the regiment or company being now attached to the battalion or platoon, or other unit which has been brought into existence by the exigencies of warfare.<sup>18</sup>

Common sense, therefore, dictates that the comradely group must have existed throughout the Army during the Great War. The nature of the group inevitably differed from unit to unit, each fostering its own special version which it necessarily defended against criticism from outside. By the same token, the effects of exclusion from the comradely group varied from case to case depending on a number of factors, not least the nature and severity of the disorder. As the following cases demonstrate, however, exclusion could and did become an influential part of the delusional pattern.

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<sup>18</sup> Rivers, *Instinct and the Unconscious*, pp.216-7.



### 5.6. The dissolution of the 'comradely group'.

In studying these cases, the frequency with which patients referred to the breakdown of relationships within their own 'comradely group' was immediately striking. Patients who retained at least some psychological insight, and who also exhibited persecutory delusional symptoms, were particularly liable to regard the dissolution of these bonds as a significant causational factor in their troubles. 'The others were all against me', 'the other men kept talking about me', 'they said I was a German spy and would be shot' are typical of the complaints. With some older patients, their troubles were often said to have begun because of their inability to 'keep up' with younger comrades on the marches which were a dominant feature of the soldier's life. All these were used as excuses for aberrant behaviour such as a degeneration in personal hygiene, or absenting himself from the unit. Even when insight had been substantially lost, the persistence of these complaints, often over protracted periods, confirms that they constituted, as W.H.R. Rivers describes it:

...a system of thoughts, affects, [and] beliefs which are of the same order as those of the rest of the society to which the person belongs. When this ...system is dominant the person seems to be a normal member of society, but if anything happens to arouse the delusion, his conduct may be wholly inappropriate to [his] social needs...<sup>19</sup>

Whether or not the person can be regarded as insane, Rivers went on to say, depended on how much his delusional synthesis is 'out of harmony' with socially acceptable norms.

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<sup>19</sup> Rivers, *Instinct and the Unconscious*, p.83.



The present study shows, however, that delusions - whether of persecution or grandeur - constituted only part of the psychopathology of delusional mental disorder. Rivers, drawing on his experiences at the Moss Side and Craiglockhart War Hospitals, held that persecutory delusions were some of the most frequently encountered ways in which the human organism attempted to rationalise the mental conflict between acceptable modes of social behaviour, and the irrational tendencies indicative of deteriorating mental health.

As a further test of the role of disrupted relationships within the comradely group, the 96 cases in which persecutory delusions had been noted as a symptom were subjected to further analysis. The aim at this stage was to assess the extent to which specific negative reference had been made by the patient to his own rejection by the comradely group. What emerged was that in 27 cases, detailed reference was made by the patient to the behaviour of comrades, accusing them of persecution of one sort or another. This represented 28.1% of the 96 cases, and 5.4% of the 500 case study sample as a whole. The following cases illustrate the nature, influence and persistence of these delusions, as well as the spectrum of aberrant behaviour, and the extremes to which some patients believed they had been driven.

Study Case No.199  
 Archive ref. PRO/MH106/2212  
 1397 Private Byrne W.  
 Age: 46  
 Service: 1 year 3 months  
 Unit: Army Veterinary Corps 'C' Section.



Byrne was admitted to Napsbury from Woolwich Hospital on 29 February 1916, diagnosed as suffering from neurasthenia.<sup>20</sup> He had enlisted in November 1914 and went to France in the following December. There, he developed a urinary condition and was sent back to the U.K., where he underwent an operation for urinary stricture. Rejoining at Woolwich Depot, he claimed to have been rejected by the other men;:

'...they all got on to him there and accused him of self-abuse, set traps for him and put gas into him. They told him he was going to be 'outed'.<sup>21</sup>

At Napsbury Byrne was said 'to hear imaginary voices' and believed that there was 'gas under his pillow'. He admitted alcoholic excess. Over the next five months Byrne gradually improved until, on 26 June 1916, he was said to be 'quiet, amenable [and] occupied'. He went before a Medical Board soon after and was discharged as permanently unfit on 14 July 1916, his records marked 'Alcoholic'.

Byrne's case is of particular interest in the sense that the alleged victimization by his comrades occurred, not in the fighting zone, but at the depot. In places such as depots and transit camps, however, comradely groups quickly formed around billet and unit affiliations. In Byrne's case the fact that he had undergone an operation for urinary stricture may well have been sufficient for him to have been made the butt of ribald jokes. At 46, he was also of an age where he might be derided as 'past it' by younger and fitter

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<sup>20</sup> Woolwich casenotes missing.

<sup>21</sup> The impression is that 'outing' involved some kind of social exclusion similar to being 'sent to Coventry', not the homosexual 'coming out' of modern parlance.



men. His conviction that gas was being administered to him is a not uncommon persecutory delusion: similar delusions were noted in a number of cases studied.

#### **5.7. The end of the tether: suicide as an escape route.**

As far as the ultimate sanction of suicide was concerned, even away from the fighting and at home in England, those who failed in the attempt risked the full weight - not to say savagery - of a legal system still deeply imbued with religious proscriptions against self-destruction. For sheer callousness, the court case described below rivals anything in Marian England or Inquisitorial Spain.

Study case No. 336  
 Archive ref. PRO/MH106/2233  
 138370 Private Simpson W.  
 Age: 37  
 Service: 3 years 6 months  
 Unit: Royal Army Medical Corps

Simpson was admitted to the County of Middlesex War Hospital, Napsbury, on 31 May 1918, suffering from melancholia and from self-inflicted wounds of the wrist and throat. During the initial examination it was established that in civilian life Simpson had been a Durham miner. In 1910 he had been buried by a roof fall, an event that had affected him badly. He suffered from giddy spells and was frequently off work.

Even so, he was one of the first to volunteer, enlisting (in an unspecified infantry regiment) in September 1914. Sent to France in July 1915, he was hospitalised for trench fever around Christmas of that year. Returning to duty



after six weeks, he was wounded for the first time in February 1916 near Armentieres, when he sustained a serious 'through and through' gunshot wound of the right knee. He spent the next year in hospital and convalescing. Returning to France in March 1917, he was wounded again at the Battle of Messines Ridge in June of that year, on this occasion sustaining multiple shrapnel wounds in the back. On returning to duty in the following September, he was put into a lower physical category, and transferred to the R.A.M.C. This 'demotion' from the infantry apparently affected Simpson deeply. He was then transferred to the King George V Hospital, London. There, his physical and mental condition deteriorated further: his giddy spells became more frequent; he suffered badly from insomnia, and was upset by Zeppelin raids.

Increasing memory lapses and periods of confusion interfered with his work, and he was more than once 'in the Orderly Room' on petty charges. Most significantly, Simpson complained that he was the subject of incessant 'chipping' by his comrades.<sup>22</sup> All this proved too much for him. Concealing his razor, he left the hospital on the afternoon of 28 May 1918 and took a bus to Hendon, intending to find 'some solitary place where he might commit suicide'.

In the early hours of 29 May 1918, Simpson was found in a railway wagon by the guard, George Hawkes. When found, Simpson was said to have been bleeding profusely, his clothing 'saturated with blood'. Hawkes rendered first-aid and called the police. A search revealed an open razor 'covered in blood' as

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<sup>22</sup> The modern slang equivalent of 'chipping' would be 'taking the mickey' or 'taking the piss', i.e., constant attempts to belittle or humiliate the victim. Loss of comradely regard was frequently cited by sufferers as a precipitating cause of their mental troubles.



well as a pocket knife, and a note which read; 'Good-bye, I am fed up with this weary lot.' Despite the seriousness of his injuries and the fact that, in the words of a police witness, he had 'lost a lot of blood as his clothes were saturated with it', Simpson was not taken to hospital but to a police station, where he was examined by a Dr. Cox, the Police Surgeon. He was then taken on a further journey (of unspecified duration) to a Dr. Robertson, who stitched the wounds. In this 'dangerous condition' Simpson was again held at the police station until he could be brought before a magistrates' court. From the time he was discovered until the time he was actually admitted to hospital, about ten hours had elapsed. Attached to the case notes is an undated cutting from an unidentified newspaper (presumably a Luton local daily) carrying a report headed:

#### BLEEDING TO DEATH

A distressing story was told at an occasional Borough Court yesterday, before Councillors Geo. Warren and A.Attwood, when Wm. Simpson, aged 37, a soldier in the R.A.M.C., was charged with attempting to commit suicide by cutting his throat and wrist with a razor. He had to be half-carried into Court by the police, and Insp. Janes explained that the man was a private in the R.A.M.C., stationed at Blackpool, having been a patient or detached for duty at St. George's Hospital, London.<sup>23</sup>

What transpired in the courtroom intensified the grotesque atmosphere which up to then had surrounded the affair. Inspector Janes, who had presumably brought the charges and was therefore responsible for Simpson's being there in the first place, apparently suffered a pang of conscience and urged that Simpson should be 'remanded to the Infirmary, as he was in a critical state.'

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<sup>23</sup> The hospital was in fact King George's not St. George's.



However, the Clerk, a Mr. Austin, advised against this.<sup>24</sup> Asked if Simpson was being sought by the military, the police Inspector said that 'the time had been so short we have been unable to make inquiries. Dr. Cox (the Police Surgeon) will say he is in a bad way and that pleurisy and pneumonia are developing.' Dr. Cox duly confirmed this, adding that Simpson was 'confused' - a state he attributed to 'shell shock', a consequence of Simpson's service in the Dardanelles and France.<sup>25</sup> 'The man ought to be in bed.' he concluded.

Yet still the court kept the wretched Simpson in the dock, while Austin, the Clerk, 'explained that the Government [had] asked magistrates not to put soldiers in the workhouse, but in this case they were at a loss to know what to do.' After further delay It was suggested that 'the police should ring up Wardown [military] Hospital.' The court waited while this was done, with Simpson apparently kept standing in the dock. Within minutes, 'the unfortunate soldier seemed to become very ill, and could hardly breathe.' Doors were opened to give him more air, but there is no report of his being given medical attention, despite the presence of the police surgeon. The newspaper report continued:

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<sup>24</sup> Why transfer to hospital should have been regarded as inadvisable is not clear. In view of Simpson's critical condition, any hospital would have been appropriate.

<sup>25</sup> This is probably due to a misunderstanding. During the period of the Dardenelles campaign, (April 1915 to January 1916) Simpson was either in France, or in hospital in the U.K. His casenotes make no reference to his having served in the Dardanelles.



## 'DANGEROUSLY ILL

[...] Insp. Janes, on returning, said he had communicated with Wardown and with Major Roberts...who would at once send an ambulance and have the man admitted...this was found an excellent course, and Mr. Austin said that if the man recovered and could be brought up the police could then apprehended (sic) him. [...] This morning we learn that his condition was so grave that he had to be removed to Napsbury Military Hospital.'

Even taking into account contemporary religious and social attitudes, the action of the police in (literally) hauling Simpson before a court of law in his seriously weakened condition, rather than taking him to hospital, was indefensible. Matters were made worse by the action of the court in keeping him there while they went through their officious dithering, even after he had all but collapsed from shock, loss of blood and the early stages of pneumonia. The whole bizarre performance amounted to nothing less than the wilful hazarding of Simpson's life.

Austin the lawyer was particularly notable for his unfeeling insistence on the correct form, and for his ghoulish reminder that, if Simpson survived, he could be re-arrested. Dr.Cox, the Police Surgeon, seems to have been ineffective both as a physician and as a witness, his best advice apparently being that Simpson 'ought to be in bed.' The only authorities to emerge with any humanitarian credit in the affair were the railway guard, and later the military, in acting unhesitatingly once they were made aware of the case. Simpson remained at Napsbury, making slow but steady progress until, on 22 December 1918, he was discharged from the Army. In the Medical Board reports no reference was made to the civil charge of attempted suicide, which was presumably dropped. It can readily be appreciated how a man like Simpson



could have reached the stage, both physically and mentally, where he could actively contemplate self-destruction. The isolated location chosen for the act, the pathetic note and the secretion of instruments, all point to a man at the end of his tether. Any suggestion of an ostentatious 'cry for help' can be discounted in his case. Plagued by wounds, transferred from a fighting to a support unit, and subjected to constant derision by his new comrades, it was hardly surprising that he ended up, as his suicide note recorded, 'sick of this weary lot.'

Study Case No.335

Archive reference: PRO/MH106/2223

207707 Private Herridge G.

Age: 31

Service: 3 years

Unit: No. 277 Area Employment Coy. B.E.F.

On 27 May 1918 Herridge was brought to the Medical Inspection Room of the 5th. Army Corps Headquarters. Capt. Mathews the H.Q. Medical Officer examined him, and found him 'nervous and depressed...untidy and unshaven', complaining that men in his billet had called him a German and told him that he was to be shot the following morning. Disturbed and confused by this, Herridge said he had left the village where he was billeted and gone to Le Vent Galant a few miles away. There, he reported himself to an R.A.F. station from where he was escorted back to his own unit.

Unusually, Capt. Mathews took the trouble to make enquiries concerning the alleged victimisation and interviewed one of the men living in the same billet. This man stated that Herridge had become very withdrawn of late,



ignoring questions put to him and acting 'funny'. Predictably, the same man was emphatic that none of Herridge's comrades had accused him of being a German or had suggested he would be shot.

On 30 May 1918 Herridge was transferred to No. 26 General Hospital near Etaples, where he was diagnosed as suffering from 'obsessional insanity' and transferred to the U.K.<sup>26</sup> On arrival he was cleared through 'D' Block at Netley, and from there was sent to the Dykebar War Hospital near Paisley, Scotland, where he was admitted on 7 June 1918, diagnosed as suffering from 'Delusional insanity'. At Dykebar he was found to be 'childish' and 'still complaining of persecution' by his comrades. The very detailed history recorded at Dykebar indicated that Herridge had had a troubled army career which had included some nervous trouble. He had initially gone to France in June 1916 and was under fire, but was sent home with trench fever in March 1917. He returned to the front line in September 1917, but became increasingly nervous under fire and was 'weak and shakey.' Herridge's problems within his unit began at this time:

The other men in the unit called him a German because he was a barber by trade and said he was going to be shot. [They] talked against him from the time he got up in the morning - he knew the talk was always against him [they] talked of his home and his address although they did not address him directly.<sup>27</sup>

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<sup>26</sup> In Herridge's documents, no location is given for No.26 General Hospital. although it is known to have been in the Etaples area at the relevant time. Herridge's is only one of many cases in which patients were unaccountably sent from one end of the country to the other. This was the cause of considerable hardship and worry for patients' families. Herridge was a native of Reading in Berkshire.

<sup>27</sup> The origin of this curious association of being a barber and being German is unclear.



Casenotes from Dykebar record that Herridge perspired excessively under examination and exhibited general tremor. He also tended towards hysteria but, in general, his condition was said to be fair. '[He] has no insight into his deluded state', the report went on, '[and] shows no acute mental symptoms.' Perhaps because of the observed mildness of his symptoms at this time, Herridge was transferred from Dykebar to the Crookston War Hospital at Nitshill, Glasgow, on 24 June 1918. There, in direct contrast to his reported condition at Dykebar, he was said as be 'Noisy, excited and confused.'<sup>28</sup>

Herridge failed to make progress. During the following months his behaviour became increasingly disturbed, with extreme changes of mood from deep withdrawal on the one hand, to periods of violent excitement, during which he became destructive and dangerous. The casenote entry for 5 August 1918 describes Herridge as 'Very confused and emotional. [...] Requires constant supervision'. As noted above, Herridge, a native of Reading, was sent from Southampton for treatment in Scotland, although at the time, he exhibited no 'acute mental symptoms'. Dykebar - previously the Renfrew District Asylum - admitted mainly mental cases, but then so did Napsbury, where he finally ended up. And this after more than two months, during which his treatment amounted to nothing more than 'bed and bromide', which in his case had been of no apparent benefit.

Whether enforced isolation from his family contributed to this is, of course, a matter for speculation. Between 20 July and 27 August 1918, the

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<sup>28</sup>

The Crookston War Hospital was probably affiliated to Dykebar as a convalescent hospital, although its name does not appear in the literature.



authorities at Crookston received weekly letters from his mother, seeking news of him, and asking for assistance in visiting him despite the great distance. The response of the hospital authorities was initially quite helpful, each letter receiving a prompt and generally accurate response. On 10 August 1918, for example, a letter to Mrs. Herridge stated that:

...your son is in much the same condition as when I last wrote you. He is still nervous, restless and confused, and is confined to bed ...in the hope that rest and quiet with careful nursing will prove beneficial to him.<sup>29</sup>

The correspondence ended with a request from Mrs. Herridge for a rail voucher, in addition to the one already sent, 'for a relative to come with me as it is such a long way for me to travel alone, being rather feeble.' By this time Mrs. Herridge and her constant letters were clearly becoming tiresome, and her request was refused in the following brusque terms:

'20/8/18

Dear Madam,

I regret I am unable to send another voucher, you should have intimated that you wished your voucher made out for two persons when you applied for it.

Yours faithfully,

Lt. Col. R.A.M.C.  
Officer in Charge.'

It is difficult to imagine a bureaucracy so inflexible that it could not accommodate a simple mistake on Mrs. Herridge's part, but the hospital authorities were clearly in no mood to extend the rules for her benefit. There

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<sup>29</sup> The letter is also unwitting testimony to the fact that military hospitals offered not much more than 'bed and bromide' to mental casualties.



are no further letters from Herridge's family on file, nor is it clear whether he received any visits from them while at the Crookston War Hospital. Perhaps as the result of his mother's intervention, however, on 9 February 1919, Herridge was transferred to Napsbury, St. Albans. In the meantime, his illness had entered a new and more ominous phase. On 19 December 1918, 'when spoken to today', he replied:

'I want you to blow my brains out - blow them out at once and I will get better'.

On New Year's Day 1919, he made an unconvincing attempt at suicide by 'tying [a] towel round his throat.' The months that followed saw no improvement: he added to his delusions, claiming that he had been tortured while in France, and that;

...they tried to set him on fire in a barn and put something in [the] water that smelt of chloroform...at Crookston voices kept on saying "Whitey, Whitey, Whitey" for 2 -3 nights. His "don't care" attitude suggests Paranoid D.P.

On 22 May 1919 Herridge was transferred to the County Asylum at Wallingford, Berkshire.

Herridge's case has a number of singular aspects. It is the only known instance where surviving documents chronicle a case of mental illness from actual onset to final disposal. In addition, the case provides some insights into the comradely group itself, as well as into the family of a mental casualty. Reading the casenotes, there can be little doubt that the rejection - real or imagined - suffered by Herridge at the hands of his comrades was a central preoccupation, one that remained with him throughout and, in fact, became



more pervasive with time. As far as the denials by Herridge's comrades are concerned, it would be unrealistic to expect them to admit having victimised him, confident in the knowledge that their combined word would outweigh that of a 'loony'. Herridge had been reportedly acting 'funny' for some time prior to absconding, although in this context, 'funny' was not intended to mean 'amusing', although he may in fact have become an object of his comrades' misplaced amusement.

It is in the nature of persecutory delusions that they involve systematised conspiracies which are fastened on those in closest contact with the sufferer. Critical as the observer may be of this type of group behaviour, it is also in the nature of closely related groups that those identified as weaklings are liable to become the target of ridicule. It is probable that Herridge's odd behaviour cast him in the role of the clown or zany, provoking the victimisation of which he complained. From that point on, his fate as a misfit and an outsider becomes epicritical: as far as the comradely group is concerned, there is little chance that the mental sufferer can re-enter the charmed circle of the comradely group.

On the one hand the patient is aware of, and reacts defensively to every imagined slight. On the other, the erstwhile comrades observe, discuss and comment on the increasingly aberrant behaviour of the sufferer. His every action, gesture, word and silence come under increasing scrutiny and analysis. To a very considerable extent, therefore, 'He's acting funny' becomes self-



fulfilling.<sup>30</sup> It must obviously be a matter for conjecture whether Herridge's isolation from his family exacerbated his condition, but this factor cannot have helped his case. As it was, nothing seems to have been done to treat the early symptoms of mental instability.

#### **5.8. 'When all the world betrays me': a complete and complex persecutory delusional system.**

The following case demonstrates vividly the principle outlined by W.H.R.Rivers, that of the transpositional nature of delusion-systems with those of real life. The unusual survival of letters from the patient illustrates, in a particularly intense and graphic way, the ease with which the sufferer was able to move seamlessly from one to the other, and to weave external events effortlessly into his deluded world. It is difficult to imagine a more colourful, detailed, systematized and persistent delusional pattern than this.

**Study Case No. 359**

**Archive reference PRO/MH106/2220**

**3149 Gunner Ferguson W.**

**Age: 39**

**Service: 4 years**

**Unit: 1st. Battery, 1st. Australian Artillery Brigade.**

Gunner Ferguson was admitted to Tidworth Military Hospital on 24 July 1918, diagnosed 'Delusional Insanity'. He had enlisted in Australia in 1914 and was in the Gallipoli campaign of April 1915 when he was wounded in the leg and hand. Went to France March 1916. Back to U.K. November 1916 with 'Shell shock and malaria'. Treated at Birmingham. Back to France. Gassed. Back to U.K. Treated at 'Cowley,

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<sup>30</sup> For a clear and concise exposition of persecutory delusion, see Reber A.S., *The Penguin Dictionary of Psychology*, Penguin, (London 1985) pp.184-5.



Oxford' then to depot at Sutton Veney. Had been doing duty there up to the time of his admission to Tidworth.

On admission Ferguson was said to be 'nervous and depressed...sleeps badly...has delusions of persecution: says his "pals" are constantly calling him names and are endeavouring to do him an injury. Answers questions sensibly but is very full of his wrongs.' Ferguson was transferred to Napsbury and admitted there on 25 July 1918, diagnosed as 'Delusional insanity'.

Ferguson's primary delusion appeared to be that his wife, Charlotte Agnes (Aggie) had been unfaithful to him with a number of men, including N.C.O.s and medical officers.<sup>31</sup> His secondary delusions included complaints that he was the constant subject of comment, and the victim of a conspiracy by his comrades to harm him. He believed that the Army and the civil government had colluded to withhold his pay, to cheat him out of large sums of money which he claimed had been left to him by prominent people. These delusions and others he wove into a fantastic web of intrigue, self-aggrandisement and persecution of which he was naturally the centre, alternately characterised as victim and hero.

The unique nature of Ferguson's case lies in the survival of a series of letters written by him, giving a rare insight into his complex delusional synthesis. Typically, it is full of contradictions and inconsistencies, but centres

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<sup>31</sup> Mrs. Ferguson was living with her married sister Bella at the time, having presumably married Ferguson during one of his leave periods. How long they had been married is not made clear.



around the conviction of his wife's infidelity. It is around this, and around associated themes of criminality and criminal detection that the fantasy constantly revolves. The correspondence extends over only a brief period, starting with an application on 23 August 1918 by Ferguson to Scotland Yard, seeking an 'opening for a beginner'. He describes himself as 'a good Boxer [and] runner...and can lift a good weight [...] please send someone to interview me'. Although not stated, Ferguson's desire to become associated with Scotland Yard may have been prompted by the need to range himself on the side of law and order, and in this way gain the necessary standing which would give him the authority to investigate his grievances, and at the same time, confer on him a measure of protection from those he believed to be combining to harm him.

Ferguson's next letter, also dated 23 August and addressed to his wife, reveals something of the nature of his delusions. She is urged to come to his rescue and to demand his release from the hospital, 'indubitably the worst place ever mortal man was placed in', and to bring the police to arrest Captain Evans, one of the medical officers. Evans is accused of plotting to put Ferguson in 'a padded cell', of having driven an un-named 'Irish Australian' mad, and of committing further offences, the nature of which, Ferguson hinted darkly:

I cannot state here... [he is] slowly but surely trying to murder me. If ever a swine wanted punishing this Evans wants punishing and my God I will give him the biggest horse-whipping that ever he got.<sup>32</sup>

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<sup>32</sup>

In a subsequent letter, Ferguson alleged that Evans had attempted a homosexual assault, and had also written to Ferguson's wife, claiming a homosexual relationship with him. The object of this Ferguson rationalised as an attempt to damage his wife's good opinion of him.



Ignoring its inconsistencies, the tone of the letter is supplicatory, the accusations interspersed with terms of endearment to 'Aggie', and with repeated declarations of faith in her willingness to come to his aid. The letter ends:

May God Guide and Bless you dearest is the prayer of ever your  
loving and persecuted husband  
Arthur

Ferguson's wife wrote to him on 16 September 1918 following a visit to the hospital. Taking its tone and content at face value, Mrs. Ferguson was either an utterly devoted wife, anxious only for her husband's recovery, or a consummate deceiver. The letter deals with the most mundane, even banal matters - the weather, the cigarettes she gave him, her health, (she was suffering from a cold) and her pleasure at the prospect of a future visit. Significantly, she expressed distress that he had been suffering from a stomach upset:

I don't know what it could be as the pie was fresh unless it was  
the cheese dear.

Real or imagined, the indisposition was immediately incorporated into the fabric of Ferguson's persecutory delusions, in which the trust and affection expressed by her only the day before were quite forgotten. His next letter to Scotland Yard dated 16 September 1918 enclosed his wife's letter, claiming (quite without foundation, of course), that 'she practically accuses herself of murder...arrest her as quickly as possible it is her that got me shangied (sic).'

The medical staff were again accused of sexual misconduct and bigamy with 'Aggie'. Ferguson was also more specific concerning the alleged act of sodomy...



'Capt. Evans wrote and told my wife he had slept with me and also tried to poison me with sulphuric acid'. Then, in another sudden twist:

...my wife is not to blame tell her to turn King's evidence I will take her back and look after her poor girl she is more to be pitied than laughed at. I knew she was a bit simple poor dear deluded girl. God bless her. I am going to let her see I am not guilty of anything.

Significantly, Ferguson returned to the alleged transgressions of his comrades, this time naming his principal detractors and their crimes:

Arrest Gunr. James at Napsbury also Gunr. Fitzsimmons also Gunr. Allen also Driver Hammond take them up to Scotland Yard I am going to have them for defamation of character.

This emphasises a number of significant aspects of the hypothesis advanced here regarding the nature and influence of the comradely group. It is clear from Ferguson's letter that a comradely group of patients from artillery units had formed at Napsbury, a group of which Ferguson, as an artilleryman, would have naturally felt himself part. The reasons for that exclusion may have been real, for example that Ferguson was treated as a 'colonial'. We have seen how, in his delusionary state, Ferguson tended to be boastful about his physical prowess, claiming to be something of an all-round athlete. In the absence of a detailed and documented contemporary investigation, these matters must remain speculative. What can be said with certainty, however, is that Ferguson felt unjustly ostracised by his comrades, persecuted by the hospital authorities, and betrayed by his wife. The remaining letters consist of variations on these themes, alternately boastful, querulous, threatening or supplicatory. The last is dated 17 October 1918, a few weeks before the end of the war. On 16 January 1919, Ferguson's casenotes report that he had improved, but that he was still



'loosely controlled'. His delusions remained as firmly embedded as ever. Although he was apparently still writing letters, 'their tone is less threatening and fairly lucid'. The final casenote entry reads;

28 March 1919      'Evac[uated] to Australia'.

### **5.9. The 'comradely group: general commentary.**

The case histories summarised above show that exclusion from the comradely group formed a significant part of the semiology in cases of mental disorder in military personnel. Whether such exclusion represented a prime cause of such disorders is normally impossible to assess, since the patient's pre-hospital history cannot be checked. The 'previous history' taken on admission to hospital was usually confined to the patient's own account, and from medical casenotes or other information from earlier hospitalisations. The severity or otherwise of pre-service episodes of mental or nervous trouble can only be judged from that account. In Private Simpson's case, for example, it is recorded that he was involved in a mine collapse, that this 'affected him badly': he had subsequently suffered from insomnia and fits of giddiness. In Private Herridge's case, the medical officer concerned took the trouble to make enquiries: predictably, his comrades denied persecuting him, claiming that Herridge had started to 'act funny' some time before.

In the most complex case, that of Gunner Ferguson, no previous history of mental or nervous trouble was recorded. Like Private Simpson, however, Ferguson had a history of wounds and illnesses, and both had experienced considerable physical pain and disability. It should not be forgotten that much



of the pain and discomfort of wounds and disease went unrelieved by the kinds of powerful analgesics so readily available today. The debilitating effects of unrelieved pain were poignantly illustrated in Private Simpson's case, where his suicide note reflected the utter misery and despair he felt after a long period of such difficulties. Where factors such as combat incidents, chronic physical suffering, etc. precipitated a mental breakdown, comrades, family, nurses, orderlies and medical staff - in fact anyone close to or in frequent contact with the patient - often became the object of fear and suspicion, a focal point around which persecutory delusions could coalesce.

As stated at the outset, the feeling of exclusion from his comradely group seems to have constituted some kind of theme in cases of delusional insanity. Which came first, the aberrant behaviour or the persecution is almost always unquantifiable, as is the question of whether the persecution existed in fact, in the mind of the sufferer, or as a combination of fact and fantasy. As this chapter has attempted to show, however, the special nature and circumstances of military service - particularly the stratified nature of military society - tended to exacerbate the consequences of exclusion.

These examples demonstrate all too vividly the deep sense of deprivation, isolation and grievance often felt when, for whatever reason, the bonds of the comradely group were severed. In another context entirely, these same bonds might be damaged by other factors, some of which have been referred to above. Unacceptable behaviour such as stealing from one's comrades, failure to act in the common interest in the face of authority,



anything, in fact, inimical to the common good of the group, could result in rejection of the transgressor. For any individual, the consequences of exclusion from the comradely group could be serious. The soldier who was no longer part of 'us' could not, for example, become part of 'them', and had severely limited opportunities for meaningful social relationships outside his assigned place in the military organisation. This was especially true in the case of service outside the United Kingdom, where the barriers of language, custom, race and geography intensified the soldier's dependence on the Army in general, and the comradely group in particular. Under such circumstances, exclusion assumed added significance.



## **PART THREE**

### **CASUALTIES ON THE CONTINENT**



## CHAPTER SIX

### CHARLES SAMUEL MYERS AND THE STRUGGLE FOR FRONT-LINE TREATMENT.

#### 6.1 Background and biography.

In the history of Great War neuropsychiatric medicine, Charles Samuel Myers (1873-1946) stands out as innovative, influential and attractive, as well as contradictory, controversial and even self-destructive. His obituarist and former student, F.C. (later Sir Frederick) Bartlett, records that Myers' ancestors 'arrived in England about one hundred and sixty years ago and settled in Maldon in Essex'. The family, of prosperous Jewish stock, had emigrated from Tsarist Russia for reasons which neither Bartlett, nor Myers in his autobiography elect to explain.<sup>1</sup> Myers himself was born in London on 13 March 1873, by which time the family had again prospered in a variety of industrial, commercial and professional spheres. Throughout his life, Myers, although declining to emphasise his Jewish antecedents, preserved close ties with his heritage through marriage in 1904 to Edith Seligman, and through 'a great amount of interest and time' devoted to philanthropic work for the Jewish community. On his mother's side he inherited a love of music, both as a listener and a keen amateur performer, and the young Myers became accomplished on the violin, the playing of which was to remain 'a deep pleasure at all times and a solace in difficulty'.<sup>2</sup>

Two of his paternal uncles retired early from business, one to devote himself to the study of Egyptology, the other to indulge a passion for travel.

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<sup>1</sup> Bartlett F.C., 'Charles Samuel Myers 1873-1948' in *Obituary Notices of Fellows of The Royal Society*, Vol.5, 1945-48, Morrison and Gibb, (London 1948) p.767.

<sup>2</sup> *Ibid.*



Both made a deep impression on the young Charles, one that was to inspire him when it came time to choosing a career. Science, in the form of medicine and anthropology, and music, as expressed in the study of the functions of rhythm and tone in the music of primitive societies, were, according to Bartlett, 'probably about the best original work of a purely scientific character that he achieved'. From his mother also, Myers inherited an outstanding talent for developing strong personal relationships, as well as a charm of manner that was sincere and patent. In his later years as a Cambridge don, his students remembered 'with delight' his warmth and understanding:

Nobody could be more popular at conferences and meetings and all over the world people are to be found who speak more than anything else of.....the extraordinarily attractive manner in which he managed a great diversity of personal contacts.<sup>3</sup>

It was natural that given his family background, this man, who later provided for so many an admirable and enviable model, had in turn those to whom he looked for example and inspiration. He recalled, for example, that it was his admiration for a 'handsome first cousin' that provided his first lead in the matter of a career. 'He took a medical degree and I wanted to imitate him.' From 1891 at Cambridge, where he first studied natural sciences, Myers showed the abilities that were to distinguish him, and it was at Cambridge that he first came into contact with W.H.R.Rivers, and with physical anthropology, a subject which interested them both. Having taken his first medical degree, and while a student at Bart's Hospital, Myers, together with Rivers, William McDougall and others, joined the 1898 Cambridge Anthropological Expedition to the Torres Straits and Borneo. Personal relationships formed during twelve months abroad

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<sup>3</sup> Bartlett, Myers obituary, p.767.



began to move Myers towards experimental psychology, the subject that was to lead to his involvement in the treatment of mental and nervous disorders during the Great War. Before that, however, he returned in 1902 to Cambridge to assist Rivers in teaching the physiology of the special senses. Together, they also laid the foundations of a department of experimental psychology, and this 'remained the principal scene of his activities until the outbreak of the first world war.'<sup>4</sup> At this time, psychology as a subject was reflected largely in work being carried out on the Continent:

The great bulk of what was then regarded as of any importance in experimental psychology was written in German, usually at immense length and in a very difficult way, and was untranslated. There was no single book in English with which any ordinary student had much chance of making headway.<sup>5</sup>

With typical energy and intensely focused determination, Myers read everything he could lay hands on, selecting, distilling and synthesising, until he was able to produce a single volume which 'lucidly covered almost the whole field' of experimental psychology as far as it had developed up to then, demonstrating the 'unusual insight and powers of exposition' that were to mark much of his wartime activity. Myers' innate talent for the organization of funding, in addition to money he himself had donated, had allowed the movement of the department at Cambridge to progressively larger and better equipped quarters, culminating in the commissioning in 1912 of 'a first-class laboratory designed for psychological experiments.' In the process he had, with Rivers and James Ward, founded the *British Journal of Psychology*, and had almost single-handedly reorganized the British Psychological Society. Possessing a traditional medical

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<sup>4</sup> Bartlett, Myers obituary, p.769.

<sup>5</sup> *Ibid.*, p.772.



degree, combined with active involvement in the expanding discipline of experimental psychology, Myers had placed himself in a strong position to face the psychological problems thrown up by the Great War.

Free from the introspective traditions of the prevailing asylum system, and with an already enviable record of achievement in organising psychological medicine at Cambridge, Myers had, by the outbreak of war, demonstrated qualities that were to distinguish him during the next four years. At the same time, his lack of experience of military medical bureaucracy, combined with his intolerance of anything he regarded as needless delay, were to prove deeply frustrating and dangerous to his success as a senior military medical officer. They were all too frequently to bring him into conflict with the military medical establishment, and were ultimately to obscure his wartime achievements, as well as radically altering the direction of his subsequent career.

## **6.2 War work: Myers at Le Touquet**

When war came, Myers, like many other medically qualified men, felt compelled to offer his services in the treatment of the sick and wounded. Strenuous efforts and a good deal of string-pulling could not overcome the 'great difficulties' presented by his age - he was then over forty - and he failed to secure the desired commission in the R.A.M.C. With characteristic determination - his critics might have preferred 'self-opinionated arrogance' - Myers travelled to France as a civilian, and, by dint of trading on 'an old acquaintance', managed to get himself appointed as Registrar with the Duchess of Westminster's Hospital unit. This had just arrived in France and was urgently looking for a suitable location, eventually securing the premises which in



peacetime had housed the Casino at Le Touquet. Although the Duchess and her entourage had set off for France with permission of sorts from the War Office, there were few in the military medical services who welcomed independent units of this kind, and fewer still willing to assist them in 'setting up shop'. No matter how lavishly equipped or well staffed, such units were likely to pose problems of discipline and organisation which the authorities in the field viewed with a distinctly jaundiced eye.

After strenuous efforts on the part of the commandant, Major H.E.M. Douglas, and representations by the Duchess herself, the hospital's official status was confirmed, and the first patients were admitted on 4 November 1914.<sup>6</sup> This was one of many privately endowed hospitals and ambulance units being set up in France at the time, often by wealthy patrons anxious to demonstrate their patriotism. As a general hospital it had no particular expertise in dealing with mental and nervous casualties (the only expertise to which Myers could justifiably lay claim), and his early weeks were fully taken up with the duties of Registrar. In this capacity Myers' flair for organisation served him well, and the innovations he introduced significantly improved the general administration of the hospital. It was also work which he 'thoroughly enjoyed' and, for a time at least, it gave him the desired sense of being of real service. With qualifications in medicine, however, Myers felt able to take on what he probably regarded as the 'real' work of the hospital, although he possessed little in the way of practical experience in either medicine or surgery. Having trained orderlies in the routine work of the

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<sup>6</sup> Myers C.S., *Shell Shock in France*, Cambridge University Press, (Cambridge 1940) p.7.



Registry, Myers badgered Major Douglas, the Commandant, into giving him charge of some cases.

Lacking clinical experience other than his time 'walking the wards' as a student at Bart's, ambition far exceeded ability: after only 'a few days trial' Myers was unable to cope, and asked to be relieved of the responsibility, returning to 'the duller routine of a registrar's work.' Whether the cases handed over to Myers were deliberately chosen for their difficulty, or whether younger medical officers resented Myers taking a comparatively senior post over their heads is not clear. What is clear is that there was considerable friction between Myers, and some of those he described as 'young consultants in civil life' who were also on the staff. The motivation of this type of young specialist, Myers observed caustically:

...is one of ceaseless push, [...] he takes an expensive house or consulting rooms far beyond his means, and invests in a large motor car speculating on his future success. No wonder is it, then, that self-seeking and jealousy enter so much more into his life than into one previously spent, like mine, in the quieter backwaters of a University town.<sup>7</sup>

The strain of setting up the hospital, the tension between the regular R.A.M.C. and those they regarded as 'amateurs', not to mention the difficulty of trying to reconcile his own position and that of the redoubtable Duchess, 'proved too much' for Major Douglas, and discipline suffered badly. After only 19 days he was transferred, and a new Commandant appointed. The military authorities decided to regulate the operations of the voluntary medical sector, and many volunteers returned to England to find other patriotic occupations. As part of

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<sup>7</sup> Myers, *Shell Shock in France*, p.10.



the process of 'militarisation', Myers was made a Temporary Captain by Sir Arthur Sloggett, Director-General of Medical Services, when the latter visited the hospital on 9 December 1914. It was at this time that Myers first began investigating those cases of functional nervous disorder which were to become universally known as 'shell shock', the results of which he published in February 1915.<sup>8</sup> This same visit resulted in a major change of policy for the Duchess's hospital. Regarded by the military medical authorities as excessively luxurious for other ranks, the Casino premises became an 'officers only' hospital and remained so until its closure on 31 July 1918.

The preceding paragraphs give some insight into Myers' many-sided personality, and the characteristics that were to guide his thoughts and actions during the war. Between 4 November 1914, when the hospital at Le Touquet opened its doors, and 16 March 1915, when he replaced William Aldren Turner as the Army's specialist in psychological medicine, Myers had set up an entirely novel patient records system, (incidentally discarding the official Army forms and bringing special index cards from England). He had carried out investigations into trench foot, and had also collated the notes of 'over 150 cases in the hospital' for later publication. Of even greater significance, he had begun to see and treat 'those cases of functional neuropsychiatric disorder with which he and many others were soon to become deeply involved.

It was typical of Myers to want to be the first to publish at length on shell shock. Although he later deprecated the popularity of the term, and

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<sup>8</sup> *The Lancet*, 13 February 1915, pp.316-20.



sought to play down his part in its introduction, there is no doubting his satisfaction at being the first to use the novel term in print. In his autobiography Myers confessed his life-long 'love of novelty', and F.C.Bartlett believed it to have been the essential tragedy of Myers' career that he found it impossible to remain faithful for long to a single cause: <sup>9</sup>

Could he have reconciled himself entirely to the life of laboratory investigation there is no telling what he might have done. But it seemed that no sooner had he carried experimental study to a certain stage than other interests would break in and stop him from going farther.<sup>10</sup>

This tendency to take up new ideas with glowing enthusiasm, only to move on all too quickly to the next self-perceived challenge, can be seen in Myers' whole involvement in the psychological medicine of the Great War. At the age of 40 he would not have been criticised had he remained at Cambridge, conducting his psychological experiments. Or he might have offered his services as an *a la suite* medical officer at one of the general and auxiliary military hospitals in Cambridge. Local physicians and surgeons, some of them brought out of retirement, did just such valuable work throughout the war. In such an environment Myers' lack of practical clinical experience would have been much less of a handicap, and he would have undoubtedly been given a temporary or honorary commission. Alternatively, if only the care of neuropsychiatric casualties would satisfy, such cases were being admitted to hospitals in the United Kingdom within weeks of the outbreak of hostilities.<sup>11</sup> Also, by 19

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<sup>9</sup> Myers C.S., in Murchison C., (Ed.), *A History of Psychology in Autobiography*, 3 vols., Russell & Russell, (New York 1961), Vol.3, p.230.

<sup>10</sup> Bartlett, Myers obituary, p.773.

<sup>11</sup> See: Archive reference PRO/MH106/2101. The '500 Cases' study shows that 1716 Pte. Mitchel J. was admitted to the 2nd Northern (Territorial) General Hospital, Leeds, on 20 August 1914, only 16 days after the declaration of war. 3077 Rifleman Johnson H. was admitted to Moss Side on 19 December 1914.



December 1914, the Moss Side Military Hospital near Liverpool was admitting such patients, and Myers would undoubtedly have been welcomed had he chosen to exercise his obvious influence in the right quarter.

### 6.3 Early results: 'shell shock' enters the language

The results of Myers' personal involvement in the treatment of neuropsychiatric casualties appeared in *The Lancet* between 13 February 1915 and 11 January 1919, under the general heading of 'A Contribution to the Study of Shell Shock'. In the first of these articles, he described three cases treated by him at Le Touquet between November 1914 and January 1915. These are summarised below.

#### Case No. 1

This concerned Private A, aged 20, admitted on 5 November 1914. He had been caught up on barbed-wire defences and had been subjected to heavy shell fire. On admission he was generally tremulous. His visual fields were restricted, with objects seeming to be surrounded by a haze. He sweated profusely during examination. His only physical injuries were a slightly burned little finger and a bruised left side. He stated that he had wept a great deal during the journey from the front, and was preoccupied with his narrow escape. He did not urinate for a day after admission, nor defecate for three days. He claimed to have lost the sense of both taste and smell, and made serious errors when tested. Private 'A' remained at Le Touquet for two weeks. Myers records that hypnotism was tried, but the patient resisted and the experiment was abandoned. 'Suggestion' was also tried but the results are not recorded. On 15 November 1914, in line



with the policy of the time, Private 'A' was transferred to the U.K. Unusually, Myers checked on his progress at the Middlesex Hospital, London. Where interest seems to have centred on the ophthalmological symptoms: on 1 February 1915, Myers noted that 'A' was still attending the Middlesex as an out-patient.

### Case No.2

The patient, Corporal 'B', had been buried when the trench he was occupying was blown in. This man had fought in the very earliest battles at Mons and La Bassée, and had endured the long retreat to the Aisne. He said he had slept badly since then, and habitually took 'large doses' of whisky to ensure sleep. He confessed to having led a 'fast' life as a civilian, leading to (unspecified) marital problems, Myers added that 'B's manner 'does not inspire one with confidence as to his reliability'. He could recall little of the events of the journey to Le Touquet, which had reportedly involved several other hospitals. Myers records that this was the first case in which he successfully restored the patient's memory by means of 'slight hypnosis'.

### Case No.3

The patient, Private 'C', had reportedly been blown off a stack of bricks, and had fallen some 15ft (4.57m) apparently landing in water, since his clothing was said to be 'soaking wet' when he was found. In contrast to the other cases described in this first article, 'C' appeared to have been of a very nervous disposition prior to the incident. When examined he was generally very tremulous, with violent contractions of the abdomen and legs when touched.



He was still under Myers' care when the article was written. These three cases offer some insight into Myers' early methods, at least in respect of these 'classic' shell shock cases. At the time, the numbers of such cases were not such as to attract special attention. Not all cases were recognised as shell shock and were classified as 'sick' rather than as battle casualties. Even when the term 'shell shock' was applied, such cases were viewed more as medical curiosities than as a cause for alarm. Faced as they were with overwhelming numbers of casualties of all kinds, the military medical authorities were slow to recognise the growing problem. In the words of the Official History:

it was not until 1916 that functional nervous disorders assumed importance as a cause of wastage.<sup>12</sup>

Even at this early stage, however, it is clear that Myers rejected the kind of explanation for which Frederick Mott was then attempting to find evidence, namely, that violent near explosions caused microscopic haemorrhages in the brain and spinal cord. It was these essentially physiological changes, Mott contended, that caused the neurological symptoms, not the psychological factors for which Myers was arguing. It is also clear that, whilst giving what treatment he could, Myers carried out his tests with an eye firmly on the professional advantages of being first in the field.

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<sup>12</sup> Macpherson W.G. *et al*, (Eds.) *History of the Great War based on Official Documents. Medical Services: Diseases of the War*, Vol. 2, H.M.S.O., (London 1923), p.2.



Table 5.

C.S.Myers, synopsis of 12 early cases of shell shock.<sup>13</sup>

|                      | 1.  | 2.  | 3.                                  |
|----------------------|---|---|-------------------------------------|
| Cause... ..          | Shells bursting about him when hooked by barbed wire.<br><br>Preceding period of sleeplessness. | Shell blowing trench in.<br><br>As in case 1. | Shell blew him off a wall.<br><br>? |
| Vision ...           | Amblyopia. Reduced visual fields.   | "   | As in Case 1.                       |
| Hearing ...          | Slightly affected for a brief time.   | Not affected.                                 | As in Case 2.                       |
| Smell... ..          | Reduced acuity.   | Total anosmia.                                | Unilateral anosmia and parosmia.    |
| Taste... ..          | Almost absent.  | Reduced acuity.                               | As in Case 2.                       |
| Other sensations     | Not affected.   | As in Case 1.                                 | As in Case 1.                       |
| Volitional movements | "   | "   | "                                   |
| Defæcation           | Bowels not opened for five days following shock.  | "   | "                                   |
| Micturition          | Urine not passed for 48 hours.  | Not affected.                                 | As in Case 2.                       |
| Memory ...           | Apparently slightly affected.   | Very distinct amnesia.                        | "                                   |
| Result of treatment  | Gradual improvement by rest and suggestion.   | As in Case 1, supplemented by hypnosis.       | As in Case 1.                       |

As Myers pointed out, there were striking similarities between the effects of the cases, as well as some puzzling differences. For example, the shelling in each case was very close. In Case 1 the patient was 'bracketed' by enemy artillery, with shells bursting in front of and behind him. In Cases 2 and 3, the explosions were sufficient in the former to bury the man, and in the

<sup>13</sup> *The Lancet*, 13 February 1915, p.316.



latter to blow him off a stack of bricks. Despite the nearness of the explosions, however, in Case 1, Private A's hearing was only slightly affected, while in the other two cases hearing was unaffected. Myers' interest in the physiology of the special senses (the subject he had taught at Cambridge) was clearly aroused by the absence of hearing damage, which might reasonably have been expected in the circumstances. Exposure to the noise of large calibre weapons in naval gunnery had given every expectation of damage to the auditory system. The nature of 'gun deafness' and theories regarding appropriate protective measures had occupied a good deal of space in the columns of the medical press at the outbreak of the war. Loss of hearing caused by the noise of large calibre guns was also confused with the psychologically generated functional deafness caused by shell shock.<sup>14</sup>

Even at this early stage, Myers concluded that the 'close relation of these cases to those of "hysteria" appears fairly certain', an observation that was eventually to be amply borne out by events. In the short term, however, a variety of opinions regarding mental and nervous casualties in general, and shell shock in particular, were advanced, many of them coloured by the assumption that shell shock was an entirely new condition, the causes of which had yet to be ascertained.

As early as December 1914, the British military medical authorities had found it necessary to provide at least some accommodation for casualties of

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<sup>14</sup> Horne J. 'Gun Deafness and its Prevention' *The Lancet*, 15 August 1914, pp.462-4. This article gave rise to a protracted correspondence, largely concerned with the mathematical *minutae* of acoustics and ballistics.



this type. The Moss Side Military Hospital (previously the Moss Side State Institution) admitted its first patients on 21 December 1914, initially providing only 300 beds. At its closure on 14 June 1919 this number had risen to 546. From 10 May 1915, additional accommodation became available through the Asylum War Hospitals Scheme, with further accommodation being provided as necessary throughout the War.<sup>15</sup>

Compared to their French allies, the British were slow off the mark in establishing treatment centre for mental and nervous casualties on the Continent. This was entirely due to the policy of automatically transferring such casualties to the United Kingdom. King's Regulations, as they then existed, required that 'all soldiers who have suffered from insanity must be invalided'. This in turn reflected the statutory provisions of the 1890 Lunacy Act, under which a person was either sane, and therefore not certifiable, or insane, in which case certification and confinement became legally possible. True to the more leisurely Cambridge investigative ethos, Myers retained patients for considerable periods in order to complete his tests. In *Shell Shock in France* he recalled how, in doing so, he had fallen foul of the these rules, earning himself the reputation of being something of a trouble-maker, 'desirous of breaking ...the regulations of the Army Medical Service'.<sup>16</sup>

As a 'civilian in uniform' Myers had had no military training whatsoever and, at the time, was blissfully ignorant of the requirements of King's or any

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<sup>15</sup> Accommodation for mental and nervous casualties was still being opened ( e.g. the Ashurst War hospital, Oxford) as late as 13 September 1918.

<sup>16</sup> Myers, *Shell Shock in France*, p.85. See also *Manual of Military Law*, (Sixth Edn.) H.M.S.O., (London 1914), esp. pp.193 and 468-9.



other military regulations. During his time at the Duchess of Westminster's Hospital, however, he had formed the view that many of those being sent back to the U.K. were in fact recoverable if treated promptly by specialist medical officers. In Myers' view, the neuroses and psychoses of modern warfare demonstrated, in the most emphatic terms, the bankruptcy of the 'all or nothing' ethos which was the foundation of the asylum system.

The abandonment of that policy, and its replacement by arrangements which took account of the great variety and complexity of mental and nervous conditions needing treatment, now became Myers' central preoccupation, and the focus of his considerable organisational talents. The task before him, however, was to stretch those undoubted talents, as well as his dubious patience, to their limits. The generals at the Front meanwhile, remained convinced that the next big attack would bring the longed-for breakthrough and an end to trench warfare. The war would then become the kind of conflict for which they had been trained. There would be attack and counter-attack, cavalry charges and flanking movements. Paradoxically, therefore, the Army was psychologically unreconciled to the realities of trench warfare, and therefore not fully ready to accept and deal with its special kind of casualties.

Unrestrained by the weight of the Army's historical medical baggage, Myers was inclined from the outset to attribute the symptoms of shell shock to psychological rather than physiological causes. These men, he pointed out, had been in very close proximity to loud explosions, yet their hearing had 'been (practically) unaffected'. There must therefore have been some psychological



reason why the effects of the explosions were confined to their senses of sight, smell, taste and memory:

I attributed them, as they are now generally attributed, to mental 'repression' and 'dissociation', but I was inclined to lay some emphasis on the physical shock produced by the bursting of a shell as a prime cause of the 'dissociation'. Later familiarity with the disorder, however, showed that emotional disturbance alone was a sufficient cause.<sup>17</sup>

Few medical officers at the time, however, accepted the emotional explanation. There was a patently novel situation in the use of unprecedented quantities of high explosives: the functional nervous damage being observed was equally clearly associated with violent near explosions. Therefore, it was reasoned, the mechanical interaction between explosion and human organism - whatever it turned out to be - was sufficient cause. The explanations of the 'physicalists' and the 'psychologists' thus directly mirrored the controversy that was running strongly when war broke out, namely, whether the 'new psychiatry' could provide answers to the problem of mental ill-health.

Arguments came from all sides; the pages of *The Lancet* and *The British Medical Journal* being filled with articles, editorials and correspondence. The military hospitals springing up everywhere found themselves having to treat neuropsychiatric casualties with whatever came to hand. In the few specialist centres, neurologists, psychologists, psychopathologists - anyone in fact with the slightest claim to expertise - donned their new uniforms and prepared to examine their first patients:

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<sup>17</sup> Myers, *Shell Shock in France*, p.13.



...neurologists and psychiatrists were not long in taking advantage of the opportunities thus given them. [...] Indeed, certain members of the profession lectured and wrote on the subject as if it were some new and mysterious malady. A complex terminology was evolved, and special treatments were manufactured in bewildering profusion.<sup>18</sup>

For the military medical officer in the field, the situation was confused and frustrating. Writing in 1916, Captain Harold Wiltshire, R.A.M.C. complained that:

....the etiology of so-called 'shell shock' is buried in confusion, owing to...bad terminology...dubious...histories (and) rapid changes in clinical condition'<sup>19</sup>

The official policy of repatriation was therefore not entirely unwelcome, since few front-line medical officers possessed the knowledge and experience which Charles Myers was able to bring to bear. His success was only partial, however, due to the obligatory transfer of his patients to the United Kingdom. It was not until very much later that, in response to his constant representations to the military medical authorities, early treatment centres on the Continent for neuropsychiatric casualties were introduced.<sup>20</sup>

Prior to his appointment as Consulting Psychologist to the British Expeditionary Force, however, Myers continued his work in France and Belgium, treating cases of shell shock and other functional nervous disorders at casualty

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<sup>18</sup> Macpherson, *Medical Services, Diseases*, pp.8-9.

<sup>19</sup> Wiltshire H. 'A Contribution to the Etiology of Shell Shock' *The Lancet*, 17 June 1916, pp.1207-12.

<sup>20</sup> The distinction between neurological and psychological casualties was not always clearly made at the time or since. The N.Y.D.N. centres were never intended for the treatment of mental disorders, admitting them (if they did) only as a means of sorting them prior to transfer to the base. See Chapter Seven *passim*.



clearing stations and base hospitals. As before, details of selected cases appeared in the pages of *The Lancet*, the next groups being published on 8 January and 18 March 1916. These dealt with 'certain cases treated by hypnosis' and 'certain cases of cutaneous sensibility' respectively. Myers' final article on the subject of shell shock did not in fact appear until after the War, when the topic was '...unsettled points needing investigation'.

#### 6.4 Determination, diversion and dissent.

In early 1915 Myers met Lieut.-Colonel Aldren Turner, a senior R.A.M.C. Territorial officer, who had been appointed Consulting Neurologist to the B.E.F. and who was preparing a report for the War Office on the growing numbers of functional nervous casualties. 'By this time', Myers wrote:

it was clear to me that my previous psychological training and my present interests fitted me for the treatment of these cases.<sup>21</sup>

In a development that was to have considerable later significance, Myers also met Gordon Holmes, a neurologist, at that time working at the Boulogne base with the eminent neuro-surgeon, Percy Sargent, treating 'war lesions of the central nervous system'. Holmes and Sargent urged Myers to seek a transfer to their area in order to take charge of 'the psychological work in this district'. The prospect of gaining access to the psychological raw material at the base was too tempting. Armed with a letter from Percy Sargent, Myers, on his next leave in England, sought an interview with Sir Arthur Keogh, Director-General of the Army Medical Service. The outcome of this interview, however, was not at all what Myers had anticipated. On returning to France, he found he had

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<sup>21</sup> Myers, *Shell Shock in France*, p.14.



been given the much greater responsibility of replacing Aldren Turner in the work of assessing and reporting on the rapidly increasing problem of neuropsychiatric casualties in the whole of the B.E.F., for which purpose he was promoted to Major and, on 6 April 1915, transferred to General Headquarters at St. Omer, at first being mainly involved in the selection of 'suitable cases of nervous and mental shock and neurasthenia for transference to the appropriate institutions in England for treatment'.<sup>22</sup>

Partly stemming from 'ignorance on the part of those who issued (the orders)', and partly due to the fact that at the time Myers took over there was no one else available in France to do the work, more and often irrelevant duties were attached to the post. Eventually, there was very little in the fields of neuropsychiatric medicine for which Myers did not bear some responsibility.<sup>23</sup> Of greater concern, however, was that he was expected to deal with 'purely neurological' cases involving organic lesions in the brain and spinal cord, and to distinguish these from 'functional' cases. In vain he pointed out, to anyone who would listen, that these tasks in particular were beyond him. He had no asylum or psychiatric experience, and was therefore unqualified to make decisions concerning mental disorders, nor did he have 'a specialist's knowledge of neurological diseases.' From the Army's standpoint, however, the choice must have seemed obvious. The matter of neuropsychiatric casualties was an immediate one, pressure was mounting in Parliament and the press for action, and recognised experts like Myers were thin on the ground. Myers had shown interest in the subject and had demonstrated outstanding organisational

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<sup>22</sup> Myers, *Shell Shock in France*, pp.15-16.

<sup>23</sup> *Ibid.*, p.16.



talents, attracting the favourable attention of Aldren Turner, Percy Sargent and, not least, Sir Arthur Sloggett and Sir Alfred Keogh. He was a distinguished figure in academic circles, and his qualifications were at least connected with the problem at hand.

By accepting the post, however, Myers had also taken on the military medical ethos, along with its intrinsic conflict between the demands of professional medical ethics and those of military exigency. The position of 'civilians in uniform' like Myers was doubly difficult, since they had expectations of returning to civilian medicine in due course. In Myers' own words, 'an Army Medical Officer has to obey commands'. He had only two options: firstly, of resigning his commission and, secondly, making the best of a bad job. At this stage he still believed in his own ability to change the attitude of the military medical establishment and chose the latter course.

On launching his initial investigation, Myers found that there was 'no one special hospital either there or at any other Base' dedicated to the treatment of mental and nervous casualties. He was dismayed by the conditions under which mental and nervous patients were housed, and by the lack of any logical and coherent scheme of classification and treatment. All patients arriving from the forward areas were classified as 'mental', occupying the 'attic floor' of a large hotel converted into a military general hospital. Here, Myers identified a number of distinct patient groups, namely those of;



- (i) undoubted 'insanity'
- (ii) suspected epilepsy
- (iii) severe 'shell shock' which, owing to temporary stupor, confusion, depression etc., could not be safely left in ordinary medical wards without a special attendant, and;
- (iv) men who, after committing some military offence, had been admitted for a report on their sanity and responsibility

Following the arrival in France of the 'Kitchener Armies' after the great recruitment drives of 1915, and consequent on the introduction of conscription in January 1916, Myers observed:

..the patients of class (i) rapidly grew in number; they included also cases of sub-normal intelligence (even of 'mental deficiency') and former 'Asylum' patients, many of whom had only been in France for a few weeks. Those of classes (ii) and (iv) often remained for several weeks in this dismal, ill-ventilated and over-crowded 'Mental Ward' under observation.<sup>24</sup>

All these were lumped together in a 'homogenous' mass with no organised attempt at treatment related to the condition. Amazingly, some of the shell-shock casualties actually recovered to the extent that they could be returned to duty. At the other extreme, many curable cases deteriorated for lack of careful observation and correct treatment, forcing their removal to the United Kingdom. All too often it proved 'virtually impossible' to treat cases, or even to conduct observation that would allow reliable diagnoses. It was obvious to Myers that 'much harm was being done' to the less serious cases through being herded together with the 'acutely demented, melancholic, maniacal, delusional

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<sup>24</sup> Myers, *Shell Shock in France*, p.77.



or suicidal' cases. The pervading atmosphere was one of fear that all were destined for a lunatic asylum.

Albeit in the face of opposition, Myers was soon able to arrange for the 'walking' patients (with the exception of the 'prisoners') to be allowed out for sea-front walks. Following a report to the Medical Director at Boulogne, and despite further opposition, Myers persuaded the authorities to re-house the entire cohort of 'so-called' mental cases in new 'huted' premises, where proper segregation could be imposed, and where all patients including the 'prisoners' could be allowed into small, secure compounds for fresh air and exercise. Later in 1916 Myers won further concessions from the authorities, with respect to prisoners convicted or accused of crimes and awaiting a decision on their mental state:

It seemed to me undesirable that innocent men who had mentally broken down under the strain of warfare should be closely associated with those accused, or convicted, of such offences as murder, attempted suicide, theft or desertion.<sup>25</sup>

The result of his pressure was that patients in this category 'unless obviously insane' were kept in prison at the various bases, under the care of the mental specialists located there. Eventually, 'often not without considerable initial difficulty and delay', all, or nearly all Myers's recommendations on care in the rear areas had been adopted. The situation in the forward areas, however, remained highly unsatisfactory. Particularly during major military operations, hard-pressed medical officers at Dressing Stations, Field Ambulances and Casualty Clearing Stations had little time for diagnosis, and none at all for

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<sup>25</sup> Myers, *Shell Shock in France*, p.79.



lengthy observation. The result was that many men who might have recovered quickly given rest and reassurance were sent to the rear.

### 6.5 Growing opposition.

Military legislation current at the time required that 'insane' soldiers should be repatriated to the United Kingdom.<sup>26</sup> This, added to the general scarcity of medical officers skilled in the care of mental and nervous casualties, encouraged their prompt removal to the base. Myers himself fell foul of this aspect of military medicine in proposing to the Deputy Director of Medical Services that a memorandum of guidance should be circulated to all medical officers having charge of mental and nervous casualties. Initially, the idea seemed to find favour, but later, as Myers wrote gloomily:

But again the old difficulties, due to ignorance and misunderstanding, occurred...[I was] described as desirous of breaking one of the regulations of the Army Medical Service which lays down that all soldiers who have suffered from insanity must be invalided.<sup>27</sup>

Myers' statement suggests that by this time (July 1916) he had encountered sustained opposition to his efforts at bringing about policy changes in the treatment of mental and nervous casualties. The Army's insistence on classifying soldiers as 'sane' or 'insane' with no intermediate gradations, directly reflected the civil legal situation. It was not surprising, therefore, that medical officers, many of whom had been civilian doctors only a short time before, should be reluctant to alter their ways. The Army could not retain genuinely insane soldiers indefinitely, and sooner or later had to discharge them into the

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<sup>26</sup> Army (Annual) Act 1913, Ch,X, s.32, *Manual of Military Law*, H.M.S.O., (London 1914) pp.193, 468-9.

<sup>27</sup> Myers, *Shell Shock in France*, p.85.



tightly regulated, parish-based civilian asylum system, which itself insisted on certification before a patient could be accepted. For the Army, there was little choice but to conform to the same all or nothing, 'sane or insane' dogma. It was a vicious circle that could only be broken by extra-regulatory action, action which at that time no authority was prepared to countenance. This, together with the British Army's characteristic administrative inertia in the face of changing circumstances, ensured that the chaotic situation in respect of mental and nervous casualties remained largely unchanged during the ensuing years of war.

Through his work at Le Touquet, his visits to other British treatment centres - frequently going as far forward as Advanced Dressing Stations - and through discussions with other medical officers, Myers had, by the middle of 1916, acquired considerable experience in the early treatment of functional nervous disorders. More importantly, he had come to the firm conclusion that these disorders sprang from 'essentially psychological' causes, and that the appropriate treatment should concentrate on psychotherapeutic techniques, especially the 'recall of repressed memories'. In obtaining recall, hypnosis had shown itself useful in some cases.<sup>28</sup> Contact with those medical officers actually dealing with mental and nervous casualties had given Myers access to observations, suggestions and not a few complaints concerning the most effective means of dealing with the problem. The majority, while supporting the idea that genuine cases should be removed from the front line, agreed with Myers that they should not be automatically transferred to the United Kingdom.

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<sup>28</sup> Myers in Murchison, *History of Psychology in Autobiography*, pp.215-230.



As one medical officer observed to Myers, moving some cases away from the fighting zone was often wholly unnecessary:

Several of my cases have been so temporary as to pass the border line from insanity to sanity while under my care...I think that the future disposal of [these] and many others must be left to those who are in charge of them.<sup>29</sup>

During the winter of 1915-16' the Official History records, 'it was rare to see or hear of a case of psycho-neurosis in the forward areas'. Following the start of the Somme campaign on 1 July 1916, however, 'several thousand' such casualties were sent out of the front line. In order to relieve pressure on general hospital accommodation on the Continent, many of these were evacuated to the United Kingdom. There, the unfamiliar nature of their symptoms gave rise to a plethora of theories and therapies:

...similar cases formed a well-recognized branch of medical practice before the war. (However), certain members of the profession lectured and wrote on the subject as if it was some new and mysterious malady. A complex terminology was evolved, and special treatments were evolved in bewildering profusion.<sup>30</sup>

The Official History is misleading on this point. It was undoubtedly the case that the hysterical symptoms exhibited by many of the Somme casualties - mutism, blindness, deafness, contractures, tremors, paralyses and the rest - had been observed by the medical professions of many countries for years prior to the Great War and, for that matter, in previous wars. This was particularly so in relation to the condition popularly known as 'railway spine' and the hysterical symptoms observed in those involved in rail and other violent

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<sup>29</sup> Quoted in Myers, *Shell Shock in France*, p.83.

<sup>30</sup> Macpherson, *Medical Services, Diseases*, p.8.



accidents.<sup>31</sup> But what had not been seen until the Great War was the enormous volume and complexity of these symptoms, with the consequent difficulties of processing, diagnosis and treatment. So-called shell-shock jostled for attention with anxiety states. Simple exhaustion merged into neurasthenia, and insanity came in these and many other guises. This clamorous horde of mental and nervous disorders threatened previous assumptions regarding sanity and insanity, founded as they were on historically sanctioned medico-legal distinctions. Amongst the crowds streaming from the firing line were the shirkers and malingerers, the dodgers and the cowards inseparable from any armed host. They saw opportunities for an easy escape from danger and discomfort, and their presence, with all the disciplinary and moralistic implications they carried, further complicated an already confused situation. It was clear to Myers, and confirmed by a growing number of other medical officers who were actually engaged in coping with these casualties, that an entirely new approach was needed. Something had to be done to sort out the easily cured from the intractable hysterical cases; to distinguish mental from neurological disorders, and to identify the mentally deficient and the definitely insane:

...I had come...to the conclusion that a 'centre' should be provided within each Army Area for the reception of cases of '? mental' disorder due to, and including those of, 'shell shock' and 'exhaustion'.<sup>32</sup>

Although conscious of his total lack of experience regarding mental health matters, Myers' travels inevitably brought him into contact with acute mental

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<sup>31</sup> For standard pre-war texts on the subject of hysterical functional nervous disorders, see Erichsen J.E., *Concussion of the Spine*, Longmans, Green, (London 1882).  
Page H.W., *Injuries of the Spine and Spinal Cord*, J. & A.Churchill, (London 1885).

<sup>32</sup> Myers, *Shell Shock in France*, pp.87-8.



disorders, on which he was expected at least to express an opinion. Aside from the articles referred to above, only one piece of primary evidence regarding Myers' activities emerged from the present study, as part of the surviving documentation of the following case:

Study Case No. 235  
 Archive Reference: PRO/MH106/2221  
 1276 Private Gomm G.  
 Age: 21  
 Service: 3 months  
 Unit: 'A' Coy. 22nd. Bttn. Royal Fusiliers  
 Diagnosis: 'N.Y.D.' ('Not Yet Diagnosed' - later diagnosed 'Mania')

At about 11.30 pm on 14 April 1916, Private Gomm was detained by the Military Police at Bethune railway station. He appeared to be 'temporarily deranged', was unable to give a coherent account of himself, and was taken to No. 33 Casualty Clearing Station in the same town. At first he refused to say anything at all, sitting on the end of his bed 'in a dejected attitude'. Later he began to speak, saying he remembered nothing of the past two days. His memory before that was quite good. He was able to give full details of his past life, and told of having had a 'nervous breakdown' about a year before while in training with his battalion in England. His responses were painfully slow and his answers came only 'after long thought.'

On 16 April 1916 Gomm was transferred to No.20 Casualty Clearing Station at Warlecourt. There, he was examined by Charles Myers - one of the 'many cases (seen) at various Casualty Clearing Stations.'<sup>33</sup> Myers' opinion was recorded in a brief separate note which reads:

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<sup>33</sup> Myers, *Shell Shock in France*, pp.17-18.



1276 Pte. Gomm 22 R. Fus. is in a semi-stuporose condition as if recovering from a state of shock. I recommend that he be sent to No.8 Stationary [Hospital] for further observation.

(Signed) Charles S. Myers  
Lt. Col. RAMC April 16 1916.<sup>34</sup>

The initial diagnosis of 'N.Y.D.' is interesting, anticipating by at least three months the policy changes made later that same year, which effectively prohibited shell shock as a field diagnosis. The acronym only became widely employed after the setting up of the 'N.Y.D.N.' early treatment centres.<sup>35</sup> There are no Medical Case Sheets identifiably from No.8 Stationary Hospital included in the otherwise chronologically continuous records of Gomm's case. However, it is certain that he was admitted to that hospital, since the next document in chronological sequence - a Medical Transfer Certificate (Army Form 172), confirms his having been admitted there on 17 April 1916, and transferred to 'D' Block at the Royal Victoria Hospital, Netley, Southampton, four days later. There is a Medical Case Sheet dated 18 April 1916: clearly marked 'Boulogne'.

Given that Private Gomm was admitted to 'D' Block on 22 April, the document can only have originated at No.8 Stationary Hospital.<sup>36</sup> There, Gomm was diagnosed as suffering from 'Mania'. He was said to be 'very restless and impulsive' and liable to hit out without warning. Attempts to learn more of his history met with little success: when asked about his civilian occupation he

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<sup>34</sup> This note is the only direct evidence found in the study of Myers' activities in the forward areas.

<sup>35</sup> For discussion of the work of the N.Y.D.N. centres, see Chapter Seven.

<sup>36</sup> No. 8 Stationary Hospital was located at Wimereux, a few kilometres from Boulogne, from March 1915 to March 1919.



replied, 'Tottenham Court Road' and whistled a popular tune. He claimed to hear voices saying to him, 'God save the King on a night like this', and continually shouted replies. He was extremely resistive to examination, and 'frightened that something was going to be done to him.' He complained that three people had tried to strangle him 'upstairs.' The ward he was in was in a single-storey building. On arrival at Netley Gomm was in much the same condition. He remained there for only a week before being transferred to Napsbury War Hospital, where he was admitted on 2 May 1916. Correspondence with his father established that Gomm had been treated for bilateral pneumonia in 1904 and again in 1915. In 1913 he had suffered from 'sunstroke' (location not given), followed by a 'nervous breakdown', treated 'partly at Hanwell Asylum and partly at home.' Details of his enlistment and Army experience are not given, but it is obvious that, on either physical or psychological grounds, Gomm ought never to have been allowed to enlist. The case also illustrates how difficult it was, even for someone in Myers' position, to make accurate diagnoses. Had Private Gomm's history been known from the outset, it would undoubtedly have expedited his transfer to the U.K. He remained at Napsbury without improvement or recorded treatment, and was sent to Long Grove Asylum (London County) on 23 June 1916.

By this time, Myers' main concern was that many relatively mild cases, not requiring admission to one of the mental wards attached to the Base Hospitals, were being sent out of the line, only to end up in one of the many general hospitals on the Continent. Since there were no mental or nervous specialists at these places, they received no treatment other than 'bed and



bromide'. If they were eventually sent back to the United Kingdom, the treatment they received - or more accurately did not receive - meant that they were almost certain to relapse:

...when they returned to their unit in France after four or five months' absence, their recovery was not more stable than if they had at once received treatment in France.<sup>37</sup>

This was the nub of Myers' argument. He was convinced that early treatment along psychotherapeutic lines - suggestion, persuasion, analysis, etc. - offered the best chance of a permanent recovery for this class of patient.

In support of his case Myers claimed that, while attached to a Casualty Clearing Station at St.Omer, he had been able to return 31 per cent of the 'so-called 'mental' cases' to duty, 'with a quite negligible proportion of relapses.' The hostile attitude of the military authorities, he believed, stemmed from the mistaken assumption that specialist treatment centres would become the focus of subjective and fashionable therapies, wrapped in impenetrable language, and delivering unsafe and transitory 'cures'.

There were many, particularly in the higher echelons of the military, who believed that any concession to the 'weakness' of psychological illness was a betrayal of all those who had 'carried on' and 'seen it through' - as well as

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<sup>37</sup> Myers, *Shell Shock in France*, p.88.



threatening a damaging drain on the Army's ability to continue the war:<sup>38</sup>

Everyone in the fighting zone realized how thin was the line which separated the milder cases of psycho-neuroses...from those individuals whose disability lay in an insufficient stoutness of heart. The military school disputed the possibility of separating the one from the other, and took up the position that the establishment of special centres would open up a flood-gate for wastage from the army which no-one would be able to control.<sup>39</sup>

During his many front-line excursions, Myers records hearing men boasting that they were suffering from shell shock. Perhaps feeling some measure of responsibility for having publicised the term in the first place, he sent in a strong recommendation that it should be replaced by the term 'nervous shock', believing that 'fewer would be disposed to boast of suffering from this disorder.' Myers later took up a distinctly ambivalent stance on shell shock, and towards those who claimed to be suffering from its effects. On the one hand he was convinced that staying at one's post and resisting psychological pressure was entirely laudable, and that those who broke down, apparently without trying to 'pull themselves together' were manifestly of less admirable stock.

In *Shell Shock in France*, Myers recounted the story of a 'gallant artillery officer', in charge of a battery that had been severely shelled. A sergeant had been killed and two of his men sent down the line marked as suffering from 'Shell Shock - Wound', because their mental condition stemmed directly from the effects of a near explosion. Knowing that his battery was on the point of

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<sup>38</sup> For a concise exposition of the political and disciplinary tensions set up by the rise in numbers of neuropsychiatric casualties caused by the Somme campaign, see Brown E.M., 'Post-traumatic Stress Disorder and Shell Shock' in Berrios G. and Porter ., (Eds.), *A History of Clinical Psychiatry*, Athlone, (London 1999), esp. pp.505-507

<sup>39</sup> Macpherson, *Medical Services, Diseases*, p.10.



being relieved, the officer refused to report sick, believing, in Myers's words, that he could 'pull himself together' for the remaining few days. This he did, but on returning from 'rest' the next shell that came over, although not near him, caused him to break down immediately:

Whereas his two men, by giving way immediately, became entitled to rank as wounded and to wear a 'wound stripe', he (the officer), by 'bravely refusing to do so', was sent down later stigmatized as 'nervous'.<sup>40</sup>

Myers cited this case primarily as an example of discrimination against bravery and fortitude, but did so at the expense of the two soldiers, whose immediate breakdown he clearly regarded as a sign of weakness, if not cowardice. The fact that shell shock, however caused, was used as a bolt-hole by malingerers and cowards was not the fault of the condition itself, nor of those who claimed to be its victims in order to escape the rigours of the front line.

If anything, the fault lay with the Army Medical Services' failure to issue prompt guidelines on diagnosis and treatment, and the lack of a clear policy on which cases were to be treated on the Continent, and which were to be repatriated. The Army had, after all, spent a good deal of time protesting that there was nothing new about shell shock, and that its symptoms had been noted, albeit on a much smaller scale, in previous conflicts. There was no valid excuse, therefore, for the 'confusion' about which Harold Wiltshire complained so strongly. Myers heard similar complaints during his visits to front-line treatment centres:

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<sup>40</sup> Myers, *Shell Shock in France*, p.98.



With these views I was in hearty agreement: I had also seen too many men at Base Hospitals and Casualty Clearing Stations boasting that they were "suffering from 'shell shock', Sir", when there was nothing appreciably amiss with them save 'funk'.<sup>41</sup>

## 6.6 Indecision and discrimination

It needed something more before the various misconceptions and prejudices could be overcome, and before the Army could bring itself to accept that all mental and nervous casualties were not either lunatics or cowards. The initial reaction of the Director-General of Medical Services to Myers' urgings, however, was to order that all cases of 'genuine' shell shock, that is, cases where the patient had actually been blown up, blown down or buried by a near explosion, should be marked 'W' to denote that they had sustained a 'wound'. The remainder - for example those who had broken down under prolonged heavy bombardment - should be marked 'S', denoting that they were 'sick'. This was the Army's attempt at removing any spurious glamour from the condition. Diagnosed as 'Shell Shock (W)', the man became entitled to wear the coveted gold 'wound stripe' on his sleeve. Diagnosed as 'Shell Shock (S)' he was denied any such entitlement, and might equally well be regarded as a weakling, lacking fortitude or 'stoutness of heart', or who had simply 'got the wind up'. To make matters worse, the question of whether a man did or did not qualify as 'Shell Shock (W)' could only be answered by reference to the Commanding Officer of the soldier's unit.

The reason given for this was that the Army had to reconcile the demands of humanity in patient care with the primary task of winning the war.

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<sup>41</sup> Myers, *Shell Shock in France*, p.96.



At the same time, it was patently unfair to those thousands who had been involved in near explosions, but had 'carried on' for days and weeks before finally succumbing to the effects. Such men would almost certainly be classified as 'Shell Shock (S)' and be liable to attract the opprobrium described above. The present study of 500 cases contains numerous examples, such as those detailed below.

Study Case No.119

Archive Reference: PRO/MH106/2101

2890 Private Leybourne W.

Age: 45

Service: 4 years

Unit: Royal Warwickshire Regt.

Date first admitted to hospital: 12 Sept. 1915 (Estimated)

Diagnosis: Neurasthenia. (Later annotation: 'Buried by shell explosion').

Early in July 1915 Leybourne was buried when his dugout collapsed under shell fire. He did not report sick at the time, but began to sleep badly and to 'lose...interest and energy and became quite apathetic and depressed'. Some time later he fell heavily over some barbed wire, and this made him worse. He began to complain of a sore throat, headaches and pains between the shoulders, for which he was hospitalised twice (dates not given) without any real improvement. At some stage his mental condition became such that he was 'taken to hospital under escort' and later transferred to the U.K. (The above events are summarised in the only surviving case notes, from the Wharncliffe War Hospital, Sheffield). After 22 days stay, during which he was reported to be 'Slowly improving and brightening up mentally' Leybourne was discharged on 10 days furlough, marked 'fit for light duty.'



Study Case No. 120  
 Archive Reference: PRO/MH106/2101  
 1529 Private Mears H.  
 Age: 25  
 Service: 3yrs. 8 months.  
 Unit; 1st Battn. South Staffordshire Regt.  
 Diagnosis: Neurasthenia

Private Mears went to France on 4 March 1915. He was quite well until the 'beginning of September', when a shell burst near to him. After that he had great difficulty in speaking and stammered badly. Only one Medical Case Sheet survives, from Wharncliffe War Hospital, Sheffield, where he was admitted on 12 September 1915.<sup>42</sup> Apart from the comments regarding his speech difficulties, the only other observation was to the effect that his chest was 'sound'. On 21 September 1915 he was discharged on 10 days furlough, after which he presumably returned to duty. It is not known if his speech problems had improved. Whether Leybourne or Mears were awarded a 'wound stripe' is likewise not known, but this would not normally be entered on their medical records.

Leybourne's case is a good example of involvement in a near explosion, following which the patient 'soldiered on' for weeks before apparently unconnected symptoms began to supervene. The study contains numerous examples in which, under very similar circumstances, the individual was evacuated from the line and hospitalised immediately. Mears' case also illustrates the extraordinary efficiency with which casualties were passed out of the line and transferred to the U.K.

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<sup>42</sup> Mears' case is also a good example of the carelessness with which some War Hospitals approached the matter of dates. If a reasonably accurate chronology was not obtained at the patient's admission, little or no effort seemed to be made later.



An equally serious consequence of this order was that men were kept for 'needlessly long' periods awaiting details from officers who might be on leave, sick, wounded or dead.<sup>43</sup> In the meantime, men were classified 'N.Y.D.N.' but, while this was going on, the situation with regard to mental and nervous casualties was rapidly deteriorating. While Myers urged the adoption of different terms in order to dim the alleged lustre of shell shock, and while the authorities labelled as 'nervous' men who had fought bravely for months and even years before finally breaking down, the lists of mental and nervous casualties lengthened.

By April 1916, Myers had been promoted to Lieutenant-Colonel and his title later changed from 'Specialist in Nerve Shock' to 'Consulting Psychologist'. Also, 'expert mental specialists' had been appointed to supervise the mental wards at the Base Hospitals. This had left Myers free to indulge his fondness for travel, and, as shown in the case of Private Gomm, had spent much of the first half of 1916 visiting Field Ambulances and Casualty Clearing Stations in the forward areas, gaining valuable experience of the early stages of mental and nervous conditions. Coincidentally, his constant criticism of the policy of repatriating all mental cases regardless of severity was having effect. Added pressure was brought to bear by Gordon Holmes, who joined Myers in urging a major change of policy in the treatment of neuropsychiatric casualties. Significant events on the battlefield also added to the need to treat as many as possible in the fighting zone:

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<sup>43</sup> Myers, *Shell Shock in France*, p.97.



The problem did not become acute until July 1916, during the battle of the Somme. In the first few weeks several thousand soldiers were rapidly passed out of the battle zone on account of nervous disorders, and many of them were evacuated to England.<sup>44</sup>

During the second half of 1915 the number of admissions to hospital with shell shock alone totalled 1,246. During the first half of 1916, this figure had more than trebled to 3,951, and early returns for the second half of that year were causing the gravest anxiety. It was an anxiety that was to be more than justified: the final total of shell shock cases for July-December 1916 reached 16,138. More than ever, it became a matter of urgency to put in place an effective system for distinguishing between the various categories of mental and nervous casualties, and to return those who were fit for duty to the firing line.<sup>45</sup>

### **6.7 Charles Samuel Myers: a historical assessment.**

At first amicable, the relationship between Myers and Holmes was destined to deteriorate to Myers' lasting disadvantage. As noted above, Holmes had been in a very successful partnership with the neurosurgeon, Percy Sargent, but this had come to an end, and Holmes was, in Myers' words, 'seeking other specialist work.' Holmes, who had also been promoted to Lieutenant-Colonel and given the title of 'Consulting Neurologist', asked Myers whether he had any objection to his (Holmes) dealing with the 'purely functional' neurological cases at the Base Hospitals.

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<sup>44</sup> Macpherson, *Medical Services Diseases*, pp.8-9

<sup>45</sup> *ibid.*, p.14.



Having agreed to this, Myers was angered to learn that Holmes had in fact surreptitiously negotiated far wider terms of reference for himself, fundamentally altering the balance of responsibilities. Instead of being responsible for mental and nervous casualties in the whole of the B.E.F., Myers found himself restricted to 'the Fourth and Fifth Army areas, plus the Base Areas of 'Dieppe, Le Treport, Rouen and Havre.' The rest were to be handed over to Gordon Holmes. Myers was furious. He suspected that Holmes had deliberately misinterpreted his limited consent regarding 'functional' cases to the authorities, and had been working behind the scenes to take over territory and responsibilities on which Myers had expended enormous effort since leaving Le Touquet in March 1915. He deeply resented what he regarded as sharp practice - not to say ungentlemanly and unprofessional conduct - by someone to whom he had extended an unselfish and friendly hand:

The proper course would have been for him to be employed in diagnosing and advising on the treatment of strictly neurological cases throughout all hospitals and for me to continue my 'shell shock' and 'mental work' as before, each calling in the other in doubtful cases when the use of his special experience was desirable.<sup>46</sup>

Myers' suspicions were confirmed when Holmes admitted that, having been appointed Consulting Neurologist for the whole of the B.E.F., he regarded Myers' continued involvement with 'shell shock' cases as an intrusion, while confessing that he himself was 'quite incompetent' to deal with them, or with putative 'mental' cases. Holmes admitted that 'functional' nervous cases had always formed a substantial part of his civilian practice, and thus a considerable source of income. His professional standing (and therefore his

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<sup>46</sup> Myers, *Shell Shock in France*, p.19-20.



earning capacity) would inevitably suffer if it became known that such cases had been excluded from his wartime brief:

Naturally, therefore, he was little disposed to relinquish in Army life what was so important a source of income in time of peace, although he confessed that (like most 'pure' neurologists) he took little interest in such cases.<sup>47</sup>

Not unnaturally, Myers suspected that Holmes, having noted the growing acceptance of the psychological basis of the war neuroses and the success of Myers' policies in their early treatment, was intent on securing a foothold in what promised to be an important and lucrative area of activity in post-war neurology. Writing of these events in 1940, Myers pointed to the fundamental nature of the changes that had taken place in neurology since the Great War, changes which, in his eyes, more than justified the view he had formed of Holmes's conduct at the time:

During the past twenty-five years, however, thanks to the work of Janet, Prince, Freud, Jung, Adler, Hart, Rows, Jones and many others, the position has now changed: the neurologist's methods of treating the psycho-neuroses have been very largely superseded by those of the psycho-therapist.<sup>48</sup>

The neurological and psychological approaches, Myers went on, were 'fundamentally opposed'. The neurologist treated the obvious symptoms and signs, mostly by 'persuasion or force'. The psychologist, on the other hand, recognised that a permanent recovery required the removal of the underlying causes. Merskey (1990) refers to Holmes's 'quarrelsome' nature but, whatever the reality of the disagreement, it is clear that the passage of time had done

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<sup>47</sup> Myers, *Shell Shock in France*, p.20.

<sup>48</sup> *ibid.*, pp.20-1.



little to assuage the bitterness which coloured Myers' views, views which largely dictated his actions over the ensuing years.<sup>49</sup>

Setting aside the questionable nature of Holmes's manoeuvrings, it was clear that no single individual could adequately hold the whole of France as his personal fiefdom, and some division of responsibility was appropriate and inevitable. It was regrettable, however, that clumsiness on Holmes's part should have been met with over-sensitivity on Myers'. Whether Myers recognised it or not he was ready to move on, needing only a plausible excuse to abandon France, Holmes's 'quarrelsome' nature and the war neuroses for good. In January 1917, pleading that he was 'worn out with worry over the conditions of his work' he asked for extended leave, offering his resignation as an alternative. He was granted two month's leave and, on returning to France, resumed his work 'under the old conditions.'

In June 1917 Myers sought and was given permission to make a series of visits to treatment centres in the French Army. In the following October he was summoned to London to take part in a special conference on neuropsychiatric casualties, after which Sir Alfred Keogh, Director-General of Medical Services at the War Office, asked him to remain in London as a member of a committee, recently set up to prepare 'a scheme of treatment and administration' for 'shell shock' cases in hospitals in Great Britain.'

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<sup>49</sup> Merskey H., 'Shell Shock', in Berrios G. and Freeman H. (Eds.), *150 Years of British Psychiatry*, Vol.1, Gaskell, (London 1990), pp.262-3.



Meetings of this committee kept Myers in London for a further week, during which time he seems to have undergone something of a Damascene conversion. With the committee's report completed he returned to France apparently already convinced that he had 'done all that [he] was likely to be able to do [there].' He wrote to Sir Arthur Sloggett 'with the confidential approval (and indeed encouragement) of Sir Alfred Keogh', asking to be relieved of his duties on the Continent. Keogh's effusive confirmation of these arrangements ('...how gladly I should welcome you here') forces the conclusion that the whole business of the planning committee, as well as the suspicious eagerness of Sloggett and Keogh to fall in with Myers' wishes, amounted to a put-up job, an elaborate charade designed to allow Myers to be 'edged out by (...) Gordon Holmes' while preserving the niceties of professional medical etiquette and military protocol.<sup>50</sup>

Whatever the true nature of the politics behind this curious episode, Gordon Holmes was left with the best possible outcome; a field unencumbered by Myers' prickly sensitivities and the inconvenience of his independent wealth, and a field open to the application of Holmes's more muscular brand of neurology, in place of Myers' increasingly psychological emphasis. Splints, supports, faradism, massage and hydrotherapy were given a new lease of life.

The remainder of Myers' time with the Army was divided between a brief spell at R.G.Rows's hospital at Maghull and, arising from his meeting with T.H.Pear there, a somewhat bizarre association with a little-known project on

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<sup>50</sup> Shephard, *150 Years of British Psychiatry*, p.436.



submarine location, known only as 'H.M.S. Crystal Palace'.<sup>51</sup> Myers' scarcely concealed rancour re-emerged when the time came to distribute the usual post-war honours. Angered by the Army's 'studied neglect' of military 'mental specialists', Myers declined the award of a C.B.E. until, in 1919, he bowed to what he described as 'the King's command to attend one of the investitures'.<sup>52</sup> His sense of grievance could not have been lessened by the fact that most of the Medical Superintendents of asylums taken over under the Asylum War Hospitals Scheme received the C.B.E., while his successor in France, Gordon Holmes, was given a knighthood.

Nursing his wounded pride to the last, Myers refused to contribute to the Official History's chapter on neuropsychiatric medicine - a chapter, T. H. Pear believed, Myers alone could write with the necessary authority. He likewise declined to give evidence to the 1922 Southborough Committee on shell shock. The sad fact was that neither Myers nor the military medical authorities seemed willing to heal the rift, thus robbing the historical record of what would have been a uniquely authoritative contribution. As it is, the modern reader is left with a chronologically baffling account, containing inadequate statistics and inconsistent medical terminology, couched in what Ben Shephard has scathingly described as 'some of the dullest and most forbidding prose ever to be bound together.'<sup>53</sup> Myers' own account of events, delayed for more than twenty years, was by that time largely irrelevant, unsatisfactory either as a

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<sup>51</sup> Hearnshaw L.S., *A Short History of British Psychology 1840-1940*, Methuen, (London 1964), p.248.

<sup>52</sup> Myers in Murchison, *History of Psychology in Autobiography*, Vol.3, p.224.

<sup>53</sup> Shephard, *150 Years of British Psychiatry*, p.454.



clinical or a narrative record. Writing Myers' obituary, F.C.Bartlett summarised Myers' wartime career thus:

During the whole of this period it seemed to him that he had been waging a largely unavailing fight against a stubborn refusal on the part of the leading Army medical authorities to recognize the real importance of psychological services [...] (Always) with the unforgotten heritage of his struggles during the first world war, he would often see slights where almost certainly none were meant, and take as criticisms remarks which were intended to be wholly objective.

Bartlett's choice of words reflects well Myers' flawed brilliance. The possessor of outstanding organisational talents, he chose instead to dabble in the clinical aspects of physical medicine, for which he was singularly ill-qualified. With enviable social and political contacts, he neglected them, preferring rather to cut a dash at the Front, only to find himself disadvantaged by the tactics of others. Self-indulgent of his love of novelty and impatient of the long haul, Myers squandered his unquestioned gifts, yet coveted the respect and deference due to *gravitas* and persistence.

Myers' struggles seemed so often to be against odds of his own making, yet it is difficult to over-rate his potential. The early organisation of experimental psychology at Cambridge, the facility with which he could produce significant results, his authorship of seminal works on psychology at a time when much of the ground was unbroken were talents any one of which a lesser man would have counted himself fortunate to possess. It may have been the ease with which these prizes fell into his lap that led him to value them so poorly. All too often it seemed that the initial challenge was the only phase in



which he took any real interest: it may indeed have been the only one for which he was intellectually and emotionally equipped.



## CHAPTER SEVEN

### NEW POLICIES, NEW PRACTICES: THERAPEUTIC STRATEGIES AT THE 'N.Y.D.N.' CENTRES.

#### 7.1 Organisation and location

The Somme offensive was launched on 1 July 1916 and lasted for five months. During the first few weeks alone several thousand mental and nervous casualties were evacuated, finally convincing the military authorities that a new approach to their treatment was needed.<sup>1</sup> The most obvious demonstration of a policy change in dealing with the growing problem came in 1917, with the establishment of 'N.Y.D.N.' centres in each army area. The strictly correct name of these was 'Advanced Neurological Centres', but the practice of labelling casualties 'N.Y.D-N.' ('Not Yet Diagnosed - Nervous') led to the Centres themselves becoming universally known by the same acronym.

**Table 6. Location of N.Y.D.N. Centres - British Expeditionary Force**

| Army area | Parent unit                        | Location |
|-----------|------------------------------------|----------|
| 1st & 2nd | No.4 Stationary Hospital           | Arques   |
| 3rd       | No.6 Stationary Hospital           | Frevent  |
| 4th       | No.21 Casualty Clearing Station    | Corbie   |
| 5th       | No. 3 Canadian Stationary Hospital | Doullens |

In July 1917 the Centre for the 5th Army was relocated at No.62 Casualty Clearing Station, Haringhe. Figure 12 gives a schematic layout of a typical Centre.

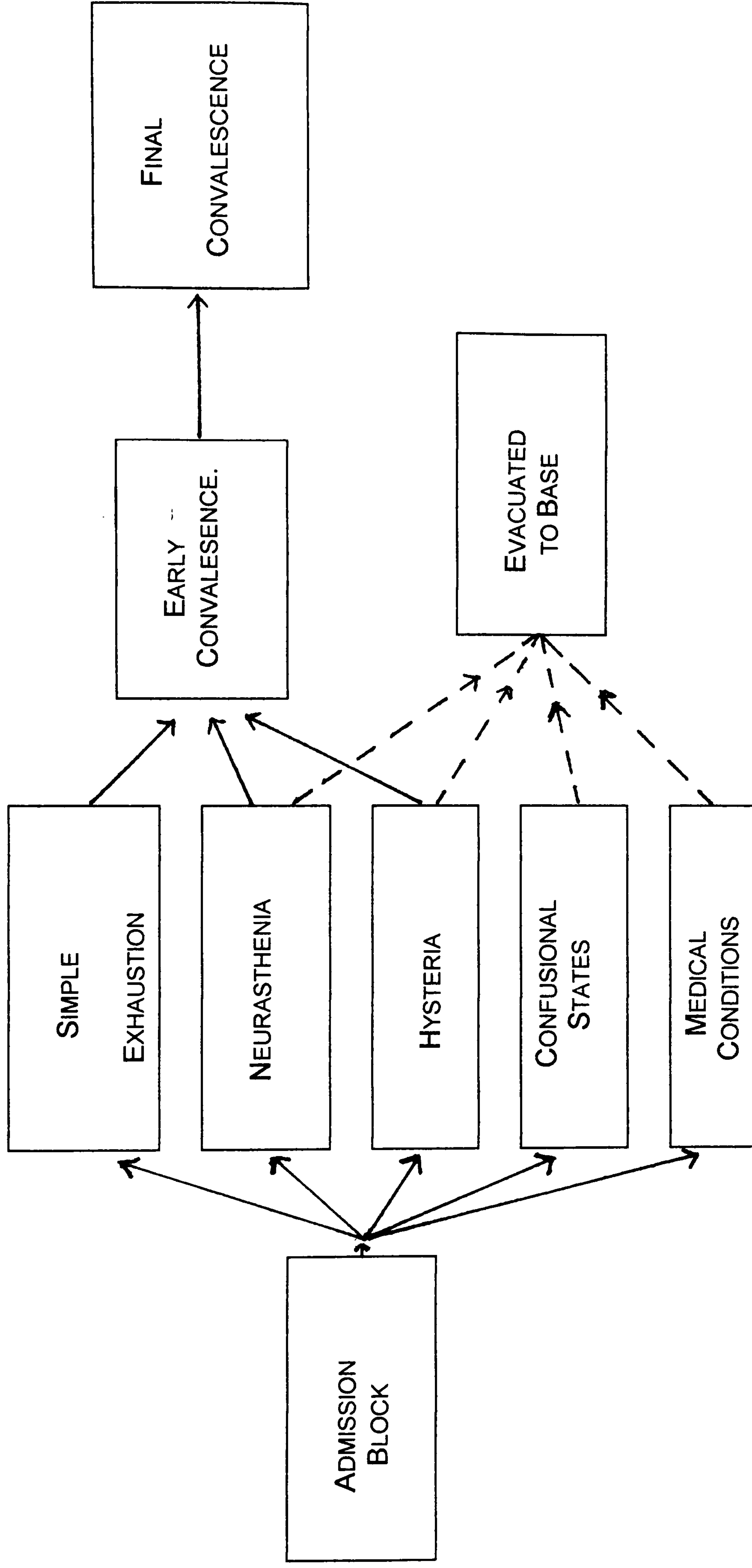
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<sup>1</sup> Macpherson W.G., *et al* (Eds.) *History of the Great War: Vol.2, Medical Services, Diseases of the War*, H.M.S.O. (London 1923), p.8.



# DIAGRAM OF AN ARMY N.Y.D.N. CENTRE

Source: Macpherson W.G., et al (Eds.), *Official History: Medical Services, H.M.S.O.*, (London 1922)





The primary function of the N.Y.D.N. Centres was to examine, diagnose, classify and, where appropriate, provide early treatment for neuropsychiatric disorders in the relevant Army Area. Where treatment was not appropriate, for example in cases of obvious insanity, or in the case of severe nervous disorders requiring prolonged treatment, these were referred to the appropriate Base Hospital Mental Wards. Each centre was under the overall command of a R.A.M.C. Lieutenant-Colonel, with a staff of suitably qualified and experienced medical officers, treating the various categories of patient. An important aspect of these appointments was that, in addition to possessing appropriate medical skills, the officers had to be able to maintain discipline. This, the Official History states, 'was difficult for those in England to understand, ignorant as they were of the actual conditions in the fighting line'.<sup>2</sup> The mental condition of the troops sent out of the line following a major battle, the History continues, was such that it was easy to tip the balance towards a rapid improvement or towards a 'confirmed psycho-neurosis'.<sup>3</sup> The N.Y.D.N. centres were founded on the wholly pragmatic and unsentimental principle of getting men who were fit to serve back into the trenches.

On arrival at a Centre patients were put into the Admission Block, where they were examined and sorted into one of the following groups: simple exhaustion, neurasthenia, hysteria, confusional and mental states. These groups were kept apart and, as they recovered, were passed on to an 'Early' and then to a 'Final' Convalescent Block. Those who did not improve within ten

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<sup>2</sup> Myers C.S., *Shell Shock in France*, Cambridge University Press, (Cambridge 1940), p.11.

<sup>3</sup> Macpherson, *Medical Services, Diseases*, pp.11-12.



days were evacuated to the base. After three or four days, patients in the 'simple exhaustion' group were generally sent direct from the admission to the convalescent blocks. The other groups - particularly the neurasthenic and hysterical, were passed on to the convalescent blocks as soon as and when they were considered fit. Exercise and drill were under the command of an Army instructor, whose task was to ensure that all patients who were physically capable were subjected to a regular and taxing regime of physical exercise. To emphasise the disciplinary nature of the regime, there were no 'doctor's rounds' in the conventional hospital sense. Wards were put in charge of N.C.O. patients, and men were marched to and from meals and drill periods as they would be in training, in billets or in a rest camp.<sup>4</sup>

The whole ethos was aimed at convincing the patient that his condition was known and understood, and that fresh air, good food and healthy exercise, combined with the ministrations of skilled and experienced doctors, would soon restore him to health. This air of conviction was underlined more than anything else by the fact that, situated as they were within sound of the guns, patients were constantly reminded of the war to which, it was implied, they would naturally return before long, fit and well in body and mind:

...a continuance in the forward area during the period of recovery had much to be said in its favour. Had the course been taken of isolating the centre in some remote spot, it could only have resulted in helping to foster those false ideas which so many patients possessed, that their disease was incurable.<sup>5</sup>

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<sup>4</sup> Macpherson, *Medical Services, Diseases*, p.13.

<sup>5</sup> *Ibid.*, p.14.



To pick up those patients who failed to respond to the N.Y.D.N. regime, special hospitals were set up at the base. This combination of early diagnosis and treatment, together with a 'safety net' provision at the base meant that it was theoretically impossible for any case to avoid the special line of evacuation. The Official History admits, however, that 'many did escape this control'.<sup>6</sup> The case summarised below illustrates the limitations of the arrangements.

Study Case No. 313

Archive Reference: PRO/MH106/2231

47272 Private Piper E.

Age: 28

Service: 5 years

Unit: No.112 Machine Gun Corps

(Attached 6th. Battalion Bedfordshire Regt.)

Diagnosis: Confusional insanity

Private Piper joined his unit on 1 December 1917, when his mental condition immediately began to attract attention. A battlefield note (undated) from his Section Commander, Lieut. Saunders, reads;

'This man has been of very curious behaviour since arrival 4 days ago from base. Some of his conversation follows:

When some big guns went off - "I can smell them, like fires going to my head". When the Guard challenged him - "Turn out the Guard". He attempted to fire the machine gun against all orders. He does not obey orders, or obeys at first and then in a few minutes appears to forget. He left his post at 9 am on 5th. December and was met by some of his own company 1500 yds back, he told them he had been sent out for physical exercise 'with this' (indicating his handkerchief). In some cases he has to be restrained but has not been violent. He frequently bursts into tears.

J. Saunders Lt.  
112th. M.G. Corps'

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<sup>6</sup> Macpherson, *Medical Services, Diseases*, p.14.



Further notes from the 49th Field Ambulance and No.53 Casualty Clearing Station (Bailleul) accompany Piper's casenotes, and give graphic details of subsequent irrational behaviour. At the latter location, for instance, a note dated 9 December 1917 records Piper suffering 'a kind of fit which was nothing like an Epileptic' and which the attending Medical Officer considered 'hysterical in nature'. His delusions persisted: he claimed he was an officer in a flying machine and had 'flown from France to England and back.' On 9 December 1917 he was admitted to the Mental Division of No.8 Stationary Hospital, Boulogne Base, where he was diagnosed as suffering from 'Confusional Insanity'. Piper was sent back to the U.K. and, on 20 December 1917, was admitted to 'D' Block, Royal Victoria Hospital, Netley.<sup>7</sup>

On admission he was said to be 'obstinate, insolent and aggressive'. He said he heard voices calling him a German spy, and believed that his comrades were trying to read his thoughts. He was incurious as to his location because in the Army 'you can read each others feelings.' On 14 January 1918, he was admitted to the Welsh Metropolitan War Hospital.<sup>8</sup> On admission it was noted that he was... 'dull... and scarcely speaks. Exhibits echolalia.'<sup>9</sup> Habits wet and dirty. Shows no improvement. Was treated by massage in bed on verandah but without result.<sup>10</sup> On the morning of 9 March

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<sup>7</sup> Prior to the outbreak of war, 'D' Block, Netley, was the Army's main centre for the treatment of mentally ill soldiers. During the war it was designated a 'Clearing Hospital' for mental cases arriving in the United Kingdom from Expeditionary Forces and Garrisons overseas.

<sup>8</sup> Previously the Cardiff City Asylum. For discussion of the use of asylums as War Hospitals, see Chapter Eight.

<sup>9</sup> See glossary.

<sup>10</sup> The therapeutic purpose of massage in a case of severe mental disturbance such as this is not made clear in Piper's casenotes. Possibly an attempt to induce relaxation.



1918, Piper suddenly became violent and struck one of the orderlies in the mouth. At this same time tuberculosis was suspected, and Piper was put to bed on the verandah because he was 'losing flesh'. Because of his disturbed state there was difficulty in carrying out a pulmonary examination. Sputum tests eventually proved negative. On 18 July 1918, Piper was transferred to Napsbury War Hospital, remaining there without improvement until 17 March 1919, when he was transferred to Long Grove Asylum, Epsom. Total hospital stay 463 days.

In view of the date and the nature of Pte. Piper's symptoms, his case should have been processed, at least initially, through the appropriate N.Y.D.N. Centre. That it was not suggests that official policy was always subject to the exigencies of field conditions. Also, Piper's symptoms were so obviously those of a serious mental disorder that any delay in transferring him to a specialist treatment centre was unjustified. Piper's casenotes give no indication of his combat experience or a possible causative event.

## **7.2 Treating the 'simple exhaustion' cases.**

Although in itself non-morbid, 'simple exhaustion' as a physiological, mental and nervous state was important to the work of the N.Y.D.N. Centres on at least two major counts. The first was its function as a predisposing factor in the development of more serious conditions; the second the effect of the very great numbers of such cases requiring treatment. There can be little doubt that the initial wave of mental and nervous disorders with which the military medical authorities had to deal arose directly from the unprecedented physical



and psychological stresses imposed by the early battles and, in particular, to the reverses of August - September 1914. In later months, to say that a man had been 'involved in the retreat to the Aisne' was regarded as sufficient explanation for nervous or mental illness. Lieutenant Reginald Owen, a survivor of the battle of Le Cateau, described the nightmarish confusion of those days:

(E)verybody completely exhausted - staff officers asleep bent double in motors - men asleep over horse's necks and in wagons and on limbers and all along the roadside - personally I slept on the march and kept crashing into the corporal in front at any checks. When eventually a halt was called before we got strung out again, I was woken by someone shouting "fall in"; so I fell in, and after marching a short way I began to wake up to the fact that things were a bit strange, and I found I was with the Middlesex Reg. - quite a different division.<sup>11</sup>

The significance of Mons, Le Cateau and the 'Great Retreat' was that they not only constituted a major setback for the Allies, they also brought to an end the *hubris* with which initial contact with the invading German forces had been anticipated. The ignominious forced retreat was to push mental and nervous casualties much higher up the British Army's list of problems. Despite the 'excellent physique, the perfect training and the splendid *esprit de corps*', this confused and dispirited rabble was all that was left of that brashly confident band which, only a few weeks before, had marched to the Channel ports. The catch-phrase "It'll all be over by Christmas" flung jauntily over their shoulders to comfort and reassure those left behind began to sound increasingly hollow and desperate. By 1916, when the N.Y.D.N. centres came on the scene, the spirit of late 1914 had all but evaporated.

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<sup>11</sup> Brown M., *The Imperial War Museum Book of the Western Front*, Sidgwick & Jackson, (London 1993). p.15.



Exhaustion, simple or otherwise, now arose more from the after-effects of major battles, when planned rest periods went by the board and leave was suspended. Even so, these instances were not recorded as a disease in the strict sense of the word, with the result that data are entirely absent from the surviving statistical record. It is not possible, therefore, to quantify the 'extreme importance' attached to the condition by the Official History.<sup>12</sup> The matter is further complicated by the fact that, for administrative and organisational purposes in the N.Y.D.N. Centres themselves, it was decided to include in the simple exhaustion group the 'milder forms' of neurasthenia, although no indication is given of the criteria adopted for such inclusion. It follows, therefore, that any given number of cases recorded as 'neurasthenia' may contain a proportion of cases of exhaustion.<sup>13</sup> However, evidence revealed by the present study in the form of medical casenotes from other treatment centres shows clearly that even the mildest cases diagnosed as neurasthenia could, in certain circumstances, develop into much more serious conditions. The following is an example.

Study Case No. 154

Archive Reference: PRO/MH106/2225

12287 Private Kelly G.

Age: 29

Service: 11 years

Unit: 5th Battalion Grenadier Guards

First hospitalised (for mental/nervous disorder) 30 November 1915

Diagnosis: Neurasthenia

Private Kelly was first hospitalised as the result of wounds sustained during the battle of 'First Ypres' on 31 October 1914. His right testicle was shot away, and

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<sup>12</sup> Macpherson, *Medical Services, Diseases*, p.20.

<sup>13</sup> *ibid.*



his left 'injured and rendered functionless'. After treatment at Boulogne and the Royal Victoria Hospital, Netley, he was discharged to duty on 19 February 1915. On 30 November 1915 he was admitted to the 2nd London (Territorial) General Hospital, Chelsea, suffering from a gunshot wound of the left chest, having 'endeavoured to take his own life with a service rifle'. The wound was not life-threatening, however, the bullet having glanced off the fourth rib and re-emerged some 38 cm from the point of entry. He remained at 2nd London General until 26 January 1916, during which time the wound healed well. At the same time, however, Kelly became depressed and sleepless, saying repeatedly, 'life is not worth living'. He was transferred to Napsbury War Hospital on 27 January 1916.

On admission to Napsbury, as well as the wound scars described above, Kelly exhibited 'multiple lipomata' on his arms and legs.<sup>14</sup> He was described as 'dull, depressed [and] confused in his answers.' He claimed to have had 'bother' with his family but would not elaborate. On 15 February 1916 he was noted as 'Confused, depressed and irrational.' 28 March 1916: 'Has improved and is much less depressed, but is nervous and hesitating in speech.' On 25 April 1916 Pte. Kelly was said to be; 'depressed and complaining constantly of his throat. Thinks he (has) syphilis - there is nothing to be seen in (his) throat.' A few days later; 'now better, much more cheerful, realises that he was deluded as to the state of his throat.' On 27 June 1916. 'improvement continues. No longer depressed but is highly nervous and unstable.' Kelly was brought before a Medical Board and discharged, leaving for his home on 14 July 1916.

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<sup>14</sup> Usually benign, well-differentiated accumulations of fat. In this case possibly associated with the patient's earlier traumatic castration.



In this case the diagnosis of 'neurasthenia' was extended well into the province of what today would be recognised as chronic depression, of which Kelly exhibited several classic symptoms. Although reportedly improved by the time he was discharged, Private Kelly apparently received no psychiatric treatment, and remained in a highly nervous and unstable condition. Interestingly, no action seems to have been taken regarding Kelly's self-confessed suicide attempt. This apparent leniency on the part of the military authorities is in direct contrast to the harshness with which Private Simpson was treated by the civil courts in the case described earlier.<sup>15</sup> Lacking the contemporary familiarity with and intuitive understanding of neurasthenia, it is even more difficult to maintain a clear separation of the two groups. In general, however, treatment of the 'Simple Exhaustion' group was confined to rest and an ample diet, and patients were allowed to sleep as long as they wished. Most 'exhaustion' patients spent only a few days in the Admissions Block, after which they were transferred to the Convalescent Block.

### 7.3 Treating the 'neurasthenia' cases.

This group accounted for approximately 60% of the average intake of a Centre. As discussed in Chapter Three, the term itself had entered the medical vocabulary through a complex series of social, cultural and nosological interactions. At first confined mostly to the leisured and professional classes, by 1914 it had apparently filtered down through the social strata to become a convenient and adaptable diagnosis for a wide range of diffuse physiological

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<sup>15</sup> For details of Pte.Simpson's ordeal before the civil authorities, see Chapter Four.



and neurological conditions. A pervasive characteristic of these in civil life had always been the marked degree of suggestibility present in patients, with a characteristic tendency to seize on the symptomatology of others to account for real or perceived disorders. The same phenomenon was observed in neurasthenic patients at the N.Y.D.N. Centres. However, the boundaries of neurasthenia as a disorder were imprecise to the point where a wide range of symptoms could be included and few were positively excluded. The list below illustrates the point.<sup>16</sup>

#### **Subjective symptoms:**

Head pains; usually of a chronic 'throbbing' type;

Dizziness;

Failing powers of concentration;

Defective memory (especially for detail);

Sense of 'helplessness' when faced with pressing decisions;

Chronic irritability;

Irregular sleep, with nightmares or 'riotous mental activity';

Constant sense of dread and anxiety.

#### **Objective symptoms:**

Fine tremor of hands, arms and head;

Tachycardia;

Irregular pulse.

Semi-dilation of the pupils with diminished reflexes;

Cutaneous hyperaesthesia, especially plantar;

Excessive sweating;

Vasomotor disturbances, often shown as pallid, cyanosed hands;

Pilo-motor reflexes such as 'gooseflesh' and marked erectility of hair follicles;

Recent loss of weight.

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<sup>16</sup> Macpherson, *Medical Services, Diseases*, pp.20-24.



The signs and symptoms were present to a greater or lesser extent in the majority of neurasthenic patients. One interesting difference between the experience recorded by the Official History, and the evidence revealed by the present study, is in respect of the condition referred to in the History as 'exophthalmos'. This term was and is still used to describe an abnormal protrusion of the eyeball, and is most commonly associated with 'hyperthyroidism', i.e., over-activity of the thyroid gland. The forward bulging of the eye exposes a larger area of the sclerotic coat - the white of the eye - giving rise to a characteristic staring look. According to the History, the condition was prevalent in neurasthenic patients to the extent that

...patients who exhibited exophthalmos...will be taken as the (neurasthenic) type. [...] In the more marked instances exophthalmos was pronounced and the thyroid gland was definitely enlarged...<sup>17</sup>

The present study found no recorded evidence of this symptom in the many cases of neurasthenia studied. In the course of analysing the 500 case histories, great care was taken to determine whether, in addition to any mental or nervous symptoms, the patient concerned suffered from, or had recently suffered from, any physical wound, injury or disease which might have had a bearing on the neuropsychiatric disorder. The rationale for this will be obvious. Trauma occasioned by acute or chronic suffering was liable to tax the patient's bodily resources, exacerbating mental and nervous symptoms in some cases to the extent of constituting the primary cause of the neuropsychiatric

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<sup>17</sup> Macpherson, *Medical Services, Diseases*, p.21.



complaint itself. However, in the 105 cases of neurasthenia and the 14 cases of traumatic neurasthenia analysed, only one makes any reference to dysfunction of the thyroid gland. This single case is summarised below.

Study Case No. 19

Archive reference: PRO/MH106/2101

2616 Private Parkister W.

Age: 25

Service: 4 months

Unit: 4<sup>th</sup> Battalion West Riding Reserve

Diagnosis: Neurasthenia

First hospitalised (during military service) 21 January 1915

Private Parkister was admitted to the 2nd. Northern General Hospital, Leeds, (a Territorial General Hospital) diagnosed as suffering from neurasthenia. He exhibited enlargement of the thyroid gland, and gave a history of having had several episodes of this condition over the preceding four years. Parkister enlisted on 18 September 1914, but found himself unable to keep up with his comrades during training. Other than tremulous hands, there was reportedly 'very little to see' on examination. He was kept at Leeds only four days, during which time the thyroid swelling subsided. He was discharged on 25 January 1915 as unfit for further military service. The only other mention of 'thyroid' occurred in a case, not of neurasthenia, but of shell shock. The details are as follows:

Study Case No.107

Archive Reference: PRO/MH106/2102/56656 <sup>18</sup>

1433 Rifleman Bullock W.

Age: 20

Service: Not stated

Unit: 'B' Company, 7th Battalion, Rifle Brigade

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<sup>18</sup> Medical Case Sheets kept at the Public Record Office which carry a five-digit reference number form part of the 'Representative Selection' of injuries and diseases of the Great War. (Class MH106, Pieces 2079-2129 and 2158-2384) The numbers do not appear to follow any recognizable pattern and are of no help in locating casenotes.



Rfm. Bullock was reportedly sent back from Flanders in May 1915 suffering from shell shock, but records of that episode have not survived. He was admitted to Dublin University V.A.D. Auxiliary Hospital on 7 August 1915.<sup>19</sup> The symptoms observed in this patient on admission and supervening during the course of almost a year in hospital included amnesia, mutism and other speech dysfunction; deafness, tremors of tongue, hands, arms and legs, hallucinations of sight and hearing, excitability, hyperactivity, abasia, astasia, disordered sleep, vertigo, depression and suicidal tendencies. Bullock's case is also distinguished by being the only instance of total hysterical blindness in the 500 cases analysed in the course of the present study.<sup>20</sup>

On 11 September 1915 Bullock was transferred to the King George V Hospital, Dublin, where his condition underwent a number of sometimes dramatic changes. In October 1915, for example:

(H)e suddenly...recovered speech and for 72 hours he remembered about his time in Flanders, forgetting meanwhile all he knew of the Dublin University V.A.D. Hospital where he was being cared for.

Just as abruptly he again forgot about his time in the trenches, his mental clock once again jumping back 72 hours. Some weeks later he became 'extremely depressed, actively contemplating suicide.' On the advice of 'Major W.D.Dawson R.A.M.C., Mental Specialist,' Bullock was treated with 'thyroid,

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<sup>19</sup> Bullock's is a striking example of the Army's often incomprehensible distribution arrangements for the sick and wounded. His home was in Reddish, near Stockport, Cheshire, (now Greater Manchester). During the 373 days of his hospitalisation in Ireland he was moved twice, but the advantages of transferring him to a suitable hospital nearer his home seem not to have been considered.

<sup>20</sup> In view of Bullock's symptoms, a diagnosis of hysteria rather than neurasthenia would seem more appropriate.



large doses, up to 60 gr(ains) in 24 hours.' After about a month of this treatment he was 'considered cured.'<sup>21</sup> This apparently miraculous recovery was not maintained. A period followed during which severe hysterical symptoms developed. These included great difficulty in sitting and standing, and at one stage Bullock fell down a flight of steps. He was transferred to Mercer's Hospital, Dublin, (a civilian hospital) on 15 February 1916, but made little progress there, 'despite thorough and constant treatment.' The nature of this treatment is not specified.

On 22 August 1916 Bullock was described as 'very shaky and nervous especially in the company of strangers.' He was unable to recall events of the previous day, suffered from general weakness of all his muscles, and was incapable of standing and walking unsupported. The military authorities seem to have decided to emphasise his physical, rather than his obvious mental and nervous difficulties in considering his final disposal. On 29 August 1916 he was examined by a Medical Board and discharged from the Army as "no longer physically fit for War Service". The fact that none of the casenotes studied mention exophthalmos cannot be taken as conclusive evidence that such a condition did not occur in any of the study group cases, only that the condition was not noted by the attending physicians. If, however, exophthalmus was as typical of the neurasthenic condition as the Official History suggests, its complete absence from the primary source records studied cannot as yet be explained.

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<sup>21</sup> Medical texts of the period advocate the use of thyroid extract, usually of calf or lamb, for some forms of insanity. In its modern form 'thyroxine' thyroid extract is used in the treatment of cretinism. (See Glossary).



This reservation is one which might be made of the study as a whole. Throughout the analytical process, the greatest possible care was taken to subject the medical records of each case to detailed scrutiny and, in particular, to extract as complete a symptomatology as possible. The amount of information to be extracted from any given case, however, depends entirely on the amount of information contained in the surviving records. As obvious as this might appear, the case of Rifleman Bullock is only one of numerous instances in which it was clear that potentially enlightening documents were missing, either because treatment centres failed to pass on casenotes when transferring patients, or that documents were discarded when the 'Representative Selection' was made, or for some other reason.

The emotional state of neurasthenic patients was generally anxious, worried and troubled, with a pervasive air of 'subdued excitement'. They possessed very little or no self-control, were highly suggestible, and were given to sudden fits of weeping for no apparent reason. Because of this greatly enhanced sensitivity, medical officers were urged to avoid suggesting symptoms to patients, relying rather on their own direct examination and observation. The aim of this policy was obvious - to avoid implanting symptoms in the suggestible mind:

A display of ignorant sympathy or an impressive medical examination would tend to produce or confirm all those symptoms which it was important to avoid. Once a man had received outside confirmation of his own introspective imaginings, a chronic state of neurasthenia was very apt to be induced.<sup>22</sup>

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<sup>22</sup> Macpherson, *Medical Services, Diseases*, pp.20 -1.



Neurasthenic patients were given bed rest, combined with symptomatic treatment and the 'simpler forms of psycho-therapy'. One of the symptoms which played 'a dominant part' in the overall syndrome of the neurasthenic patient was anxiety, often expressed in a conviction that he would never completely recover, or that he would be regarded as a shirker or a coward. Above all, the Official History maintains, was the fear that he would be made well only to the extent of being sent back 'to face the line again.' As a form of insurance against such an eventuality, patients were liable to become 'intensely introspective' and hypochondriacal, rehearsing their various complaints, 'to an almost nauseating degree'.<sup>23</sup>

In the great majority of the milder neurasthenic cases, treatment was based firmly on providing new interests and occupations, designed to replace the memory of recent experiences, rather than a process of abreaction, i.e., re-living and analysing the individual's experiences in the line. Therapy also included positive and repeated assurances by the medical officers to the patients that their symptoms were treatable and that they would recover. For the purely physiological symptoms, established remedies such as bicarbonate of soda for digestive disorders and extract of senna for constipation were employed. Disturbances of sleep were at first treated with 'a regular small dose of Bromide' but this was soon found to be largely ineffective and was discontinued. Instead, an occasional large dose when the symptoms became problematic was found to be more beneficial.

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<sup>23</sup> Macpherson, *Medical Services, Diseases*, p.34.



#### 7.4 Shell shock: practical treatment at a N.Y.D.N. Centre.

One of the most revealing accounts of how an N.Y.D.N. centre dealt with cases of shell shock appeared in *The Lancet* in August 1918.<sup>24</sup> The article is noteworthy on at least two counts. Firstly, it affords a rare comparison between officer and other rank casualties treated at the same centre and, secondly, it is unusually specific regarding the therapeutic strategies employed. From November 1916 to February 1918, William Brown, who in civilian life had been Reader in Psychology at King's College, University of London, was in charge of a N.Y.D.N. centre in France. During that time the centre processed 'between two and three thousand' cases of neurasthenia, hysteria and psychasthenia. The vagueness of the number is not explained, nor is it made clear how many cases fell into each category. Taking the numbers as 2500, however, the centre had treated something like 150 cases a month of all kinds. Also, both the title and text of Brown's article make it clear that it deals solely with the hysterical consequences of shell shock.

According to Brown, the fundamental processes involved in shell shock were mental and emotional. The intense and often sustained fear aroused by extreme violence and danger induced a loss of self-control and apparent unconsciousness. In cases of very near explosion and burial, this could be actual concussion unconsciousness. In cases of breakdown under sustained bombardment, however, insensibility was more often a mental flight from intolerable reality:

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<sup>24</sup> Brown W., 'The Treatment of Cases of Shell Shock in an Advanced Neurological Centre', *The Lancet* 17 August 1918, pp.197-200.



There is no real loss of consciousness, but the attempted repression and control of the fearful emotion at its inception brings about a splitting of the mind, which appears later as an amnesia of greater or less extent, often involving other losses of function also, such as dumbness, deafness, tremulousness or paralysis.<sup>25</sup>

One of the most controversial aspects of shell shock was the variability of the consequences following exposure to a near explosion, and the consequent response of different individuals. One man might be badly affected by a single near explosion, but would recover rapidly with no further trouble. Another might survive hours or days of heavy shelling with seeming impunity, only to break down as the result of a trivial and apparently unrelated incident. Brown's explanation for this disparity lay in his interpretation of contemporary psychological theories, particularly those of Jules Dejerine, the French neurologist, whose book on psychotherapeutic methods had been published in English in 1913.<sup>26</sup> According to Dejerine, the causative event was followed by a chronologically variable period of 'subconscious emotional development', during which:

The...emotional reaction develops gradually...as the patient's intellectual awareness...arouses by association early emotional memories. The symptoms that eventually arise are such emotional manifestations in a state of relative dissociation and permanence.<sup>27</sup>

In some cases, the 'incubation period' - the length of time elapsing between the incident and the appearance of hysterical symptoms - represented the subconscious struggle of the individual to repress the unpleasant memories.

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<sup>25</sup> Brown, 'Treatment of Shell Shock', *The Lancet*, 17.8.18., p.198.

<sup>26</sup> Dejerine J. and Gauckler. R., (Transl. Jolliffe S.J.) *The Psychoneuroses and Their Treatment by Psychotherapy*, Lippincott, (Philadelphia 1913).

<sup>27</sup> Brown, 'Treatment of Shell Shock', *The Lancet*, 17.8.18., p.198.



The actual manifestation of symptoms marked the culmination of that struggle and, paradoxically, represented both success and failure:

The final outbreak of symptoms represents the partial failure of this effort of repression, or rather is a condition of the success of the *psychological* repression. The symptoms are "conversion" symptoms, in Freud's sense of the term - i.e., they represent painful emotion converted into physical innervations.<sup>28</sup>

In the civilian context, this theory offers an attractive explanation. In the context of the Great War, however, its acceptability was complicated by the fact that the ability to 'stick it out' was universally regarded as an admirable quality, one worthy of the highest praise. Conversely, those who broke down at the first sound of the guns were - despite all the pleas for sympathy and understanding - objects of suspicion and contempt. In both the positive and negative cases, the patient's reactions were regarded as a matter of personal choice, not the involuntary helplessness of the Dejerine/Brown theory. Charles Myers, who had been Consulting Psychologist to the B.E.F., and from whom Brown acknowledged 'unfailing encouragement and most helpful advice', later took up a less tolerant position, much more critical of those who had broken down at an early stage, and warmly appreciative of those who had 'stuck it out'.<sup>29</sup>

### 7.5 The doctor as 'psychological traffic controller'.

An important aspect of the N.Y.D.N. therapy for shell shock cases was to firmly implant in the patient's mind the conviction that the absent functions had not been truly lost, but had been pushed by the trauma into a kind of mental railway

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<sup>28</sup> Brown, 'Treatment of Shell Shock', *The Lancet*, 17.8.18., p.198.

<sup>29</sup> The contrast between Myers' views during the Great War and those expressed in his *Shell Shock in France* in 1940, is dealt with at length in Chapter Six.



siding, along with the repressed emotions. It was therefore of little use attempting to retrieve the one without the other. Treatments which concentrated on restoring the purely physical functions through hypnotism, suggestion, or by physical means such as splints and supports, electrical stimuli, massage, warm baths, gymnastic exercises or whatever, were likely to be of limited permanent value, unless accompanied by effective psychological treatment.

The standard therapeutic regime was based on an early and exhaustive examination to establish the exact status of the patient's nervous system, and to identify any purely physical conditions which might inhibit treatment.<sup>30</sup> Alongside these went a sustained doctor/patient dialogue, the object of which was to force on the patient's consciousness the conviction that any loss of physical function was temporary, caused by an identifiable psychological motivator concealed within the mind. Once the patient ceased retreating from the painful memories and turned to face them, the power to feel, speak, hear and generally to control the bodily functions would also be regained. Secondly, the message of recovery was repeated at each consultation - 'forced upon the patient's notice' - arousing what Brown called the 'sthenic emotion' until the patient's consciousness was thoroughly suffused with the conviction that he would recover.

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<sup>30</sup> For example, serious ophthalmological defects were occasionally discovered, the effects of which had been misinterpreted as symptomatic of neurological disorder.



A therapeutic session would begin in the conventional way, with the patient lying on a couch and being urged to give himself up to sleep; told that he was getting drowsy, that his eyelids were heavy, and all the usual paraphernalia of the mesmerist's art. When fully relaxed, breathing deeply and regularly, the patient was deemed to be in 'a state of very light hypnosis, quite sufficient for my purposes.' The patient was then told that, when Brown's hand was placed on his forehead, he would be back in the fighting, and that he would live once again the experiences in which he had sustained the original trauma. Again, he was told, 'in a tone of absolute conviction' that Brown's words would come true. A hand was then placed on his forehead. At once the patient behaved as if he were back in the trenches. He would conduct one-sided dialogues 'like a person speaking at the telephone', interspersed with silences as if listening to a conversation by others. He would curse violently, shouting warnings to his comrades:

*In every case he speaks and acts as if he were again under the influence of the terrifying emotion.*<sup>31</sup>

The repressed memories were thus brought back with 'hallucinatory vividness'. According to Brown it was this immediacy, combined with the credibility previously established by the physician, which brought about the return of the lost functions.

Another distinctive feature of the N.Y.D.N. method was the technique of re-awakening the patient. Accepting that the original functional losses were of emotional rather than physical origin, and that they were due to a form of

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<sup>31</sup> Brown, 'Treatment of Shell Shock', *The Lancet*, 17.8.18., p.198, (Italics original).



'dissociation' as described above. It frequently happened that too deep a hypnotic state 'accentuates this dissociation', actually inhibiting the process of re-connecting the patient with his repressed memories, delaying or preventing altogether retrieval of physical functions. The primary objective of Brown's method was to force the patient to come to terms with his disability through a process of 'abreaction'. Rather than detaching the patient from reality, therefore, the aim was to keep him as closely connected as possible to contemporary events. Conversation, therefore, routinely included the events of the real world, his family, the hospital, the war and so on:

I always suggest at the end of the hypnotic sleep that he will remember clearly all that has happened to him in this sleep. More than this, I wake him very gradually, talking to him all the time and getting him to answer, passing backwards and forwards from the events of his sleep to the events in the ward, personalities of the sister, orderly, doctor and patients - i.e., all the time re-associating or re-synthesising the train of his memories and interests.<sup>32</sup>

Brown was at pains to distinguish his method from others employing suggestion without hypnotism. In such methods, he maintained, the patient tended to develop 'equivalent symptoms'. For example, when mutism had been cured by abreaction, the patient developed head pains or digestive problems. By combining suggestion with light hypnotism, Brown maintained, 'this tendency is completely eliminated.' The method just described was needed only for what Brown described as the more severe cases, i.e., those displaying the 'major hysterical symptoms.' In two series of 1000 patients, 173 such patients were treated in the first and 132 in the second. In the whole series, 121 patients

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<sup>32</sup> Brown, 'Treatment of Shell Shock', *The Lancet*, 17.8.18., p.199.



(6.05% of the total) suffered from hysterical mutism: Brown claimed to have cured '*every single one of these cases*'.<sup>33</sup>

## 7.6 Treating the 'confusional' and 'mental' states

Treatment in these cases closely followed the essentially physical approach adopted for similar conditions in the public asylum system, and was in sharp contrast to the psychotherapeutic methods adopted for the other groups. In the 'simple acute' confusional states the first priority was to overcome the typical intense excitement, preferably by prolonged bed rest. Once the early state of excitement and restlessness had passed, patients were usually able to 'volunteer a fairly complete account of themselves'. At this stage also, many of the objective and subjective symptoms noted in the neurasthenic group - particularly headache, disordered sleep, fatigue and extreme emotionalism supervened, and these were treated along similar lines. Convalescence usually consisted of a programme of 'graduated physical exercises' twice daily for several weeks, followed by a month's agricultural or other work in a back area before returning to duty.

In the more severe confusional states, confinement to bed 'as long as there (were) any traces of confusion' was mandatory, even if this meant forcible restraint. 'Regular feeding, free movement of the bowels, and the early securing of sleep by every means possible' were considered vital. Immersion in baths at temperatures of 103° to 105° F followed by doses of chloral hydrate, potassium bromide, veronal or paraldehyde, were routinely used to calm patients and

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<sup>33</sup> Brown, 'Treatment of Shell Shock', *The Lancet*, 17.8.18., p.199, (italics original)



induce sleep. In this group lack of interest in food was common, and 'forcible feeding' was not infrequently required. Alcohol exacerbated these states and was strictly prohibited. The Official History makes no reference to the eventual disposal of the more severe mental states. The schematic diagram in Figure 12, however, implies that the N.Y.D.N. Centres simply received these cases in order to render them reasonably quiet and manageable before transferring them to the Base.

As explained at the outset, the present research has failed to locate medical records from any of the N.Y.D.N. Centres located in France from the middle of 1916 onwards nor, as far as can be ascertained, has any other writer researched such records. Table 6 (page 221) shows how the Centres were attached for administrative purposes to Stationary Hospitals and Casualty Clearing Stations in the relevant Army areas. Medical Case Sheets for these - presumably including their attached N.Y.D.N. Centres - were destroyed in 1975.<sup>34</sup> Also, what is stated to be a comprehensive index of medical treatment units operating with the British Expeditionary Force in France during the whole of the war period, lists the 'parent' hospital or C.C.S., but makes no reference to N.Y.D.N. Centres.<sup>35</sup>

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<sup>34</sup> For details of this and the background to the present fragmentary state of British Army medical records for the Great War period, see Chapter Three.

<sup>35</sup> 'Location of Hospitals and Casualty Clearing Stations, British Expeditionary Force.' Unpublished typescript, Ministry of Pensions, London 13 July 1923, (author's collection).



## **PART FOUR**

# **CASUALTIES IN THE UNITED KINGDOM**



## CHAPTER EIGHT

### CRISES AND SOLUTIONS: THE ASYLUM WAR HOSPITALS SCHEME.

#### 8.1 General description.

Before the Great War, military hospitals in the United Kingdom provided approximately 7,000 beds: by the end of hostilities in November 1918, this number had risen to 364,133.<sup>1</sup> The Asylum War Hospitals Scheme was devised as part of this unprecedented expansion. As originally conceived, eleven public asylums in England and Wales were to be loaned to the War Office to be converted for use as military general and surgical hospitals, initially aiming to provide 15,000 beds. In its fully developed form, the Scheme involved 24 asylums, accommodating up to 31,000 patients, the great majority physically sick and injured:

At first there was no idea of making provision in these hospitals for men suffering from mental or nervous breakdown, but, as time went on it was found absolutely necessary to reserve a number of beds for such cases.<sup>2</sup>

This statement is slightly misleading, giving the impression that neuropsychiatric casualties did not emerge as a problem until well into the period of hostilities. In fact, the Moss Side Military Hospital, utilising a newly-built but unoccupied state institution, began admitting patients as early as 21 December 1914. Although the number of beds initially provided was only 300, the experience of adapting a mental institution to military use - even one that

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<sup>1</sup> Macpherson W.G., *et al*, (Eds.), *History of the Great War based on Official Documents: Medical Services: Diseases of the War*, H.M.S.O. (London 1923).p.71.

<sup>2</sup> Cooke M. and Bond C.H., *History of the Asylum War Hospitals Scheme*, Command 899, H.M.S.O., (London 1920) p.1.



had never held any patients - was to prove invaluable as a pattern for the much more ambitious scheme that was to follow.<sup>3</sup> In due course, ten institutions were listed as being wholly or partly given over to the treatment of mental and nervous disorders, between them dealing with 38,440 cases during the period of hostilities.<sup>4</sup>

Despite its scope and complexity, the Asylum War Hospitals Scheme as such, has almost entirely escaped scholarly attention. Leaving aside the official *History* of Cooke and Bond, the only contemporary comment on the scheme is that of Thomas W. Salmon, who studied British arrangements for the care of neuropsychiatric casualties on behalf of the U.S government in 1917. Anticipating that a similar scheme might well become necessary in his own country, Salmon's meticulously detailed report included a full description of the scheme.<sup>5</sup> A number of modern authors of academic theses and of published works cite his report with approval, but these references are confined to Salmon's often sharply critical view of the administrative and policy aspects of the British arrangements. Speaking of the difficulties already facing asylums on the eve of the Great War, Kathleen Jones has noted:

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<sup>3</sup> For discussion of the influence of Moss Side and its Commanding Officer, R.G.Rows, see Chapter Ten.

<sup>4</sup> Cooke and Bond, *Asylum War Hospitals*, pp. 49-50. In addition to the 10 listed institutions, neuropsychiatric cases were treated at 'Smaller Sections of other War Hospitals' but these are not identified.

<sup>5</sup> Salmon T.W., 'The Care and Treatment of Mental and Nervous Disorders and War Neuroses ("Shell Shock") in the British Army, The Mental Hygiene War Work Committee of the National Committee for Mental Hygiene, (New York 1917).



In all areas there was overcrowding. This became worse in 1915, when nine of the larger asylums were transferred to the War Office as emergency military hospitals. The remaining mental hospitals became crowded with displaced patients. Standards of care suffered from lack of space and lack of staff, and the tuberculosis rates rose alarmingly.<sup>6</sup>

The fact that the Asylum War Hospitals Scheme has so far been unresearched means that the account given in the following chapter is more descriptive and narrative than would normally be desirable. In all cases, however, the inferences drawn are supported by such relevant contemporary sources as are available, and by authoritative secondary sources on asylums generally. On the basis of statistics alone, it is clear that the Asylum War Hospitals Scheme played a central role in the treatment of mental and nervous disorders of the Great War. Less obvious, but potentially of equal importance, was its role in providing the vehicle by means of which asylum medical officers, through their wartime experience, were able to lay claim to the practice of general psychiatry in Britain. It was on these factors that the subsequent controversy was to become focused.<sup>7</sup> In order to appreciate the nature and scope of the scheme, however, and to set these developments firmly in their contemporary context, a brief general description is a necessary preliminary.

## 8.2 The Scheme: crisis and conception.

The Asylum War Hospitals Scheme was conceived in early 1915 in response to the unexpectedly large numbers of casualties being returned to the United Kingdom. Initially, these pressures were met by increasing the accommodation at existing military hospitals, particularly at the 23 Territorial General

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<sup>6</sup> Jones K., *Asylums and After*, Athlone, (London 1993), p.124.

<sup>7</sup> For a fuller discussion of this controversy, see Chapter Nine.



Hospitals located throughout the United Kingdom, all of which had been mobilised on 3 August 1914. Subsequently, a number of measures had been forced on the authorities in order to increase the number of beds available. The amount of bed-space allotted to each patient was reduced; beds were moved into day rooms and recreation areas and, where the nature of the site permitted, R.A.M.C. 'other ranks' were moved into tented accommodation.<sup>8</sup>

At mobilisation, each of the Territorial General Hospitals provided 520 beds, a total of 11,960 nationwide. In most of the Territorial areas, however, accommodation for these hospitals had been found by requisitioning buildings such as schools, colleges, Poor Law infirmaries, workhouses, lecture halls and the like. This was supplemented by an emergency expansion programme in the many small depot and garrison military hospitals up and down the country, and by setting aside wards in civilian hospitals for military use. By these means, the total number of beds available at the end of December 1914 had risen to 16,702.<sup>9</sup> The Territorial and other military hospitals made strenuous efforts to expand as fully as they could. In many areas, however, the potential for physical expansion was strictly limited. In any case, expansion into a large number of physically separated buildings created problems of communication and efficient nursing.

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<sup>8</sup> Harrison L.K., 'History of the 5th Northern General Hospital' Unpubl. typescript, Leics. County Record Office, Ref. LM/11/8/TS 1919, pp. 12, 24-5.  
Hopkins J.R. 'Leicester's Great War Hospital', Unpubl. M.A.Dissertation, University of Leicester, (1995), pp.36 & 67.

<sup>9</sup> Macpherson, *Medical Services, Diseases*, pp.72-3.



The situation worsened daily. Between the commencement of hostilities on 4 August and the end of December 1914, 73,555 sick and wounded had been received from the Expeditionary Force in France alone, and it was clear that very large numbers of additional beds would be needed.<sup>10</sup>

Towards the end of January 1915 the Army Council contacted the Board of Control, drawing attention to the need for at least 50,000 more hospital beds, and seeking urgent assistance. The Board immediately prepared a scheme, the effect of which would be to provide about 15,000 beds. This was to be achieved by evacuating patients from a number of what were to be known as 'vacated' asylums. The displaced patients would be distributed amongst 'receiving' asylums in as localised a region as possible. It was realised at the outset that such a scheme would mean an enormous amount of work by the Board and those asylums selected for clearance. It would also involve extreme inconvenience, if not real hardship, for the receiving asylums, the displaced patients and for their families.

In contemplating such a scheme, the Board of Control faced a number of singular difficulties. Generally speaking, public asylums were designed to be self-sufficient institutions, complete with their own laundries, workshops, farms and market gardens - walled city-states in fact, the purpose of which was not to keep would-be intruders out, but to contain the insane populace and their overseers. Most, if not all, of the things needed for the feeding, clothing, health and welfare of the inmates was produced 'in-house', the management

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<sup>10</sup> Macpherson, *Medical Services, Diseases*, p.388.



of which was a vital part the asylum economy. The manual labour needed to sustain these isolated communities came substantially from the inmates themselves, with many asylums finding it 'easier to get inmates to contribute to the...running of the institution' than to release them into the outside world.<sup>11</sup> Drawing on its unique experience, the Board of Control was able very quickly to draw up a scheme, which involved the clearing of nine asylums, and the dispersal of their patients to 92 asylums throughout England and Wales.

### 8.3 Geography and grouping

The following (in italics) are the asylums to be vacated in each geographical region, together with the designated 'receiving' asylums to which the patients were to be dispersed.<sup>12</sup>

#### GROUP 1

*Newcastle-on-Tyne County and City Asylum; Northumberland County Asylum; Durham County Asylum; Sunderland Borough Asylum; York City Asylum; Middlesborough Borough Asylum; Gateshead Borough Asylum; North Riding of Yorkshire Asylum; Cumberland and Westmoreland Asylum.*

Total: 9 asylums

#### GROUP 2

*West Riding of Yorkshire Asylum, Wadsley; West Riding of Yorkshire Asylums, Menston; Scalebor Park; and Storthes Hall; East Riding of Yorkshire Asylum, Beverley; Nottingham City Asylum; Leicester Borough Asylum; Hull City Asylum; Lincolnshire (Bracebridge) County Asylum; Lincolnshire (Kesteven) County Asylum; Nottinghamshire County Asylum; Leicestershire and Rutland County Asylum.*

Total: 12 asylums

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<sup>11</sup> Jones K., *Asylums and After*, pp.119-20.

<sup>12</sup> Cooke and Bond, *Asylum War Hospitals*, pp.3-4.



**GROUP 3**

*Lancashire County Asylum, Winwick; Lancashire County Asylums, Lancaster; Rainhill; Prestwich; and Whittingham; Chester County Asylums, Chester and Parkside; North Wales Counties Asylum, Denbigh; Derby County Asylum; Derby Borough Asylum.*

Total: 10 asylums

**GROUP 4**

*Birmingham City Asylum, Rubery Hill; Birmingham City Asylum, Winson Green; Staffordshire County Asylums, Stafford; Burntwood; and Cheddleton; Shropshire County Asylum; Warwick County Asylum; Worcester County and City Asylum, Powick; Worcester County Asylum, Barnsley Hall; Oxford County Asylum; Northampton County Asylum.*

Total: 12 asylums

**GROUP 5**

*Norfolk County Asylum; Norwich City Asylum; Suffolk County Asylum; Ipswich Borough Asylum; Essex County Asylums, Brentwood and Severalls; West Ham Borough Asylum; Cambridge County Asylum; Three Counties (Bedfordshire, Hertfordshire, and Huntingdonshire) Asylum; Hertfordshire County Asylum; Buckinghamshire County Asylum.*

Total: 11 asylums

**GROUP 6**

*Cardiff City Asylum; Gloucester County Asylum; Monmouthshire County Asylum; Glamorgan County Asylum; Joint Counties Asylum; Carmarthen; Hereford County Asylum; Newport Borough Asylum; Brecon and Radnor Asylum.*

Total: 8 asylums

**GROUP 7**

*West Sussex County Asylum; Hampshire County Asylum; Berkshire County Asylum; East Sussex County Asylum; Kent County Asylums, Barming Heath and Chartham; Portsmouth Borough Asylum; Brighton Borough Asylum; Canterbury Borough Asylum; Isle of Wight County Asylum.*

Total: 10 asylums

**GROUP 8**

*Bristol County and City Asylum; Dorset County Asylum; Somerset County Asylums, Wells and Cotford; Plymouth Borough Asylum; Wiltshire County Asylum; Devon County Asylum; Exeter City Asylum; Cornwall County Asylum.*

Total: 9 asylums

**GROUP 9**

*London County Asylum, Horton; London County Asylums, Banstead; Cane Hill; Colney Hatch; Hanwell; Long Grove; Bexley; Claybury; Ewell; and Manor, Epsom.*

Total: 10 asylums



In selecting asylums for conversion the guiding principle was that as far as practicable, the burden should fall equally on all the asylums in England and Wales.<sup>13</sup> It was also important to select, as far as possible, the more modern institutions, which would lend themselves most readily to rapid conversion. This was important later on, when mental and nervous casualties began to be treated. For this category, the 'villa' or 'colony' type of institution, where a series of wards in separate buildings surrounded a central administrative complex, was found to be most useful. In such buildings, it was possible to safely accommodate all grades of patient, from those in the very earliest stages of illness to the seriously disturbed.

Although it was no easy task to find places for these hundreds of insane patients, a much more difficult one lay in the redeployment of the staffs of the vacated asylums, and their integration into the strictly maintained hierarchies of the receiving asylums. The Board decided on a radical solution. Rather than hand over totally vacated buildings, it was proposed that the whole of the incumbent staff - medical, nursing, maintenance and ancillary - should be kept on and, in various ways, assimilated into the military medical services. This was a fundamental departure from what by this time was a fairly well established practice. Following mobilisation of the 23 Territorial General hospitals, it had been necessary to requisition public buildings of all kinds, and to staff and equip them as military general hospitals. The War Office therefore

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<sup>13</sup> Cooke and Bond, *Asylum War Hospitals*, p.2. Their *History* refers only to England and Wales.

Salmon, (q.v.) also lists asylums in Scotland (Renfrew and Paisley) and in Ireland (Belfast) as having been converted for military use and re-named 'War Hospitals'. As far as is known, no account of these has been published.



possessed considerable experience in this area, and there is no reason to doubt its ability to cope with wholly vacated asylums.

From the War Office's standpoint, however, the situation was not only one of extreme urgency, it was also one of considerable delicacy. Although the Board of Control was able to draw up the scheme and to urge its adoption on local authorities, it could not order asylums to be relinquished without the passing of primary legislation. Even if such a course had been contemplated, events in the fighting zones brooked no delay. The only practicable way of ensuring the willing co-operation of all concerned was to work through opinion leaders in the asylum service, particularly the Medical Superintendents of the larger asylums, and the Chairmen of Visiting Committees. At the same time, it was important that these opinion leaders should not feel themselves the victims of a *fait accompli*. On 1 February 1915, the Board called together eight 'more experienced' Medical Superintendents representing the proposed groups,<sup>14</sup> to explain the proposals and to enlist their support.

#### **8.4 Opportunity and opportunism.**

It was at this initial conference that the subject of military commissions for asylum medical staff was first raised. After supporting the proposals in principle, the Medical Superintendents went on to agree that:

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<sup>14</sup> For unstated reasons, the London Metropolitan group was not represented.



...the groupings of the asylums as suggested was satisfactory and that steps should be at once taken to promote the loan of the selected asylums to the Army Council...that the entire staffs of officers, attendants, nurses and servants should remain attached to each vacated asylum and form a part of the war hospital...and that in the interests of discipline it was desirable that all the Asylum Medical Officers...should be accorded temporary military rank.<sup>15</sup>

At this stage, the idea that the Medical Superintendents of the vacated asylums should actually be put in charge when they became military hospitals, seems not to have been postulated. A further conference was proposed, involving the 'Chairman, Clerk to the Visitors, and Medical Superintendent of each asylum represented', together with 'a few other' Medical Superintendents from other asylums. This conference was duly held on 8 February 1915. After recording their support for the idea that the entire staff should 'remain and be utilised' some additions were made to the earlier list, the most significant of which was that:

Visiting Committees should, in conjunction with the War Office, undertake the equipment of the asylums as far as might be necessary for the purposes of military hospitals, augmenting the staff with a sufficient number of trained hospital nurses.<sup>16</sup>

Although apparently no more than a helpful suggestion, the implications of this were profound. Rather than surrendering the asylums to be staffed, equipped and run by the military as they saw fit, what was now being proposed was that the new War Hospitals should be in effect a joint venture. More than that, the language suggests that the asylum authorities regarded themselves as the senior partner in the project. If accepted, the effect would be that the asylum authorities would retain a very substantial measure of control over the running

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<sup>15</sup> Cooke and Bond, *Asylum War Hospitals*, pp.4-5.

<sup>16</sup> Cooke and Bond, *Asylum War Hospitals*, p.5.



of what were intended to be military hospitals. On 9 February, (the day following the second conference) the Board of Control wrote to the Visiting Committees of all the asylums affected by the scheme, informing them of the proposals, and formally requesting their co-operation. This having been pledged, the actual work of clearing the vacated asylums of patients could begin.

For many patients the asylum had been their home for many years. Many had never seen, much less travelled in a train or bus. Some had been committed as children and had known no other home, nor any guardian other than the nurses and attendants; the scenes on separation were often 'sadly pathetic'. D.G.Thomson, Medical Superintendent of the Norfolk County Asylum, recorded something of the scenes during the exodus:

...the whole gamut of emotions was exhibited...ranging from acute distress and misery, through gay indifference, to maniacal fury and indignation. Personally...I did not realise the strong mutual attachment till it was severed.<sup>17</sup>

By the end of the first week of March 1915, that is, within five weeks of the War Office's first approach to the Board of Control, all the necessary administrative machinery was in place. Local meetings had determined the numbers of patients to be placed in each receiving asylum; a policy on new admissions had been agreed, and the War Office had inspected and had formally accepted the offer of the vacated institutions.<sup>18</sup>

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<sup>17</sup> Cooke and Bond, *Asylum War Hospitals*, pp.55-6. In an address to the Medico-Psychological Association on 27 July 1916 the President, Sir George Savage, stated that some male patients had been discharged and had enlisted in the Forces, only to break down in training or in their first days at the front. See: *The British Medical Journal*, 5 August 1916, pp.179-80.

<sup>18</sup> Cooke and Bond, *Asylum War Hospitals*, p.7.



By the end of March, the Army had assumed control of eleven asylums for use as War Hospitals, between them providing over 14,000 beds. In addition to the nine listed above, two further premises had been offered by the Board of Control and accepted. The larger, situated at Whalley, Lancashire, was in the process of commissioning; its acquisition provided a welcome 2000 additional beds. The eleventh asylum was a physically separate division of the Birmingham City Asylum at Rubery Hill, and added a further 700 beds. Even at this early stage, therefore, practically all the public asylums in England and Wales were involved in the scheme; totally, in the case of the nine vacated asylums, or partially, at the 82 receiving asylums.

#### **8.5 Staffing the War Hospitals: opportunism and opposition.**

Evacuation of some 12,000 patients from the nine asylums, 'including many who were dangerous and violent' had been carried out without incident. The only patients remaining were a small number who at the time were too ill to be moved, together with those who were to be retained to work on the farms and gardens.<sup>19</sup> While this was going on, negotiations between the Board of Control and the War Office continued, in order to agree how the huge costs of the scheme were to be distributed. At this stage the Board of Control took a decisive lead, putting forward proposal which the War Office must have found too tempting to refuse.

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<sup>19</sup> Cooke and Bond, *Asylum War Hospitals*, pp.5-6. The total number of patients retained for this purpose within the scheme is not given. It is known, however, that 23 were kept on at the Norfolk War Hospital. The total overall may therefore have exceeded 500.



The Board offered to assume sole responsibility for 'adapting, organising, equipping and staffing' the vacated asylums, as well as arranging for their subsequent management. This was to include negotiating contracts for the physical adaptation of the buildings, organising the purchase of equipment and stores, arranging for the whole of the necessary financial structure, and the provision of advice and assistance to the local authorities in each area. A lengthy and detailed draft agreement was then sent to the War Office for approval.<sup>20</sup>

The draft included paragraphs, the effect of which was to ensure that management of the War Hospitals would remain in the hands of the Board of Control. At national level, the Board was to act as the sole representative of the asylum system, the agency through which all negotiations with the War Office were to be conducted. At local level the Board's authority was to be exercised by the relevant Visiting Committee. It was pointed out to the War Office, for example, that all asylum staff were in 'established pensionable employment' and that it was 'necessary that their Asylum service should be unbroken'.<sup>21</sup> This was only one of many semantic levers which the Board used to persuade the War Office to their point of view, with the clear objective of insinuating their nominees into positions of authority.

On the staffing issue, the Board had pointed out that the Medical Superintendent, under the direction of the Visiting Committee, was 'the head and director of the asylum administration', and that 'In most instances [he]

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<sup>20</sup> Cooke and Bond., *Asylum War Hospitals*, Schedule A, pp.9-10.

<sup>21</sup> *ibid.*, p.10.



will no doubt be appointed by the War Office to be the officer in charge of the Hospital.' The War Office apparently had no rooted objection to such appointments being made; whatever doubts may have been entertained concerning the professional competence of these men, they were not voiced. However, the War Office insisted on the words 'under the General Officer Commanding in Chief of the Command concerned' being entered into the heads of agreement. This was a reminder to the Board of Control and to local authorities that, whatever special measures might be agreed under the pressures of war, the Army remained the ultimate disciplinary power.

By taking the initiative in the negotiations throughout, the Board of Control had managed to gain acceptance for most of its proposals. In all but one case, Medical Superintendents were appointed as Commanding Officers, with Visiting Committees exercising complete control of 'the business side' of the new hospitals. To that extent, the practical relationship between the Board, the Visiting Committees and the asylum medical staff retained much of its previous character. It was also proposed that those male attendants who were eligible for military service would be drafted into the R.A.M.C. if they wished, and many chose to do so as a means of 'doing their bit'.<sup>22</sup> In the matter of female nursing staff, however, the asylum authorities' proposals suffered a major setback.

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<sup>22</sup> This course had been adopted when the Moss Side State Institution at Maghull was handed over to the military in December 1914.



## 8.6 Problems with nursing services.

The most obvious difference between the hospital and asylum environments was their approach to the treatment of the sexes. In general hospitals men and women were treated as a matter of course by female nurses. Particularly in the older asylums there was a 'male side' dealt with by male 'attendants', and a 'female side', the exclusive province of female 'nurses'. Other differences were that in asylums, acute infections and gross injuries were rare: the knowledge of anatomy and physiology important to a hospital nurse was therefore largely unnecessary. In asylums female nurses usually supervised the laundry: where patients were capable they taught their charges sewing, knitting and other domestic skills, largely as a means of keeping them occupied. As a matter of necessity, male asylum attendants also carried out nursing duties on the 'male side', but, in addition, undertook duties as diverse as supervising the boot-making and tailor's shops, as well directing the work of asylum farms and market gardens.<sup>23</sup> The other singular difference between asylum and hospital nursing staff was, of course, the question of security. No asylum attendant or nurse was properly dressed without his or her bunch of keys. In some asylums, staff were held responsible for security to the extent that, if an escape was shown to have been caused by the negligence of an attendant or nurse, the cost of recapturing the escapee was deducted from his or her wages.<sup>24</sup> Asylum and hospital nurses therefore inhabited quite different worlds. For the hospital nurse, qualification by examination was a necessary

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<sup>23</sup> Nolan P., 'Mental Health Nursing in Great Britain', in Freeman H. and Berrios G.E., (Eds.) *150 Years of British Psychiatry: Volume 2, the Aftermath*, Athlone, (London 1996), p. 177.

<sup>24</sup> Orme G. and Brock W.H., *Leicester's Lunatics*, Leicestershire Museums Publication No.87. (Leicester 1987), p.51.



prerequisite to her career. Following a brief flowering in the later years of the nineteenth century, interest in asylum nursing qualifications rapidly waned following the introduction of the 1890 Lunacy Act. Since only those actually certified as insane could be admitted, the result, according to Nolan, was that the nature of asylum populations changed from being a mixture of mild to severe conditions, becoming predominantly those with:

...far-advanced and florid mental illnesses. (N)ursing became primarily a job of controlling inmates, maintaining order on the wards and managing large numbers of very seriously ill people as efficiently (not necessarily as humanely) as possible. The position of qualified nurses was exactly the same as that of the untrained attendants.<sup>25</sup>

Only a few of the more self-motivated asylum nurses bothered with qualifications and certificates at all, and those who did so were not necessarily at an advantage. For these and similar reasons, professional nursing qualifications were historically regarded as much less relevant in asylum work than in general nursing.

Only a year or so before the outbreak of war, asylum doctors - particularly the junior ranks who had recent hospital experience to draw on - were complaining of the poor quality of nursing with which they had to contend. In a letter to *The Lancet* 'Reform' complained of 'the great lack of medical atmosphere', and the fact that few asylum infirmaries practised

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<sup>25</sup> Nolan, 'Mental Health Nursing', p.179-80. Prior to the passing of the 1919 Nurses' Act, the Medico-Psychological Association had offered a basic qualification in asylum nursing. After 1919 both it and the General Nursing Council's certificate were available. Possession of neither, Nolan contends, was a prerequisite for employment as an asylum nurse.



nursing 'as is ordinarily understood'.<sup>26</sup> In a subsequent letter, this same correspondent maintained that, in his experience, female asylum nurses were 'mainly recruited from the domestic servant class' and male attendants 'from agricultural labourers [and] ex-privates in the army, etc.'

Most excellent people, indeed, but often very deficient in the preliminary education so necessary if they are to benefit from training in nursing.<sup>27</sup>

Within the isolated world of the asylum service these shortcomings were of only marginal concern. With their patients gone, and their asylums about to be transformed into military hospitals, the question of their competence became immediate and challenging. The problem was compounded by the fact that the pattern of nursing provision in military hospitals had been planned before the war, was thoroughly understood and accepted, and had been implemented in the hundreds of existing military hospitals up and down the country. It involved relatively small cadres of the Queen Alexandra's Imperial Military Nursing Service, (Q.A.I.M.N.S.), or the Territorial Force Nursing Service, (T.F.N.S.). These were the military nursing elite. They functioned essentially as nursing management, wore a distinctive uniform, and were referred to as 'Sister'. The auxiliary element of the military nursing corps consisted of members of the Voluntary Aid Detachments - 'V.A.D.s' as they were popularly known. These were organised on a county basis and had been authorised by the War Office in 1908 along with the Territorial Force itself. V.A.D.s received training in basic

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<sup>26</sup> *The Lancet*, 12 April 1913. p.1054. Understandably, none of the Assistant Medical Officers who wrote on these issues were prepared to reveal their identities.

<sup>27</sup> *The Lancet*, 26 April 1913, p.1195. For further comment on the quality of asylum nurses and attendants, see Orme and Brock, *Leicestershire's Lunatics*, pp.46-8.



military nursing skills through lectures, demonstrations, simulated emergencies and annual 'camps'.

The agreement between the Board of Control and the War Office anticipated the need for 'hundreds of trained hospital nurses and probationers.' As with all other aspects of management, this problem had been delegated to local Visiting Committees, and was solved, in the case of professional nurses at least, by ordinary means. Appeals were made through training schools and associations, advertisements were placed in medical and nursing journals. The 'magnificent' response of nurses eager to serve was such that some London War Hospitals were 'able to pick and choose'.<sup>28</sup> In some cases, where recruitment was less satisfactory, Education Authority school nurses were seconded to War Hospitals for the duration of hostilities. Recruitment of V.A.D.s was a relatively easy matter, and was effected as elsewhere through the appropriate county organisation.

It was in accommodating the incumbent female asylum nurses that difficulties arose. Despite the limitations referred to above, many of these women had been in the asylum service for long periods, and felt themselves badly treated. The established military nursing hierarchy, however, did not regard their asylum experience as relevant:

All the asylum nurses, however great their experience in nursing bodily illness in insane patients, were classed as probationers and had to work - sometimes in wards of which they themselves had had charge - under the supervision of the trained sisters and trained hospital nurses, a trying position for them.<sup>29</sup>

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<sup>28</sup> Cooke and Bond, *Asylum War Hospitals*, p.57.

<sup>29</sup> *Ibid.*, p.20.



According to Thomas Salmon 'some friction developed', particularly in the case of the older asylum nurses, who naturally felt their summary demotion very keenly.<sup>30</sup> As frustrating as the Army's decision must have been in those hospitals devoted to the treatment of physical injuries and diseases, it must have been doubly so in the War Hospitals used for the treatment of neuropsychiatric casualties. Unfortunately, Cooke and Bond's *History* offers no insights into how these conflicts were resolved. Of the nine asylums vacated in the first phase of the scheme, four were shortly afterwards used for the treatment of neuropsychiatric casualties. Of the 24 institutions eventually involved in the scheme, ten were wholly or substantially used for this purpose.<sup>31</sup>

### 8.7 War Hospital treatment of neuropsychiatric casualties.

According to Cooke and Bond, the *History* which was eventually published in 1920 was intended to be more comprehensive. In particular, it was to include extended reports by the Commanding Officers of all the War Hospitals, including those devoted to the treatment of neuropsychiatric casualties. Probably in order to restrict costs, Cooke and Bond were obliged to 'abandon that idea' and, in the event, only extracts were printed.<sup>32</sup> Frustratingly, those extracts relating to neuropsychiatric hospitals seem more concerned with matters such as transport, catering, recreation and entertainment and the

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<sup>30</sup> Salmon T.W., 'Mental and Nervous Disorders and War Neuroses ("Shell Shock") in the British Army', Appendix 2, p.11.

<sup>31</sup> These were the Lord Derby, Welsh Metropolitan, Napsbury and Springfield War Hospitals.

<sup>32</sup> Cooke and Bond, *Asylum War Hospitals*, p.40. Research has so far failed to locate Cooke and Bond's original source material.



actual process of converting asylums, than with methods of treatment and their results. Lt.-Col. Rolleston, who commanded the Napsbury War Hospital throughout, either chose not to furnish Cooke and Bond with a report at all or, for some reason, they elected not to include an extract from it. This is doubly frustrating, since it is in relation to Napsbury that so much primary source material has survived.

A notable exception to the above comment is the report of R.G.Rows at Moss Side. Rows was in any case a lucid and concise writer, and his report goes into considerable detail concerning the rationale and practical methods of the therapies adopted at his hospital. Rows's reputation is such that there exists a considerable body of scholarly work on the man himself, and on the influence of Moss Side in the development of Great War neuropsychiatric medicine. These previous studies, however, have overlooked Row's important contribution to Cooke and Bond's *History*. Given the importance of Moss Side as a treatment centre, and the personal influence of Rows as a practitioner, it was thought more appropriate to deal with these subjects separately.<sup>33</sup>

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See Chapter Ten.



## CHAPTER NINE

### STIGMATIZED SOLDIERS: SARAH ELIZABETH WHITE AND THE ASYLUM DOCTORS.

#### 9.1 Background

On the eve of the Great War, psychiatry in Britain was in a state of flux, striving to find its feet in a rapidly changing professional medical environment. New ideas from the continent were gaining currency, and the concept of a curative system of mental health, outside the walls of institutions, was increasingly being urged. To add to the sense of anticipation and change there were those in influential positions inside the asylum system itself - Rows at Lancaster, Armstrong-Jones at Claybury, Bedford Pierce at the York Retreat, Hart at Long Grove and Goodall at Cardiff - who wrote and spoke strongly in favour of reform.

As far back as 1908, Hart had described the 'fascinating vista' opening up before mental health specialists as the result of the ideas of Freud and others, and had urged the necessity for challenging the physiologically-based assumptions of the past:

...we must act against the most cherished dogma of the alienist, the opening statement of almost every text-book: "Insanity is a disease of the brain" [...] To regard this conception as a unique and ultimate end, and to infer from it that the field of psychiatry must be reduced to a narrow path, is totally unjustifiable.<sup>1</sup>

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<sup>1</sup> Hart B., 'A Philosophy of Psychiatry', *The Journal of Mental Science*, Vol. 54, July 1908, p.481.



In the spring of 1912 the correspondence columns of the medical press were taken up with a debate on the value of psychiatric clinics for the early treatment of mental disorders. The main argument from those in favour of such clinics was that treatment given before aberrant behaviour became fixed and habitual, or before the patient lost contact with reality, stood a much better chance of effecting an improvement or even a cure. It was pointed out that under the terms of the 1890 Lunacy Act, the asylum system could only be invoked as and when the patient became certifiably insane, by which time the prospect of a cure was lost or greatly diminished.

Edwin Goodall, as Medical Superintendent of the recently re-named 'Cardiff Mental Hospital' might be expected to favour the *status quo*, spoke of Britain's backwardness in this respect:

[The psychiatric clinic] ...is indispensable. A country that has not got one is, in matters psychiatric, not a leading country. [...] Is it not a little humiliating that one of the subjects selected for discussion in the Section of Psychiatry of the International Congress of Medicine, 1913, should be "The Psychiatric Clinique" [...] I am far from blaming those (amongst whom I happen to be one) who prepared for us this cup of bitterness.<sup>2</sup>

Despite growing confidence on the part of those who advocated the adoption of the 'New Psychiatry', the landscape of mental health in Britain was still dominated by the asylum system, grown during the nineteenth century to the stage where, in 1914, there were 97 public lunatic asylums in the United

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<sup>2</sup> *The Lancet*, 20 April 1912, p.1089.



Kingdom, housing close on 110,000 publicly funded 'pauper' patients.<sup>3</sup> All these had been certified as 'insane' under a system which depended crucially on the statutory involvement of the medical profession. For the mentally ill without the means to pay for treatment, there was no relief to be had outside the asylum.

This is not to suggest, however, that British medical minds were universally closed to new ideas. Those of Sigmund Freud and the 'Vienna School' of psychiatry, for example, were widely known and (not always sensibly) debated. Many inside and outside the asylum system were concerned that nothing was being done either to prevent mental illness, or to treat mental illness in its early stages. For the medical profession as a whole, however, involvement in mental illness was largely confined to the certification process. Speaking to medical students in early October 1914, C.H.Bond, Commissioner of the Board of Control and later co-author the *History of the Asylum War Hospitals Scheme*, admitted that the customary brief clinical demonstrations at the nearest asylum, which was all that medical students could expect on the subject, was woefully inadequate:

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<sup>3</sup> For contrasting views of the position of psychiatry in Britain see: Bond C.H., 'The Position of Psychiatry and the Role of General Hospitals in its Improvement', *The Lancet*, 17 October 1914, pp.935-40 and; Stoddart W.H., 'The New Psychiatry' *The Lancet*, 20 March 1915, pp.583-90, 27 March 1915, pp.639-43 and 3 April 1915, pp.689-92.



[The student] learns something of the classification of mental diseases, of diagnosis...and of their treatment, and is instructed in the mode of filling in certificates of mental unsoundness. [...] But what he almost wholly misses is an opportunity of seeing those borderland and incipient cases, with the difficult technique of whose examination he should have, if not a familiarity, at least an acquaintance.<sup>4</sup>

It should be emphasised that Bond's interest in reform centred on providing clinics in general hospitals as a means of giving students the opportunity of seeing the milder forms of mental disease, rather than only full-blown insanity. Limited reform of this kind was also favoured by prominent figures such as Sir George Savage. Although aware of the potential threat to the *status quo* posed by the advent of the 'New Psychiatry' Sir George argued for their assimilation into the existing mental health structure, believing that alienists like himself were best fitted to judge their worth.<sup>5</sup>

While Sir George Savage was defending the record of the existing mental health system, the foundations of professional alienism were already showing signs of instability. In striving for recognition as an integral part of general medicine, alienists - increasingly anxious to be described as 'psychiatrists' - emphasised the physiological basis of their specialism. Insanity, it was maintained, was a somatic disorder like measles or bronchitis. All that was needed to effect a cure was to identify, by means of 'hands on' investigation and experimentation, the relationship between the symptomatology of the patients, and the physical cause or causes.

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<sup>4</sup> Bond C.H., 'The position of psychiatry and the role of General Hospitals' *The Lancet*, 17 October 1914, p.937.

<sup>5</sup> For discussion of Savage's views of continental psychiatry, see Chapter Two (esp. pp. 36-40) and *The Lancet*, 26 Oct. 1912, pp.1134-7.



This was the basis on which the asylum doctors claimed their place in the medical firmament; not only as experts in the management of madness, but also as the logical repository of all expertise on the subject of mental health. Within the asylum medical service generally, however, only a handful of practitioners like Bernard Hart had grasped the implications of the 'New Psychiatry' and were striving to alert the deeply conservative majority to its potential. The very nature of asylum work precluded the kind of intimate personal contact and the heavy investment of time which the new psychiatric therapies demanded. As Andrew Scull has pointed out:

The notion that insanity was caused by organic lesions of the brain remained a vital prop for the asylum doctors' contention that it was essentially and incontestably a medical problem.<sup>6</sup>

Outside the asylum walls, however, new thinking from the continent was already undermining the asylum doctors' recently won respectability. The formation of a Section of Psychiatry of the Royal Society of Medicine in 1913 had enabled British psychiatrists to surmount the last significant obstacle to gaining full professional recognition. In electing a man like Sir George Savage to the Presidency of the Section, however, they had signalled their reluctance to embrace the 'New Psychiatry' too readily. While not yet ready to abandon their allegiance to physiological explanations of mental disease, however, psychiatrists - particularly asylum doctors - now faced the problem of how to establish their claim to the new territories being opened up by the protagonists of psychotherapy. The Great War was to offer them just such an opportunity. In curious reversal of history, the Asylum War Hospitals Scheme was to provide a

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<sup>6</sup> Scull A., *Museums of Madness*, Allen Lane, (London 1979), p.169.



sort of Trojan Horse in reverse, a perfect disguise which would enable the asylum doctors to emerge from their citadels to play a prominent role in the development of British wartime neuropsychiatric medicine.

## 9.2 Asylum medical staff and the war.

Dictated as it was by the urgent need for more hospital accommodation, the agreement between the War Office and the Board of Control received general approval. When these same institutions came to be used for mental and nervous cases, however, the advocates of asylum reform saw in this development ominous portents for the future of psychiatric medicine in Britain. At a time when the scent of patriotism was heavy in the air, they regarded the alacrity with which some senior asylum doctors accepted the Scheme as a thinly veiled move to gain the advantage in the debate over professional competence in psychiatric medicine.

A crucial question in the negotiations between the Board of Control and the War Office had been the position of senior asylum medical staff. Medical Superintendents of public asylums exercised almost unrestricted authority within their institutions. To have been relegated to any kind of secondary role would not only have compromised that authority, but would also have seriously damaged their standing in the medical profession as a whole. At a time when the primacy of the asylum system was the subject of controversy, the question of who would be in overall charge of the new War Hospitals was therefore one of crucial importance. Through the Board of Control, the case for Medical Superintendents to be appointed as Commanding Officers was urged on the War



Office.<sup>7</sup> Faced with an increasingly desperate need for hospital beds, and conscious of the importance of full co-operation from the asylum authorities, the War Office had little choice but to concede.

This concession was seen by the reform lobby as likely to give the asylum doctors important advantages in the debate over the future of psychiatry in Britain. The asylum ethos, with its emphasis on insanity, incarceration and the physical aspects of mental disorders would, it was feared, dominate the treatment of mental and nervous military casualties of all degrees of seriousness, with the result that reform of the asylum system would be further impeded. As is so often the case in such controversies objections were based on prejudice and misunderstanding. Nevertheless, these developments were to have a significant and lasting effect on the nature of the treatment given to neuropsychiatric casualties sent to these hospitals.

Ironically, the event which sparked off the public controversy was a legislative measure, itself designed to alleviate the most disliked aspects of the 1890 Lunacy Act. This was its failure to provide for voluntary treatment, and for the treatment of mild and incipient mental disorders. A Bill introduced into the Lords by Earl Russell in the Spring of 1914 had failed to make progress: in April 1915 its supporters tried again, and a Mental Treatment Bill, having 'precisely the same object' as the Russell proposals was brought to the Commons by the newspaper tycoon, Cecil Harmsworth. In what was perhaps an

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<sup>7</sup> Cooke M. and Bond C.H., *History of the Asylum War Hospitals Scheme in England and Wales*, H.M.S.O., (London 1920), pp. 46-9.



excess of zeal, the Bill's sponsors sought to ride on the back of patriotic sentiment, titling the Bill as a 'War Emergency Measure', intended primarily to facilitate the treatment of mentally disordered servicemen.

By this time, however, rumours that military mental casualties were being sent to asylums without due legal process had begun to circulate, and the Bill's critics saw in its imperfections a number of potential dangers. The subsequent exchanges in the columns of the medical press, in Parliament and elsewhere, were ostensibly concerned with these threats. In reality, they reflected deep divisions between the emergent specialism of psychiatry, the asylum system and those who sought reform of the contemporary mental health ethos. To the mental health reformers the Bill, while it promised some minor advantages for sufferers, introduced a number of anomalies which attracted deep suspicion.

Dr. Robert Armstrong-Jones, the Medical Superintendent of Claybury Asylum (and unusually for someone in his position a fervent advocate of reform), harked back to Lord Russell's 1914 Voluntary Mental Treatment Bill. Like Harmsworth's, Russell's Bill had proposed mental treatment 'without the usual certificate'. A single doctor, acting independently, would be authorised to send a voluntary patient to an asylum, where he could be treated without certification for a maximum period of six months. As in the 1890 Lunacy Act, the right of appeal to a magistrate was retained. The Harmsworth Bill, on the other hand, contained no safeguards against abuse of this power. As restrictive as the 1890 Act had been, it had been framed against a background of abuse,



collusion, corruption and unlawful detention: reformers had no intention of allowing unfettered power to fall into the hands of any group having a vested interest in mental health.

### **9.3 Dispute and discrimination: S.E.White joins the controversy.**

Sarah Elizabeth White was born at Tandragee, Co. Armagh, in 1855. At the age of 32 she moved to London, gaining a B.Sc. at Westfield College in 1891, and graduating M.B. at the London School of Medicine for Women in 1896. After graduation she became Demonstrator in Physiology there, and worked for a time at the Royal Free Hospital. It was during this period that Dr.White developed an interest in mental health that was to remain with her until her death in 1938. She was particularly concerned by the lack of facilities for the early treatment of mental illness, views which frequently brought her into conflict with what she insisted on referring to as the 'Commissioners in Lunacy' and with the asylum system in general.<sup>8</sup> Dr. White was convinced that, as long as the treatment of mental disorders involved what she called the asylum 'prison-bars of detention', progress in understanding and treating mental diseases would be hampered. It was this conviction that led her to become involved in a controversy that was destined to outlast the Great War itself.

In the first place, Dr. White pointed out, the stated motive for the Bill, namely that mentally disordered soldiers could not receive treatment unless certified under the Lunacy Act, was a total fiction. Army personnel were

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<sup>8</sup> In 1913 the Commission in Lunacy, without any constitutional change, was re-named the 'Board of Control'. To emphasise what they regarded as a purely cosmetic move critics, including Dr.White, insisted on using the old title.



obliged by the normal processes of military discipline to go where they were sent, and to remain there for as long as it pleased the authorities to detain them. The idea that the civil law had to be amended to allow mentally ill soldiers to be treated was at best erroneous, and at worst sinister.

A central provision of the Bill was that a medically qualified practitioner, acting alone, could cause any person suffering to any degree from mental illness to be 'taken charge of' and 'treated' for a period of six months. Precisely what, Dr. White demanded to know, was meant by "taken charge of"? Also, bearing in mind that the proposed legislation would apply equally to civilians as to soldiers, was this detention in disguise? A further criticism was that this was to be 'enabling' legislation, the practical implementation of which would be through 'certain regulations to be subsequently made by the Home Secretary and the Lord Chancellor.' Both these officials, Dr. White pointed out, 'represented the executive of the Lunacy Commission'. The legislation therefore conferred new, unspecified, and open-ended powers on that body:

[The Lunacy Commission] is to make its own rules as to the conditions under which free British subjects may be "taken charge of" by "nursing homes" or other institutions run for profit, the legal safeguards of the Lunacy Act being meanwhile in abeyance. [...] The House of Commons is asked...to "shut its eyes and swallow."<sup>9</sup>

The proposed legislation was based on the assumption that the 1890 Lunacy Act itself prevented the 'residential treatment of mental cases unless they are certified as insane'. In fact, Dr. White contended, residential treatment could be given 'so long as the patients are not "certifiable," and so long as compulsory

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<sup>9</sup> *The Lancet*, 8 May 1915, p.989.



detention is not exercised.' This, she insisted, was why the phrase "to take charge of" was so unsatisfactory and dangerous. If detention had become necessary, then the patient was by definition certifiable and his liberty must obviously be curtailed. If on the other hand detention was not one of the aims, then the obvious question posed itself - 'Why bring in the Bill?'

Finally, Dr.White turned to the 'fatal confusion' surrounding the question of 'asylum stigma'. Asylum stigma arose, she maintained, not from the nature of insanity legislation, nor from the fact that an individual had been certified as insane. The mark of madness, the social brand which remained with the sufferer for life, arose from the fact of statutory detention - irrefutable evidence in the eyes of society at large that the individual was, or had been, considered a public menace and unfit to be at liberty:

This necessity for detention originates the stigma, and not the law. The function of the law is protective, and we run into great danger if we allow detention to be exercised in contravention of the law.<sup>10</sup>

The focus of the controversy now moved decisively towards the subject of military mental casualties and their treatment, the government coming under increasing scrutiny as to official policy and practice. In a Parliamentary exchange on 29 May 1915, the Under-Secretary of State for War stated that:

...under present arrangements it was intended that all cases of mental disorder should be retained in a military hospital until after the war.<sup>11</sup>

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<sup>10</sup> *The Lancet*, 8 May 1915, p.989.

<sup>11</sup> *The British Medical Journal*, 29 May 1915, p.942.



The accommodation at Netley was to be expanded and a new treatment centre established at Napsbury, near St. Albans. This emollient statement, however, failed to satisfy the government's critics. By this time it was realised that 'military hospital' could well be a euphemism for a lunatic asylum, as indeed Napsbury had been until it was taken over by the War Office. M.P.s cited cases of soldiers whose condition was considered hopeless, being sent to public 'workhouse asylums' as early as April 1915.<sup>12</sup>

In a subsequent letter, Dr.White claimed that asylum Medical Superintendents had admitted to her that they saw only confirmed cases of insanity, and that they therefore had no opportunity of gaining experience of early symptoms. That being the case, she pointed out, it was doubly to be deplored that mentally damaged soldiers were being sent to what were, in all but name, County and Borough asylums. What then, Dr.White demanded, was to become of those military cases, fresh from the Front, for whom there existed every hope of recovery if only expert treatment could be undertaken speedily? By consigning these cases to thinly disguised lunatic asylums, they had effectively been written off - shamefully delivered into the hands of those who were, by training and experience, incapable of giving them the sensitive treatment they needed. In these new circumstances, Dr.White argued, military mental casualties were doubly penalised. Not only were they being deprived of the early treatment which might lead to recovery; they were also to be treated as pauper lunatics, condemned without trial to indeterminate confinement.<sup>13</sup>

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<sup>12</sup> *The British Medical Journal*, 20 May 1915, p.942.

<sup>13</sup> *The Lancet*, 24 July 1915, pp.199-200.



It is important to appreciate that these criticisms were being made against the background of a sustained rise in the number of public asylums and in their resident populations. Quoting from the latest report of the 'Lunacy Commission' (the Board of Control), Dr.White pointed out that, during the preceding sixty years, the number of public asylums had risen 'from 37 to 97, and the number of pauper patients held in them from 12,669 to 108,337, These facts the Commission claimed as evidence of "uninterrupted progress". From this it was clear, Dr.White argued, that the need was not for the lunacy industry to be given yet more powers to extend its 'crude domination' over lunatics. That domination was already virtually complete. What was needed was nothing less than a total reversal of policy towards voluntary, non-carceral treatment, together with the application of 'our highest intelligence and sympathetic comprehension' to the problem of incipient mental illness.

Dr.White pointed out that many of the 'so-called minor cases' being sent back from the fighting zones were soldiers who had also sustained physical injuries. In these cases the physical injury was given priority and the patients sent to general hospitals, both on the Continent and in the U.K. Here, they were given no special treatment for these milder mental and nervous symptoms, simply rest, good food and time to recover. As their bodies healed, she asserted, so did their minds, strong evidence that the same kind of treatment might well benefit the less serious mental and nervous casualties who had not sustained physical wounds.



If Dr.White's aim had been to stir up a hornet's nest, that ambition was amply fulfilled. In *The Lancet* of 31 July 1915 there were three letters, all of which took exception to the content of Dr. White's letter, to its tone, its language, or to all three. Surprisingly, none referred, even in the most oblique terms, to the fact of Dr. White being a woman. On the contrary, the letter from Edwin Goodall, Medical Superintendent at Cardiff, used the male pronoun more than once, suggesting that he, at least, believed 'S.E.White', as her letters were subscribed, to be a man.

The biggest of these big guns, however, was Sir George Savage. Doyen of the asylum medical service, sometime Medical Superintendent of Bethlem Hospital, President of the Medico-Psychological Association, and first President of the Section of Psychiatry of the Royal Society of Medicine. His initial reaction was the condescending, 'We've seen it all before' approach:

Such...letters appear in the lay and medical press, and have done as long as I can remember. The study and treatment of mental disease has long been said to be inadequate, and that the fault has been that specialists and not general physicians have been responsible, and that the insane, or rather those suffering from incipient mental disorder, should be treated in hospital.<sup>14</sup>

Sir George had in fact missed the point. Dr.White's essential complaint was the lack of facilities for the early treatment of mental illness. She made no specific claims for the role of general practitioners, other than to urge that they should be better trained to detect the early symptoms, and thus be of more practical help to their patients. As both Sir George and Dr White were well aware, general practitioners necessarily played a central role in the certification and

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<sup>14</sup> *The Lancet*, 31 July 1915, p.250.



committal process. They would in the normal course of events initiate the process, acting on information usually from the family or from their own observations of the patient. What Dr. White was arguing for was a preventive and curative scheme, designed to operate well in advance of the stage where the sufferer became legally certifiable and therefore a candidate for the asylum. For his part, Sir George had, in '50 years of experience' seen more than one attempt to treat mental disorders outside the walls of the asylums and all, ~~he claimed~~ dismissively, had failed. To say that progress in mental health had been slow, Sir George went on:

...is only saying that our knowledge of mental functions is and ever will be imperfect...(R)est cures and travelling have been more in fashion, but I do not think the results have been any better than that advised by alienists. The very best work...is being done at...Claybury and Cardiff, and I fail to find that inspiration comes or will come from without.<sup>15</sup>

The reference to 'rest cures and travelling' says more about the kind of world which Sir George inhabited at the time, and his ability to forget his years as Medical Superintendent of Bethlem Hospital. For Sir George, 'steady progress, which will ever be slow', held out the best, indeed the only hope for the future of psychiatry. Fortunately, there were some who shared Dr. White's dissatisfaction with the *status quo* and were, moreover, in a position to exert pressure both in and outside the pages of the medical press.<sup>16</sup>

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<sup>15</sup> *The Lancet* 31 July 1915 p.250.

<sup>16</sup> Savage's views as expressed here are in marked contrast to a guardedly pro-Freudian stance taken a few years previously. See *The Lancet*, 26 October 1912, p.1134.



### 9.3 The political dimension.

Just such a protagonist was William Allan Chapple. Chapple was a New Zealander, born in Alexandra, Otago, in 1864. He qualified in medicine and surgery at Dunedin University in 1899 and practised as a surgeon in Wellington until 1906 when he moved to Scotland. In 1910, Chapple became Liberal M.P. for Stirling. On the outbreak of war he held the temporary rank of Major in the R.A.M.C. and combined this with his political activities. Chapple was a widely travelled man of diverse interests, prominent among which was mental health reform. Although not a mental health specialist himself, his dual identities as medical man and M.P. gave him singular advantages in debates of this kind. As a participant in the controversy, however, this lack of expertise was a positive advantage, since Chapple could not readily be identified with either Sir George Savage's comfortable conservatism, or with the 'new psychiatry' with its whiff of socially dangerous Freudian sexuality. Whatever the merits or defects of his argument, Chapple's style has a refreshing Antipodean ring:

To the alienist the ideal is to bring within his scope the whole field of mental disorder. Early and preventable cases inspire him. He is conscious of his...power when such cases are brought to him for treatment.<sup>17</sup>

The problem for those who entered an asylum, Chapple argued, was not one of treatment, it was the fact that treatment in an asylum, however brief, carried with it an indelible stigma, 'that must remain with him for life, and even be handed down to his posterity'. Dismissing such fears as a lot of nonsense, as Sir George Savage had done, was simply to ignore reality. The test of insanity in

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<sup>17</sup> *The Lancet*, 4 September 1915, p.569.



the popular mind, Chapple reminded his readers, was commitment to an asylum.

In a pointed reference to his political role, Chapple warned that there were 'large numbers' of Members of Parliament who stood 'entirely opposed to the alienists in this matter', and whose intention was to thwart any effort to establish a monopoly of mental health. Chapple pointed out that the great majority of soldiers being returned to the U.K. at the time were not 'certifiable' mental cases, but were suffering from 'nerve-wrack and mental shock'. The first was due to the extraordinary privations of the early months of the war, the second the product of exposure to artillery bombardments of unprecedented ferocity. Most of these cases recovered after 'appropriate' treatment, often no more than a brief period of rest, good diet and reassurance. 'It would be a cruel wrong', Chapple maintained, 'to brand any recoverable case' with the stigma of having been in an asylum. In order to effectively treat the preventable cases, it was necessary only to establish special sections in general hospitals, and the arrangements should be no different from those made for any other specialism:

...voluntary admission, voluntary residence, early and preventive treatment by medical specialists, absence of repugnance to patients or friends, and freedom from all suspicion of stigma.<sup>18</sup>

This was what Chapple called the 'hospital domain'. The 'asylum domain', on the other hand, was characterised by legal certification, compulsory incarceration, and the 'inevitable ineradicable stigma...and loss of liberty.' No mentally ill person, he asserted, should be consigned to the asylum domain unless he had first been through 'and not profited by,' the hospital domain.

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<sup>18</sup> *The Lancet*, 4 September 1915, p.569.



Disguised by the urgency of the war situation, however, the asylum domain was being resorted to without the safeguards which society had put in place for the protection of individuals against unlawful confinement.

In the meantime, the controversy had spilled over into Parliament. In the House of Lords on 26 July 1915, Lord Lytton asked the government 'what provision was being made for the hospital treatment of nerve-shaken soldiers who had been medically diagnosed after an interval for rest as 'uncertifiable'. Lord Newton, the Paymaster-General, replied that such cases were treated in the neurological sections of the military hospitals, 'of which there were 23', and that additional accommodation was also available 'in two institutions which were formerly under the Board of Control.'

It is clear that the question itself was carefully phrased in order to elicit as much information as possible, and also to provide an opportunity, if necessary, for supplementary questions on points of doubt. One obvious conflation pleading to be challenged was the Paymaster-General's implied existence of 23 'neurological sections in the military hospitals'. It is true that there were 23 Territorial General Hospitals set up at mobilization in various parts of the country. It is also the case that, in May 1915, Military Commands in the United Kingdom were 'instructed to establish neurological sections' in such hospitals. The instruction went on, however, to specify that these sections should be established only in such Territorial General Hospitals as were



considered suitable for the purpose'. At that time, the Official History admits, 'very few' were regarded as adequate for the purpose.<sup>19</sup>

Since the instructions were only issued to the various Commands in May 1915, it would have required a miracle of Biblical proportions for neurological sections to have been set up in the 23 Territorial General Hospitals, not to say staffed with the necessary specialists, by 26 July, the date on which Lord Newton made his statement. In any case, the majority of Territorial General Hospitals were located in schools and similar premises, at which expansion was extremely problematical. By early 1915 the urgent need for more hospital beds of all categories had indeed forced rapid expansion, but this was often in distant localities. For example, the administrative area of the 5th Northern General Hospital, centred on Leicester, extended over the whole of Leicestershire and into the four contiguous counties.<sup>20</sup> A section of the 1st Southern General Hospital was sited at Stourbridge in Worcestershire, 'with the main section...in Birmingham.'<sup>21</sup>

In predictable political style, Lord Newton was confusing intention with achievement. As he spoke, there was only one 'neurological section' established as an administrative part of a Territorial General Hospital, that at the 4th. London General, (formerly the London General Hospital) in Denmark Hill. Even here the statement was misleading, since this had been designated a 'clearing

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<sup>19</sup> Macpherson W.G. *et al* (Eds.), *History of the Great War: Medical Services*, Vol.2, General History, (H.M.S.O. 1921). p.46.

<sup>20</sup> Harrison L.K. 'History of the 5th.Northern General Hospital' (Unpubl. typescript) Leics. C.R.O. Ref. LM/11/8/TS.

<sup>21</sup> Macpherson, *Medical Services, Diseases*, p.72.



hospital' under arrangements made in March 1915, along with 'D' Block at the Royal Victoria Military Hospital, Netley, Southampton, and was not intended as a long-term treatment centre.

Comparatively few mental and nervous sections were in fact set up in military general hospitals. The official history of the Asylum War Hospitals Scheme records that, in addition to the centres set up in vacated asylums, treatment for mental and nervous disorders was also given in smaller sections 'of other War Hospitals' at a number of unspecified locations. But these general hospital sections accounted for only a very minor part of the whole, admitting between them only 3,107 patients during the entire course of the War, compared to the 35,333 admitted to the 11 listed centres.<sup>22</sup> From December 1914, when the Moss Side State Institution became the Moss Side Military Hospital, the advantages of such premises as military hospitals became more evident: from that time War Office policy for accommodating mental and nervous casualties depended increasingly on taking over vacated asylums.<sup>23</sup>

Also taking part in the Lords debate was Viscount Knutsford, whose interest in hospitals and the reform of health care dated from before the War. His most important contribution to the treatment of mental and nervous casualties was to organise an appeal, the result of which was the opening in London in late 1914, of the first of a number of special hospitals for officers.

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<sup>22</sup> See also Chapter Eight for details of the mental and nervous treatment centres set up under the Asylum War Hospitals Scheme.

<sup>23</sup> Macpherson, *Medical Services, Diseases*, pp.47-8.



Lord Knutford's contribution to the discussion of vacated asylums was to support Lord Newton's reply, stating that:

...the arrangements made by the War Office for dealing with men and officers suffering from nerve or organic shock were particularly good. The War Office had engaged neurological departments at twenty-three hospitals, and if the men were too bad or needed a change of surroundings, they were sent either to the military hospital at Liverpool or to the Springfield, Wandsworth.<sup>24</sup>

Lord Knutsford managed in this one short sentence to contradict the government spokesman twice, adding nothing to the sum of knowledge in the process. In the first place he stated that special centres had been set up in Territorial General Hospitals, few of which, if the Official History is to be believed, ever actually opened. His second assurance, namely that patients suffering from serious disorders were being sent to special centres at Liverpool and Wandsworth, betrayed ignorance of the antecedents of both these hospitals. The Moss Side Military Hospital at Maghull, Liverpool was, until taken over from the Board of Control, the Moss Side State Institution. It was a new institution intended for 'mentally deficient delinquents'. The Springfield Hospital was, until taken over, a detached block of the Middlesex County Asylum, housing 'defective children'. The Asylum itself continued to operate as such.

As far as the government's critics were concerned, great care was being taken to avoid sending officer patients to places associated with the asylum system, while no such consideration was being shown to the rank and file. Also, the suggestion that, at a time of the most extreme pressure on hospital

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<sup>24</sup> *British Medical Journal*, 31 July 1915, p.167.



accommodation in general, and with the railways crowded to capacity by the movement of troops and war materials of all kinds, patients could be transported across the country simply for a 'change of surroundings', demonstrates Lord Knutsford's poor grasp of the real situation.

Asylum doctors who had been given commissions, Lord Knutsford went on, 'bitterly resented' the suggestion that, simply because they were alienists, all those sent to them were 'necessarily insane'. Again, Knutsford missed the point. The main objection to sending soldiers to former asylums to be treated by former asylum doctors, was precisely that such places and such people had, for nearly a hundred years, specialised in insanity and only insanity. It was futile for Lord Knutsford, the War Office and the government in general to claim that some sort of miraculous transfiguration had been brought about simply by a change of name. The 'War Hospitals' looked like asylums, and no cosmetic change of name could alter that. Decked out in military uniforms though they might be, the men in charge were the same men who had run the asylums in their civil guise. It was little wonder, therefore, that some kind of deception was suspected.

It was the problem of asylum stigma in relation to military mental casualties that had forced the subject of mental health in general to the top of the political agenda, offering would-be reformers such as White and Chapple the opportunity of using the nation's natural concern for its fighting men to further long-frustrated ambitions. In that sense at least, the question of what kind of treatment should or should not be given to military mental and nervous



casualties was to some extent irrelevant. Crucially, the subject was being used by the reform lobby as a very convenient stick with which to beat the establishment and, through it, the institutions involved in the madness business.

The final letter on this subject appeared in *The Lancet* of 18 September 1915. Dr. White had withdrawn, and it was left to Chapple to sound the last note. In a curious reversal of his previous stance, he switched his attention to the subject of heredity and mental illness. Chapple now concurred with Savage's comment of 11 September, namely that 'a good deal of nonsense' was talked about asylum stigma. However, he went on to argue that the stigma, while regrettable, was a 'world fact' and was not to be altered by 'softening names and terms'. Furthermore, Chapple claimed, awareness that an individual was or had been insane, was a 'sociological necessity', of vital importance for the preservation of sound genetic stock:

The stigma is right and necessary. Insanity is the most hereditary of all disorders. Every young man and every young woman and every managing mother should know "who" and "why". The asylum tells them who and physiology tells them why. [...] It is a social asset that the community cannot afford to lose.<sup>25</sup>

The argument over asylums as treatment centres rumbled on in various places and in a variety of forms, but the intervention of more urgent matters pushed the subject out of the spotlight. There is some evidence, however, that the controversy discussed above, and similar debates elsewhere, were beginning to have an effect on attitudes to mental health in general.

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<sup>25</sup> *The Lancet*, 18 September 1915, p.672.



The Annual Report of the Board of Control for the year 1917 commented on the lack of facilities for the early treatment of mental illness and on 'defects in the law' which, it contended, rendered the provision of such facilities impossible. The Board had been obliged to recognize the 'public prejudice against the stigma of certification'; a prejudice so strong that special efforts had had to be made to minimise it in the conversion of premises loaned to the War Office for use as hospitals. In an extraordinary *volte-face* the Board admitted, not only that this prejudice was real and justified, but also that:

...in all asylums there are numbers of persons suffering from incurable insanity who, had they been subjected to expert advice and treatment when the premonitory symptoms manifested themselves, would not improbably have recovered and become useful members of the community.<sup>26</sup>

Such an admission contrasted sharply with the complacency of the immediate pre-war years, when, as Dr.White had caustically observed, a constantly rising asylum population was regarded by the Board as evidence of 'uninterrupted progress'.



## CHAPTER TEN

### R.G.ROWS AND THE INFLUENCE OF THE MOSS SIDE MILITARY HOSPITAL.

#### 10.1 Origins and organisation

In Chapter Eight, reference was made to Moss Side as a prototype for the Asylum War Hospitals Scheme. The influence of Moss Side on the treatment of neuropsychiatric casualties during the Great War is inextricably bound up with the personality of R.G.Rows, Commanding Officer for most of its existence as a military hospital. A significant outcome of the present research has been the recovery of casenotes from Moss Side, recorded by Rows himself, and previously unresearched. The six cases form part of the 'Representative Selection' held at the Public Record Office.<sup>1</sup> Although relatively few in number, the cases cover a range of mental and nervous disorders. Individually and collectively, they offer a unique insight into the clinical methods of a practitioner who was recognised in his day as innovative and successful to the extent that Charles Myers believed him capable of standing alongside Freud, Jung, Adler and Janet.<sup>2</sup>

As the first institution to be taken over from the Board of Control, Moss Side initially provided only 300 beds, a number immediately increased by the Army to 375, by cutting down on the space allotted to each patient: the figure eventually rose to 500 by the construction of huts in the grounds.<sup>3</sup> War Office policy at the time was to avoid sending officers to any institution associated with the public asylum system: Moss Side therefore catered only for 'other ranks'. Accommodation for 35 officers suffering from neuropsychiatric

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<sup>1</sup> All six cases are filed in alphabetical order of patient surname in PRO/MH106/2102.

<sup>2</sup> Myers C.S., *Shell Shock in France*, Cambridge University Press, (Cambridge 1940), p.20.

<sup>3</sup> Macpherson W.G. et al (Eds.) *History of the Great War: Medical Services, Vol.2, Diseases of the War*, H.M.S.O. (London 1923), p.45.



disorders was in fact opened nearby, but was conducted as a separate hospital. Quarry Brook House, as it was known, was the property of Frank Hornby, of model railway and 'Meccano' fame. In a patriotic gesture unconnected with Moss Side, Hornby moved to the Exchange Hotel in Liverpool, handing over his house to the War Office for the duration of hostilities.<sup>4</sup>

For some inexplicable reason, a good deal of confusion has grown up over the origins and wartime identity of Moss Side. The American mental specialist Thomas W. Salmon, in his major 1917 report on the British Army's arrangements for treating mental and nervous casualties, described Moss Side as the 'first military hospital for functional nervous diseases', stating that in peacetime, it had been intended for 'mental defectives of the delinquent type'.<sup>5</sup> In *Shell Shock* (1997) Babington states that the premises had been formerly used as a 'convalescent home for children from workhouses', and that it had been taken over as the 'Merseyside Red Cross Hospital for shell-shocked soldiers'.<sup>6</sup> Shephard, in his account of Rows's tenure at Moss Side, states that the premises were built in 1912 'as a colony for epileptics.' And that during construction, Liverpool Corporation had had 'a change of heart', and had sold the new buildings 'unused' to the Board of Control.<sup>7</sup>

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<sup>4</sup> Rowlands J.K., 'A Mental Hospital at War', Unpubl. paper read before the Liverpool Medical History Society, 1985.

<sup>5</sup> Salmon T.W., 'The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army, *Mental Hygiene*, Vol.1, No.4, October 1917, p.519.

<sup>6</sup> Babington A., *Shell Shock: a History of the Changing Attitudes to War Neurosis*, Leo Cooper, (Barnsley, S.Yorks, 1997) pp.108-9.

<sup>7</sup> Shephard B., 'The Early Treatment of Mental Disorders: R.G.Rows and Maghull 1914-1918', in Freeman H. and Berrios G.E., *150 Years of British Psychiatry, Vol. 2: The Aftermath*, Athlone, (London 1996), p.436.



P.J.Leese in his 1989 Ph.D thesis adds yet another name, the 'Maghull Military Red Cross Hospital'.<sup>8</sup> Both Shephard and Leese drew on unpublished lecture notes by Dr.J.K.Rowlands, a physician at Ashworth Hospital, the successor to Moss Side. Dr. Rowlands, who has an interest in local history and who had access to hospital records in the preparation of his paper, refers throughout to 'Moss Side Military Hospital'. Cooke and Bond also record the hospital as 'Moss Side Military Hospital', and this is the name used throughout the present work.

## 10.2 Staffing the hospital

The staffing situation with respect to Moss Side is less clear than with asylums subsequently acquired. The Official History states that, after purchasing Moss Side from the 'Liverpool Select Vestry' the Board of Control had:

...equipped and staffed it, and the Medical Superintendent, his deputy, the steward, matron, and other members of the staff were in residence, but no patients had as yet been admitted.<sup>9</sup>

The History goes on to say that the two medical officers - W. Rees Thomas, the Medical Superintendent and his (unidentified) deputy - were given temporary commissions in the R.A.M.C. Most of the male attendants were enlisted in the R.A.M.C., acting as orderlies 'in the villas staffed by sisters and nurses'. One of the villas was set aside for the most disturbed patients, with an all-male nursing staff. The distinction between 'sisters' and 'nurses' is an important one. The title 'Sister' was normally conferred only on professional nurses - that is,

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<sup>8</sup> Leese P.J., 'A Social and Cultural History of Shell Shock', Unpubl. Ph.D. thesis, Open University (1989), p.199.

<sup>9</sup> Macpherson, *Medical Services, Diseases*, p.30.



graduates of a recognised school of nursing - who had obtained further qualifications. Female asylum attendants were not usually trained nurses, a point given much attention during the pre-war asylum reform debate. In a letter to *The Lancet* in April 1913, a correspondent writing under the name of 'Reform' voiced a number of complaints, one of which was the lack of professionalism prevalent in the nursing of asylum inmates:

...a great lack of medical atmosphere is apparent as in few asylum infirmaries is there any trained nursing as ordinarily understood, attention being largely concentrated on cleanliness, feeding, and the prevention of injuries, all very necessary in their way, but falling far short of the keen clinician's ideas for the treatment of the sick.<sup>10</sup>

Kathleen Jones has pointed out that, as early as 1891, the Medico-Psychological Association had set up examinations for asylum nursing staff, and that standards were raised further in 1919 with the introduction of the Mental Nursing Certificate. Jones notes further, however, that few asylum nurses 'had the ability or the will to take either.'<sup>11</sup> Andrew Scull, in a typically morose view, describes asylums as being largely run by 'attendants...recruited from the dregs of society'.<sup>12</sup>

These points are made in order to emphasise that asylum nursing staff seldom possessed the standards of education or training which would qualify them to work outside the asylum system. Following America's entry into the war in April 1917, Thomas W. Salmon, a distinguished psychiatrist, carried out a major survey of the British Army's arrangements for the care of mental and

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<sup>10</sup> *The Lancet*, 12 April 1913, p.1054.

<sup>11</sup> Jones K., *Asylums and After*, Athlone, (London 1993), p.129.

<sup>12</sup> Scull A., *Museums of Madness*, Allen Lane, (London 1979), p.182.



nervous casualties, which included a detailed appraisal of the Asylum War Hospitals Scheme. Salmon records that the female attendants 'became probationer nurses' and that many of the younger women, 'attracted by the work of general nursing', planned to continue their training after the war to qualify as professional nurses. Salmon also notes, however, that 'friction' occurred when the older female attendants, 'who had not had...regular nurses' training but had filled places of responsibility' were also made probationer nurses.<sup>13</sup> All this suggests strongly that the 'Red Cross nurses' at Moss Side were in fact the institution's female attendants, enrolled as probationer nurses and in the process of being trained by the British Red Cross Society. The measures taken at Moss Side regarding the utilisation of existing nursing and ancillary staffs were also to set the pattern for the Asylum War Hospitals Scheme as a whole.

### 10.3 Creating the Moss Side ethos

Ronald Gundry Rows (1867-1925) qualified in medicine at University College Hospital, London, entering the asylum medical service in 1893. He worked at several asylums in Lancashire 'specialising more or less...in neuro-pathology'. From the start, his interest in research led him to publish, mainly in *The Journal of Mental Science*, and his passionate dedication to the cause of early treatment for mental illness led him to Munich, and to a growing acceptance that the future of psychiatry in Britain lay outside the asylum gates. In 1909, with his friend David Orr, Rows undertook the task of translating Ernesto

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<sup>13</sup> Salmon T.W., 'The Care and Treatment of Mental and Nervous Disorders and War Neuroses ("Shell Shock") in the British Army' Typescript, National Committee for Mental Hygiene, (New York 1917) Part 1, p.11.



Lugaro's 'monumental' textbook, *Problems in Psychiatry*. Increasing involvement in the affairs of the Medico-Psychological Association and a number of articles in the professional press urging reform of the asylum medical service, brought him to the attention of a wider professional audience.

On the outbreak of war the Medical Research Committee was asked by the War Office to nominate suitable candidates for specialist hospital appointments. Rows's determined but always reasoned and responsible advocacy of modern treatment methods resulted in his appointment, at the end of 1914, as one of the medical team at the newly opened Moss Side. Within a few months W. Rees Thomas, the hospital's first Commanding Officer, was transferred to overseas service and Rows took charge. Taking full advantage of the urgency of the early war situation to muster a 'strong medical staff' committed to the ideal of early intervention, the Moss Side team was to set the pace for much of what was achieved in the field of war-related mental illnesses and in the war neuroses.<sup>14</sup> The team included at various times Grafton Elliott Smith and Thomas Pear, both of Manchester University; William Brown, who was later to take command of Craiglockhart War Hospital near Edinburgh and W.H.R. Rivers, whose fame was to be secured through his later treatment, also at Craiglockhart, of the poet Siegfried Sassoon.

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See Shephard in Freeman and Berrios, *150 Years of British Psychiatry*, esp. pp.440-53.



### 10.5 The Moss Side approach to treatment.

The clinical ethos at Moss Side was strongly mind-based, centred on the assumption that recovery depended on what one of Rows's colleagues was to call 'autognosis' - the recognition by the patient of the causes of his own disability. In Rows's view this factor alone justified striving for the earliest possible intervention. Before aberrant behaviour had become fixed and stereotyped:

...the patient is capable of co-operating with the physician, and it is thereby rendered possible to go beyond the mere symptoms and to discover the psychic cause which has led to the determination of the form assumed by the disease and in many cases to trace the various stages through which the illness may have passed.<sup>15</sup>

The practical implementation of this philosophy can be seen in a series of casenotes recovered during research for the present thesis. These were prepared by Rows himself, and thus represent first-hand evidence of his diagnostic methods. In all, six sets of casenotes were recovered: since Rows's diagnostic procedure is the same in all six, the case detailed below suffices to demonstrate his approach.<sup>16</sup>

Study Case No. 24  
 Archive Ref. PRO/MH106/2102/56656  
 2293 Private Mantle E.  
 Age: 35  
 Service: 3 Months\*  
 Unit: Royal Sussex Regt.  
 Diagnosis: Mental instability

<sup>15</sup> *The British Medical Journal*, 25 March 1916, p.441.

<sup>16</sup> See also: Ref. PRO/MH106/2102, 3837 Pte. Connors W., 2293 Pte. Mantle E., 7256 Pte. Cox J., 46652 Pte. Knott F., and 1850 Lance-Corporal McKenzie W.



Mantle had seen previous military service. In 1902 he had been treated at 'D' Block Netley after 'some kind of fit', and again in 1903 after attempting suicide (details not given). On 1 February 1915 he was admitted to No.1 Stationary Hospital, Rouen, complaining of severe frontal head pains and stating that, on 27 January while in the trenches his comrade's head had been blown off by a near explosion. Mantle said he had had some kind of fit and had lost consciousness. Afterwards, he had been unable to use his rifle and had 'sat down for most of the day'. He was said to be 'very depressed'.<sup>17</sup>

Unusually, the medical authorities at Rouen had taken statements from men who had recently been in contact with Mantle. These indicate that he was going through a period of extreme distress and agitation. He was said to have wandered up and down the troop train and 'looked insane'. He talked constantly about the death of his friends, how 'C' and 'D' companies had been 'cut up' and how he had 'been in the thick of it'.<sup>18</sup> Others stated that Mantle talked to himself, that he talked in his sleep and disturbed other patients, and that he insisted on talking about his own mental history, that he had threatened suicide in the past, and that he had a brother in a lunatic asylum. By 7 February 1915 when on board No.2 Hospital Ship 'Asturias', however, Mantle was said to be 'quite quiet'. On arrival in the U.K. Mantle was admitted to 'D' Block, Netley, on 9 February 1915. On admission, his mental condition was said to be 'quite normal' and he answered questions promptly.

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<sup>17</sup> This probably refers to operations in the Givenchy area, when a German attack was stopped by the 'stout defence' put up by Mantle's unit, the 2nd. Battalion, Royal Sussex Regiment. (See: Edmonds J.E. *et al*, *History of the Great War: Military Operations in France and Belgium, 1915*, p.30).

<sup>18</sup> 'Cut up' apparently meant that a unit had been all but destroyed. The statement goes on to say that, while these companies had sustained heavy losses, they were not actually 'cut up'.



Mantle was transferred to Moss Side on 15 February 1915 where he was examined by R.G.Rows. The initial examination was extremely detailed, containing references to specific tests for the following physiological and psychological functions.<sup>19</sup>

**Table 7.**  
List of diagnostic tests

|                        |                           |
|------------------------|---------------------------|
| Attention efficiency   | Attention span            |
| Attention continuity   | Conative attitude         |
| Object recognition     | Object recognition/use    |
| Habit normality        | Automatism                |
| Coenathesis            | Organic sensation         |
| Cutaneous aesthesia    | Special senses acuity     |
| Instinct status        | General emotional balance |
| Time/space orientation | Memory                    |
| Language and writing   | Ideation                  |

Rows found Mantle to be depressed and suffering from defective memory, especially for current events: he also showed marked tremor of the face and hands. Although in reasonably good physical health, both testicles were seen to be 'atrophied'. Mantle had previously said that his wife had recently left him for another man. There was one child in the marriage, but Mantle claimed that it was not his. He claimed that he had had no sexual contact with his wife for 18 months. When first married about 6 years previously, however, he said they had 'indulged 4 or 5 times daily'. He complained of sleeping poorly, and other patients in the ward complained that they were frequently disturbed by his

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<sup>19</sup> The above table was compiled from the text of Pte. Mantle's casenotes. Rows followed the same diagnostic procedure and applied the same tests for a range of conditions including neurasthenia, (2 cases), melancholia (2 cases), anxiety neurosis and mental instability (1 case each).



shouting during sleep. Rows was of the opinion that Mantle had been 'markedly impressed by the death of some of his friends'.

It was a fundamental tenet of the Moss Side approach that the cause of the patient's illness could have its roots in events which predated the immediately apparent cause by months or even years. Writing in 1916, Rows expressed it thus:

...the illness is not always due to dreams and memories of incidents connected with the war. Of equal, or perhaps of greater importance...are the memories of experiences in their former life with which a strong emotional tone was connected. These also may be revived in dreams, and in some instances are added to the dreams of the incidents which occurred at the front.<sup>20</sup>

In Mantle's case for example, the shock of seeing his comrade's head blown off had an immediate effect, rendering him unfit for duty for the rest of that day. His medical history, however, was one of occasional, acute psychotic episodes, exemplified by his 1902 'fit' and the incident in 1903 when he had attempted or threatened suicide. His emotional balance could hardly have been helped by what seems to have been chronic impotence and emasculation and the failure of his marriage. As if these were not enough, Mantle's emotional burden was made infinitely heavier by the knowledge of his brother's insanity. As earlier chapters have sought to show, the stigma of the lunatic asylum was a very real and potent force in British society during this period, and Mantle may well have felt himself destined for a similar fate.

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<sup>20</sup> *The British Medical Journal*, 35 March 1916, p.442.



As in all six of the Rows case histories studied, details of the form of treatment applied in Mantle's case are not given, They presumably consisted of helping him to come to terms with the memories of his wife's infidelity, his own physical difficulties, and the deaths of his comrades. On 31 March 1915 Rows recorded that:

From the mental examination of this man one has come to the conclusion that he shows marked instability without definite evidence of any mental aberration.

Mantle was discharged from Moss Side on 31 March 1915 without any note as to his final destination.

Suppression by the patient of his symptoms in order to escape pain inflicted by the doctor, as in Yealland's unsympathetic approach at Queen Square, or relying on massage, faradism and baths to rectify dysfunctional physical faculties, were emphatically rejected. Hypnotism was used 'only in rare instances'. In his post-war contribution to the history of the Asylum War Hospitals Scheme, Rows pointed out that 'psychic disturbances depend on psychic causes'. Having been helped to make the connection between cause and effect, the patient was then able to face the problem and solve it.

There were difficulties, however, in reconciling the needs of war casualties with Freudian psychotherapy. Freud's doctrine had been developed largely in relation to civilian practice, catering for a strictly limited, largely middle-class clientele, and with ample time in which to explore potentially fruitful avenues to recovery. With growing numbers of neuropsychiatric



casualties clamouring for attention, the Moss Side team were under constant pressure. As first in the field, and facing as they did the initial waves of casualties, there was an immediate motive for Rows and his team to find out quickly what worked and what did not.

The medical journals of the Great War period carry numerous articles by practitioners working with mental and nervous casualties. Appropriately sanitised for publication, their opinions and conclusions must always be viewed with a degree of reservation, if only because they understandably tend to emphasise success and minimise failure. As the *Official History* and subsequent writers have made clear, the therapeutic techniques developed under Rows's direction at Moss Side were influential in formulating subsequent British Army policy and practice in this area. Also, from 1917, courses at Moss Side provided training in neuropsychiatric medicine for British, American and Canadian medical officers and, in the immediate post-war period, for civilian doctors working in Ministry of Pensions hospitals. Approximately 200 practitioners undertook these courses prior to being posted to other specialist centres.<sup>21</sup>

### 10.5 Clinical rationale

At this early stage of Rows's career at Moss Side, the degree of attention given to patients in widely varying stages of mental and nervous disorder, is impressive. Despite the reported pressure of numbers during this period, Rows adopted what amounted to a standard and very detailed format for the initial examination of patients, designed to identify, and assign priorities to, those

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<sup>21</sup> Cooke M. and Bond C.H., *History of the Asylum War Hospitals in England and Wales*, Command 899, H.M.S.O., (London 1920), p.30.



areas where treatment was needed. Conversely, this approach allowed Rows to examine and eliminate psychological functions conforming to accepted standards which could be discounted or assigned a lower priority. Of the thousands of casenotes examined in the course of the present study, Rows's are undoubtedly the best organised and certainly the most legible. As with almost all of the cases studied, however, details of actual therapeutic methods used are absent. After the initial examination, the casenotes consist essentially of brief progress reports. The modern reader, ignorant of any background, could be forgiven for assuming that Rows's therapeutic approach consisted of not much more than rest and a full diet.

Precisely why the details of actual treatment are not recorded in the casenotes of these, and the overwhelming majority of cases in the present study, remains unresolved. However, the therapeutic philosophy adopted at Moss Side is recorded in other sources, and these serve to fill the gaps. According to Rows himself, the rationale for his therapeutic approach lay in his conviction that physical answers to the problem provided only short-term solutions, and that the best hope of permanent recovery lay principally in the patient himself. Regrettably, the six cases analysed above do not include examples of functional hysteria - the 'contractures, paralyses, (and) mutisms' and the multiplicity of postural abnormalities which so intrigued writers then and now. Whilst allowing that such cases were more dramatic, Rows regarded them as the less significant of the two main classes of complaint he and his colleagues had to face, regarding them as by far 'the most easily cured.' The principal approach to the treatment of hysterical conditions at Moss Side was to



discover the underlying psychological causes and, in simple language, explain to the patient the 'mental mechanism' through which these causational factors invaded his psychological territory:

After this explanation he was started on the way to overcome his particular disability by the medical officer, and encouraged to carry on his own cure. It has been of great interest to observe the readiness with which many of the patients apprehended the meaning of the illness and assisted in the cure.<sup>22</sup>

Patients under treatment for hysterical conditions reported that, once rid of the original symptoms, they were able to cope with 'slight returns of the disability' by recalling the mental tools they had been given and by 'practising the separate movements':

Cases of the type referred to, although they have occurred in large numbers, did not constitute 20 per cent. of the nervous disabilities requiring treatment. The remaining 80 per cent. include types of disturbances which are quite as important and perhaps even more interesting; they are also more difficult to recognise and to cure.<sup>23</sup>

The contractures, paralyses, mutisms, tremors and all the other symptoms of functional nervous disease were, as Rows pointed out, so obvious as to command attention. But the injuries which occur in what he terms 'the psychic sphere' - the obsessions, anxieties, fears and nightmares; the loss of self-control and the collapse of self-confidence; these, Rows maintained, were uncovered only after protracted investigation and were generally much more difficult to treat. Though they might not disable physically in the same way as the functional neuroses, these injuries of the mind rendered the patient 'extremely miserable' and unable to adapt to the demands of everyday life.

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<sup>22</sup> Cooke and Bond, *Asylum War Hospitals*, p.70.

<sup>23</sup> *ibid.*



Under Rows, the guiding principle of treatment at Moss Side was the recognition that determinism acted in the 'psychic' as inexorably as it did the case of physical phenomena. The unprecedented opportunities afforded by the war of large-scale 'exploration on modern lines' had demonstrated conclusively that psychological disturbances depended on psychological causes. The mass of data accumulated over the four years convinced Rows that the regimes favoured elsewhere - measured brutality as at Queen Square under Yealland, rest and quiet, firm but sympathetic handling, advice to forget the horrors of war, hypnotism, baths, electricity, manual labour and the rest, were ineffective in bringing about permanent cures. They failed, Rows argued, for the obvious reason that they neglected to get to the root of the disorder, leaving the 'determining cause of the illness...to continue its baneful influence.'

However, Mantle's case, which Rows described as one of 'marked instability without definite evidence of mental aberration' stands at something of an angle to his own deterministic *credo*, namely that:

Exploration into these cases reveals that conflicts, depending on the patient's difficulty in adapting himself to certain incidents of his military or pre-war career, exist, and that they are accompanied by severe emotional reactions. The emotional conditions resemble those experienced at the time of the original incidents, and they are revived whenever the memory of the original incidents is recalled.<sup>24</sup>

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<sup>24</sup> Cooke and Bond, p.70-71.



## 10.6 R.G.Rows: appreciation and postscript.

Opinions differ as to the value of Rows's contribution to the neuropsychiatric discourse of the Great War. Ben Shephard has argued that Rows's work cannot be placed above 'the second league of medicine.'<sup>25</sup> Although harsh, this verdict is in some sense justified, since neither Rows's pre-war asylum work as a neuropathologist, nor his somewhat chequered post-war career, contain much in the way of wholly original thinking.

Also, if Rowlands' account is accepted, there were serious organisational, disciplinary and administrative problems at Moss Side, of which the official histories give no hint, but for which Rows must take responsibility. Taking all these into account, it is still the case that, at a time when neuropsychiatric casualties were only just beginning to emerge as a problem, Moss Side laid down a number of benchmarks for which Rows must be given the credit. Writing in 1920, Rows summarised the Moss Side approach thus:

The principal method which has been in use in this hospital...has been that of first discovering and then explaining to the patient in simple language, and by the use of examples, the cause of the disability and the mental mechanisms by which it was produced. After this explanation...he was started on the way to overcome his particular disability by the medical officer, and encouraged to carry on his own cure.<sup>26</sup>

As unwitting testimony in support of the present thesis, Rows also records that 'classic' shell shock was of relatively little clinical interest or concern to the Moss Side physicians, and was comparatively easy to cure. The great majority

<sup>25</sup> Shephard in Freeman and Berrios, *150 Years of British Psychiatry*, p.456.

<sup>26</sup> Rows in Cooke and Bond, *Asylum War Hospitals*, p.69.



were mental cases which Rows personally found much more challenging. The success of the Moss Side therapeutic regime also marked the passing of 'D' Block at Netley as the paradigm of the British Army's approach to the care of mental illness. In doing so, Moss Side established the standards to which future specialist medical officers were to be trained.

In his outstanding biography of Freud, Ronald Clark leaves no doubt as to the seminal role of Moss Side in pioneering the application of Freudian psychiatry to the routine treatment of mental and nervous casualties. However, referring to the 'extraordinarily enlightened' atmosphere there, Clark mistakenly credits W.H.R. Rivers with the success of Moss Side after he had gone there in the spring of 1915. In fact, Rivers joined the staff at Moss Side as a self-confessed 'student' and, as Alan Young has pointed out, was forced to plead with his friend T.H. Pear, who was already well established, to assist him in understanding the nature of the work being carried on there.<sup>27</sup>

A dedicated, progressive, asylum professional, rather than an Oxbridge scientist like Rivers or Myers, Rows's background in the asylum system probably made him better able to keep his footing in the tide of mental and nervous casualties which surged around the military medical world in the early days of the war. His familiarity with mental disorders *en masse*, coupled with his grounding in the essentially empirically guided discipline of neuropathology,

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<sup>27</sup> For details of the therapeutic strategies favoured by two members of the Moss Side team, see; Elliot Smith G. and Pear T.H., *Shell Shock and its Lessons*, Manchester University Press. (Manchester 1917), *passim*. See also Chapter Eleven for details of Rivers' failure to succeed as a psychoanalyst at Moss Side.



made him better fitted than most to appreciate the factors that were at work, allowing him to occupy an unusually well-balanced position between the problems posed by mental and of functional nervous disorders.



## CHAPTER ELEVEN

### W.H.R.RIVERS: PAST REALITY - PRESENT MYTH.

#### 11.1 Background

William Halse Rivers Rivers (1864-1922) is probably the best known of the 'psychiatrists' who came to prominence during the Great War. Initially qualifying in medicine at Cambridge, in 1886, he lectured there in neurophysiology and psychology, earning for himself a considerable reputation for the quality of his research, as well as for the potency of his subsequent writing. Irked by the slow pace of Cambridge life Rivers spent several years following a number of false trails - ship's surgeon, private practice, resident physician at Bart's, as well as a spell at the National Hospital for the Paralysed and Epileptic at Queen Square, London. Queen Square specialised in the treatment of cerebral and spinal disorders, and Rivers' essentially biological outlook on neurology was bolstered by the robustness of many of the therapeutic practices followed there:<sup>1</sup>

(D)rugs, surgery, electricity, hydrotherapy, massage, and other kinds of physiotherapy' dominated the Queen Square approach, but some of the earliest brain surgery was also carried out there, with Rivers assisting Victor Horsley in some of these pioneering operations.<sup>2</sup>

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<sup>1</sup> During the war, Queen Square became notorious for the harshness of its approach to the treatment of the functional neuroses, particularly through the work of Lewis Yealland. See Leed E., *No Man's Land*, esp. pp.173-6. For an alternative view of Queen Square see Leese P.J., 'A Social and Cultural History of Shell Shock', Unpubl. Ph.D. thesis, Open University (1989), esp. pp. 158-78.

<sup>2</sup> Young A., 'W.H.R.Rivers and the War Neuroses', *Journal of the History of the Behavioral Sciences*, Vol.35, Fall 1999, p.360.



At this stage of his career Rivers demonstrated little regard for psychologically based therapies. He believed, for example, that the many physical symptoms of hysteria he observed in his daily round would, as knowledge of the nervous system expanded, be found to have their basis in 'molecular' changes in the neurological structure. Even a condition as symptomatically complex and clinically diffuse as neurasthenia, he contended, would in time be seen to stem from 'identifiable neurological alterations'.<sup>3</sup> In this, Rivers identified closely with Freud's belief that both conscious and unconscious mental processes were intimately associated with physical changes in the human body. W.F.Bynum puts it thus:

(Freud) recognized...that the neurophysiology of his day was inadequate to provide an account of psychiatric diseases in neurophysiological terms. His therapeutic measures, notably psychoanalysis, were developed with little reference to his physicalist commitment. [...] It was Freud's influence more than anything else which formalizes the separation of psychiatry from neurology.<sup>4</sup>

Like Freud, Rivers was content to leave the explication of the exact nature of this 'neuropsychiatric' relationship to time and experience and, in the meantime, was prepared to accept the basic tenets of the Freudian doctrine 'as if they were independent of neurological development.'

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<sup>3</sup> Young, 'W.H.R.Rivers and the War Neuroses', p.361.

For discussion of neurasthenia see Chapter Four.

<sup>4</sup> Bynum W.F., 'Rationales for Therapy in British Psychiatry 1780-1835' in *Medical History*, Vol. 18, 1974, p.318.



It was during his participation in the Cambridge expedition to the Torres Strait in 1898-9 that Rivers began to develop an interest in psychological medicine, although it was one which was to remain largely dormant until the outbreak of war. In 1915, at the request of the Medical Research Committee, Rivers began work at the Moss Side Military Hospital. Initially as a civilian practitioner and later as a temporary R.A.M.C. officer, Rivers joined Rows's 'brilliant band', and his commitment to the cause of mind-based therapy took on more solid form.

It was clear to Rivers as it was to other practitioners at the time that, applied judiciously, much of what was propounded in the Freudian doctrine was readily adaptable to their patients' needs. In early 1917 Rivers confirmed that belief in a paper read to the Edinburgh Pathological Club, whilst also expressing reservations concerning the relevance of certain tenets of Freudian psychology to wartime experience:

In my experience this is particularly true in regard to the part played by sexual experience in the production of the functional disorders arising out of the war. We now have abundant evidence that those forms of paralysis and contracture, phobia and obsession...occur freely in persons whose sexual life seems to be wholly normal and commonplace.<sup>5</sup>

Despite such qualifications, Rivers adhered to the view that the principles set out by Freud adumbrated a new era in psychological medicine. At the time Rivers, in common with many of his British contemporaries, found great

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<sup>5</sup> *The Lancet*, 16 June 1917, p.913.



difficulty in accepting the centrality of repressed sexuality, and sought to find ways of accepting and using Freudian principles, whilst at the same time discarding others which they knew were likely to engender resistance in the majority of the medical profession. They were aware, for example, that infantile and repressed adult sexuality were subjects which the British medical profession found problematic. However, there was an awareness that physical explanations of neuropsychiatric casualties were increasingly being shown as inadequate, and a growing inclination to explore what Freudian therapies had to offer. As Rivers pointed out:

Few scientific theories escape the fate of being pushed by their advocates beyond the position which they are fitted to hold, with the result that, failing to fulfil the expectation thus aroused, their merits are underestimated or they are even thrust into the limbo reserved for dead hypotheses...<sup>6</sup>

As far as the neuropsychological casualties of the Great War were concerned, making use of Freud's doctrine meant sorting out what was useful and what was irrelevant. As a general proposition, Rivers held that there were very few cases in which Freud's principles could not be put to 'direct practical use' as both diagnostic and therapeutic tools. He regarded it as axiomatic that many of the mental and nervous symptoms with which the medical profession was grappling at the time were the direct consequence of the 'shocks and strains of warfare'. It followed, therefore, that these same symptoms were the result of tensions set up by psychological mechanisms, which strove to obliterate these dreadful sights, sounds and smells entirely, or to banish them to some remote and

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<sup>6</sup> *The Lancet*, 16 June 1917, p.912.



inaccessible part of the consciousness from which they could not emerge unbidden:

If the advice "Try not to think of it" ...is not successful and the solitude of the night allows the painful thoughts to force themselves on the attention of the patient, hypnotic drugs...hypnoid suggestion...and even definite hypnotism (are being) employed to assist the process of driving the painful thoughts below the level of consciousness.<sup>7</sup>

Such methods, Rivers maintained, were liable to produce the opposite effect to that intended. These horrific memories then prowled the borders of consciousness, waiting only for the unwary moment before leaping in to fasten again on to the victim's conscious mind. Not only that, but the indelible knowledge of their presence, and the effort of keeping them at bay, simply piled further strain on an already over-burdened mind. Rather than being encouraged to suppress these experiences, the patient should, Rivers believed, be encouraged to find some positive aspect of his experiences. In mild cases, for example, where the experiences were perhaps no more than unpleasant, the patient might be persuaded to concentrate on the patriotic aspects of the war, or on the privilege of sacrifice for a 'noble' cause. This might work particularly well where the patient held idealistic views of the war or was motivated by strong feelings of *esprit de corps*.

## 11.2 Developing strategies

At the same time, Rivers accepted that something more potent was needed in those cases where the causative trauma was intensely personal and

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<sup>7</sup> *The Lancet*, 16 June 1917, p. 912.



psychologically overwhelming. In his post-war publication *Instinct and the Unconscious* (1920), he described the case of a young officer who had been blown up and buried by an exploding shell. Apparently uninjured, he had carried on with his duties for more than two months, despite headaches, vomiting and other symptoms 'pointing to a degree of cerebral concussion'. His final collapse was precipitated by his having to lead a patrol into No Man's Land to locate a missing friend, only to find his body 'blown into pieces with head and limbs lying separated from the trunk'. From that time the patient was haunted by dreams, in which his dead friend had appeared, either in a horribly mangled state or, even worse, as someone 'whose limbs and features had been eaten away by leprosy'. This dreadful apparition pursued him, coming closer and closer until the patient would wake abruptly, 'pouring with sweat and in a state of the utmost terror'.<sup>8</sup>

It was clear to Rivers that for this patient, the circumstances were so personal and poignant that expecting him to 'put it out of his mind' was pointless. Searching for some positive aspect, however slight, Rivers pointed out to his patient that the condition in which he had found his friend's body demonstrated beyond doubt that he had died instantly, and had been spared the protracted agonies that were 'too often the fate of those who sustain mortal wounds'. This was especially true of those left out in No Man's Land, where their sufferings could be clearly heard by comrades, powerless to go to their aid until the coming of darkness. Desperate measure though it was, this had an immediate and gratifying effect. The patient 'brightened at once'

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<sup>8</sup> Rivers W.H.R., *Instinct and the Unconscious*, Cambridge University Press, (Cambridge 1920) pp.190-1.



confessing that this was an aspect he had never before considered. He then had no dreams for several nights, followed by a night in which his friend appeared, mutilated as before, but without the terror and revulsion he had experienced previously. The two friends talked, and the patient was able to speak of the agony and despair caused by his illness, deriving comfort from the telling. He also recalled something he had forgotten, which was the search he had carried out as a 'pious duty' for any articles of value to be sent to the dead man's relatives. It was during this search that he had retrieved the 'Sam Browne' belt from the dismembered body.<sup>9</sup> At this he awoke, not in a sweat of terror, but 'weeping gently, feeling only grief for the loss of a friend'.<sup>10</sup>

### 11.3 Rivers and the 'New Psychiatry'

Rivers probably did as much as any of the wartime practitioners to confer respectability on a doctrine which, as we have seen, was in danger of being mired by morbid preoccupation with what were still widely regarded as 'unhealthy' sexual influences. In his acclaimed biography of Freud, R.W.Clark is in no doubt that Rivers played a leading role in 'breaking down British resistance to psychoanalysis.'<sup>11</sup> By using psychoanalytical methods himself, and by writing approvingly of their application and efficacy Rivers, Clark maintains, played an important role in maintaining the pace of change at a crucial period. Without the active support of such respected figures, the prejudice surrounding German and Austrian medicine - never far below the surface during the war

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<sup>9</sup> Winter D., *Death's Men*, Penguin (London 1979), pp. 64-5 and 67. Winter cites a number of instances emphasising the symbolic importance of the 'Sam Browne' belt as a distinguishing mark of the officer class.

<sup>10</sup> Rivers, *Instinct and the Unconscious*, pp.190-1.

<sup>11</sup> Clark R.W., *Freud: The Man and the Cause*, Paladin, (London 1987) p.184.



years - might well have brought about rejection of such doctrines. Scornful of the 'mixture of invective and witticism' levelled at Freudian ideas, Rivers concluded:

If this value of Freud's theory were only a probability, or even only a possibility, are we justified in ignoring it as an instrument for the better understanding of disorders of which at present we know so little? Are we to reject a helping hand with contumely because it leads us to discover unpleasant aspects of human nature and because it comes from Vienna? <sup>12</sup>

Rivers' belief in scientific co-operation as a 'step towards international friendship' was significantly modified by his wartime experiences, his view eventually being that there was no choice but to continue 'until Germany recognized defeat.' His stance, however, was not entirely altruistic or patriotic. Like many in the medical profession, initial enthusiasm and intense interest in the developing pattern of nervous and mental casualties had given way to disillusion, and a strong desire for an early return to normality. Rivers confessed that much of his frustration was born of the 'egoistic motive that I might get back to my proper studies'.<sup>13</sup> As explained above, the Moss Side Military Hospital was intended from the outset to provide treatment for neuropsychiatric casualties, with the great majority of patients coming from the ranks. There was accommodation for officers, but this was some distance away in the village of Maghull itself, providing some 35 places in what had been a private house, now known as the Quarry Brook War Hospital.

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<sup>12</sup> *The Lancet*, 16 June 1917, p.914.

<sup>13</sup> Rivers W.H.R., *Conflict and Dreams*, Cambridge University Press, (Cambridge 1923) pp.168-170. (Quoted: Young, 'W.H.R.Rivers and the War Neuroses', p.370).



R.G. Rows, who by 1915 was in command of Moss Side, was a neuropathologist by training, and had gained first-hand experience of mental disorders through his work at various asylums in Lancashire. This he had supplemented with a wide reading programme on Freud's theory and practice. In the process he had become convinced that Moss Side needed to be aimed 'in a psychological direction', rather than following the 'physicalist' doctrines to which the R.A.M.C. had been traditionally committed. Just how far Rivers expected to fit in with the Moss Side ethos is uncertain, but his writings make plain his reservations concerning some aspects of the Freudian doctrine, not least his repudiation of the pre-eminence of the analyst's role in the interpretation of dreams.

Freud had insisted that, since only the analyst had knowledge of the patient's dreams in their entirety, it was for the analyst alone to decide in what way a particular element of the dream was to be interpreted. In Rivers' view this turned science on its head. The duty of science and of scientists as he saw it was to elicit, through the application of known principles and replicable techniques, evidence in support of given hypotheses. For practitioners to assume the sole right of interpretation ran perilously close to tampering with the evidence. It was certainly true that with the foundation of the Section of Psychiatry of the Royal Society of Medicine, psychiatry in Britain had recently won a long-sought prize within the medical profession as a whole. Psychiatry's claim to empiricist credentials, however, still lay open to dispute, and there were many who looked on the 'mad business' with suspicion and disdain. To abandon one of the fundamental tenets of the scientific method, Rivers feared,



would be to set psychiatry apart from the solid body of medicine, risking a charge of self-fufilling charlatanism:

Such a method...would reduce any other science to an absurdity, and doubts must be raised as to whether (psychiatry) can have methods of its own which would make it necessary to separate it from all other sciences and put it in a distinct category.<sup>14</sup>

### 11.3 The making of the Rivers myth.

Rivers' conversion to the idea that neurological disorders might have psychological origins apparently dates from a visit he made to Jena in 1892, when he attended lectures by 'German neuropsychiatrists'. His diary at the time records his determination to 'go in for insanity' on his return to England, and he did in fact take up a post as clinical assistant at Bethlem Royal Hospital for a time. A further visit to Germany was made in 1893, when he researched briefly under Emil Kraepelin on the effects of drugs on mental disorders. Nothing from this period, however, seems to have taken firm root, and the later 1890s saw Rivers increasingly involved with anthropology, a new position at Cambridge, and with lecturing and writing on the physiology of the special senses. It was this work which, by 1898, had earned him an international reputation as an anthropologist, and a place on the famous Cambridge Torres Straits expedition of 1898 under A.C.Haddon.<sup>15</sup> From the turn of the century to the outbreak of the Great War, Rivers' activities centred 'almost entirely on anthropology', although he found time in 1904 to help in founding the *British Journal of Psychology*. In 1908 his earlier work on the effects of alcohol and

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<sup>14</sup> Clark, *Freud*, p.184.

<sup>15</sup> *ibid.*, p.361.



drugs formed the subject of his Croonian Lecture to the Royal College of Physicians.

It is important to appreciate the often confused situation surrounding the arrangements made for the treatment of neuropsychiatric casualties in the early months of the war. Unlike today's narrowly focused specialists, Rivers and his contemporaries enjoyed a great deal of latitude in the way they were able to practice in often quite disparate areas. Rivers' path to psychological medicine was an unusual one, but no more so than many others who came to be regarded as 'experts', 'specialists' and historically as 'psychiatrists'. The main requirement seemed to be that the individual concerned should be medically qualified: beyond that the field lay open to anyone bold enough to stake a claim. T.H.Pear, for example, was a lecturer in psychology at Manchester University, having begun his academic career as a physicist. Grafton Elliott Smith, also from Manchester, was Professor of Anatomy and Dean of the Faculty of Medicine there, but neither had any practical experience in psychological medicine there. At Oxford, William Brown had studied 'classics, mathematics, philosophy...psychology and physiology' before qualifying in medicine.<sup>16</sup> R.G. Rows, the Commanding Officer of Moss Side and the acknowledged driving force behind its success, had spent much of his career as an 'obscure pathologist' at various public asylums.<sup>17</sup>

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<sup>16</sup> Hearnshaw L.S., *A Short History of British Psychology*, Methuen, (London 1964), p.176.

<sup>17</sup> Shephard B, 'The early treatment of Mental Disorders': R.G.Rows and Maghull 1914-1918' In Freeman H.and Berrios G.E., *150 Years of British Psychiatry, Vol.2, the Aftermath*, Athlone, (London 1996), p.436.



Against such an eclectic background, therefore, there was nothing particularly remarkable in Rivers' diversity of interests.<sup>18</sup> Having displayed so little recent interest in either psychology or in mental and nervous disorders, however, it is unclear why Rivers should have been invited to join the Moss Side team at all. The answer probably lies in the fact that it was Thomas Pear who extended the invitation in the first place. Highly supportive of Rivers's ambition to make Moss Side a 'psychiatric academy *a la Kraepelin*', Pear, conscious of the lustre Rivers' name would bring to the hospital, prevailed on his old tutor to join the team. Accompanied by a great quantity of luggage, Rivers arrived in July 1915, 'prepared for a long stay'.<sup>19</sup> As a potential contributor to the work of the hospital, however, Rivers was scarcely as well prepared. He had given up teaching experimental psychology at Cambridge as far back as 1907, being instead 'preoccupied with ethnology [and had] published nothing of psychological interest'. Indeed, Rivers' ignorance of modern psychological medicine was such that he was obliged to plead with Pear, his former student, to act as his guide and mentor, in what for Rivers was clearly an uncomfortable and embarrassing situation:

Almost before he had unpacked, Rivers paid me an honour I shall never forget. He said he would like to be regarded as a student...and wanted to catch up. Would I direct his reading for the next few weeks, and on afternoon walks - Cambridge fashion - discuss it? His first desire was to grasp what Freud meant by the Unconscious, which Rivers thought the most important contribution to psychology for a long time.<sup>20</sup>

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<sup>18</sup> For further evidence on this point, see Chapter Six regarding the wartime experience of another of Rivers' former students, Charles Samuel Myers.

<sup>19</sup> Shephard, in Freeman and Berrios, *150 Years of British Psychiatry*, p.443.

<sup>20</sup> Pear T.H., 'Some early relations between English ethnologists and psychologists', *Journal of the Royal Anthropological Institute*, No.90, 1960, p.230. In deference to the memory of his old tutor, Pear withheld these revelations until almost forty years after Rivers' death.



Rivers remained at Moss Side for little more than a year, during which time he apparently failed to make any effective contribution to the work of Rows's team. Much of Rivers' conviction concerning Freud's theories derived from their correlation with his own experiences. The majority of ordinary soldiers led ordinary lives, with the result that their dreams, apart from the war-related nightmares, also tended to follow unremarkable paths. Accordingly, Rivers complained that he was prevented from putting Freud's theories of dream interpretation fully to the test. According to Pear, however, Rivers' heart was still very much in anthropology, and he spent much of his leisure hours reminiscing with Elliott Smith over their pre-war collaborative field research in remote parts of the world.<sup>21</sup> Smith and Pear stayed at Moss Side only during the summer vacation of 1915, after which they returned to Manchester.<sup>22</sup> Their book, which appeared in 1917, drew heavily on observations of what was being done at Moss Side, but was also a justification of views they had advanced before the war on the subject of early treatment for neuropsychiatric disorders.<sup>23</sup>

In July 1917, Rivers foresook Moss Side for the officers' neuropsychiatric hospital at Craiglockhart, near Edinburgh. There he met and treated Siegfried Sassoon, whose fictionalised memoirs were to establish Rivers as the archetypal Great War 'psychiatrist'. From that point on, it mattered little that at Moss Side, Rivers had failed to make an impression as a

<sup>21</sup> ~~Shankland~~, in Freeman and Garfield, p. 443.

<sup>22</sup> ~~During~~ the brevity of their stay, Elliott Smith published a major two-part article on the work being done at Moss Side. He and Pear collaborated on *Shell Shock and Its Lessons*

<sup>23</sup> Elliot G.E. and Pear I.H., *Shell Shock and Its Lessons*, Manchester University Press, (Manchester 1917).



psychotherapist. At 53, Rivers was of an age to represent experience, whilst at the same time avoiding classification alongside the 'armchair generals' Sassoon accused of needlessly prolonging the war. To a considerable extent also, the nature of their relationship and the political undertones of Sassoon's 'illness' are largely irrelevant. The continuing appeal of Sassoon's war poetry carries *Sherston's Progress* along with it, and within its pages, the name of W.H.R.Rivers.



## CHAPTER TWELVE

### CONCLUSION

#### 12.1 Context and reform.

In the year or so immediately prior to and just after the outbreak of the Great War, a good deal of space in the professional medical press was taken up by controversies centred on various aspects of the public asylum system. What was widely referred to as the 'New Psychiatry' - essentially the theories and practices of Freud and his followers - was gaining ground. While such tenets as infantile sexuality were met with suspicion and hostility, a growing number in the medical profession were at least persuaded of the potential value of Freud's doctrine. Some senior figures in the asylum medical establishment were also alive to the implications for the future, and were putting forward tentative claims to be the natural heirs to the new psychiatric territories. Those outside the asylums regarded these claims as presumptuous. A strong body of opinion, critical of what was described as the 'crude domination' of the asylum system, believed that asylum doctors lacked the finesse required to deal with the subtleties of early mental disorders:

The restoration of mental balance is a thing so delicate that it requires the application of our highest intelligence and most sympathetic comprehension.<sup>1</sup>

Demand for the early treatment of mental disorders sprang from the conviction that by the time insanity could be certified, aberrant behaviour was fixed, the patient had lost touch with reality, and the way back to mental

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<sup>1</sup> *The Lancet*, 24 July 1915, p.200.



stability was lost. What was needed, it was argued, was a system similar to that on the continent, in which early diagnosis and treatment was available in psychiatric clinics attached to general teaching hospitals. From inside the asylum medical service itself, a movement, largely driven by a desire on the part of junior asylum doctors to improve their lot, was gaining ground. A succession of letters - for the most part predictably anonymous - attacked archaic rules on marriage, poor standards of nursing, low salaries and the professional competence of asylum Medical Superintendents.

These and related issues were still unresolved when war broke out. Almost as soon as casualties began returning from the fighting, allegations that mental and nervous cases were being arbitrarily consigned to lunatic asylums emerged. Demands for treatment on 'modern lines' were renewed, and the military medical authorities came under increasing pressure to provide guarantees that soldiers - whose only fault was that they had broken down in the service of their King and country - should be treated like any other casualty of war.

This thesis explores how these controversies, together with the social, professional and cultural attitudes which motivated them, influenced the British Army in its efforts to cope with the problem of mental and nervous casualties. An important theme to emerge has been that, due to the particular way in which social provision for mental illness had developed in Britain, there was no pre-existing professional medical infrastructure capable of being mobilised to meet the crisis. The relative isolation of mental health from the medical mainstream



also meant that the medical officers who first encountered neuropsychiatric casualties in the field were, for the most part, wholly inexperienced in such matters, and thus had no option but to pass them untreated out of the line. At home, a similar lack of expertise, exacerbated by public anger at the prospect of soldiers being sent to asylums, resulted in many being sent instead to general military hospitals.<sup>2</sup> There, the official history admits, neuropsychiatric casualties felt the full effects of the gulf between general medicine and the public asylum system:

It must also be recognized that the treatment the soldier received in many of the general hospitals in England was not such as would assist him to recover quickly. He was often neglected and shown quite plainly that he was not wanted. He was transferred from hospital to hospital [and] left to his own resources to get better.<sup>3</sup>

Paradoxically, the present study of five hundred cases demonstrates that it was in precisely these circumstances that the earliest attempts to apply modern methods of treatment were made. Analysis of medical casenotes confirms that there were isolated instances of suggestion and analysis being successfully used to alleviate hysterical symptoms. However, such isolated instances were fortuitous and unco-ordinated. The overwhelming majority of mental (as distinct from nervous) cases, received little more than 'bed and bromide'. However, this was not an entirely negative therapeutic strategy. Rest, good food and an ordered hospital environment worked positively in many cases. Unlike civilian asylums, military hospitals specialising in the treatment of mental disorders employed much larger numbers of doctors,

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<sup>2</sup> See Figure 1, p.58a.

<sup>3</sup> Macpherson W.G. *et al* (Eds.), *History of the Great War based on Official Documents: Medical Services*, Vol.2, *Diseases of the War*, H.M.S.O., (London 1923), p.55.



higher standards of nursing care and, in general, a much more positive curative environment. In many ways, the clinical strategies evolved by the military medical authorities corresponded well to the ideals propounded by the pre-war mental health reform movement.

## 12.2 Shell shock: re-positioning an icon

From the very earliest days, reports of what became universally known as 'shell shock' filled the columns of the medical journals. Early research for this thesis found a marked contrast between attitudes towards shell shock during the war, and those which developed during the post-war years. This was particularly evident in the official historical accounts, and in the report of the government enquiry into the subject.<sup>4</sup> The 'Southborough Committee', as the latter has become known, was set up ostensibly to identify shell shock within the overall neuropsychiatric experience of the war, to examine how and why shell shock became a problem, and to determine what ought to be done to prevent its recurrence in future wars.<sup>5</sup>

Here again, confusion and conflation surrounded the issue. By the time the Committee began its investigation in 1920, a decision had apparently been taken somewhere in the Ministry of Pensions to impede access to the hundreds of thousands of medical records. The Committee recorded sourly that:

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<sup>4</sup> Macpherson, *Medical Services, Diseases*, pp.1-67.

<sup>5</sup> *Report of the War Office Committee of Enquiry into "Shell shock"*, (the Southborough Committee), Command 1734, H.M.S.O., (London 1922) passim.



...we have been unable to obtain any reliable statistics of "shell shock" [...] material of a statistical kind [is] buried in the archives of the War Office and other Departments. The Committee were advised [...] that it could not, in fact, be obtained without a prohibitive amount of labour and expense.<sup>6</sup>

The final sentence bears all the hallmarks of a classic Civil Service evasion. Making a virtue of necessity, however, the Committee decided that their terms of reference could be fulfilled without the aid of statistics. Arguably the best opportunity of clearing up the already serious confusion surrounding the subject of mental and nervous casualties was allowed to slip away, and the paucity of reliable statistics has affected the work of historians ever since. Some authors - notably those arguing for the centrality of shell shock - have taken advantage of the general confusion, and have conflated shell shock, together with every other kind of mental and nervous disorder, in support of their theories. This process has been aided by the involvement of literary figures such as Siegfried Sassoon, Wilfred Owen and Robert Graves. Their graphic descriptions of neuropsychiatric casualties have provided readily accessible popular images, intensifying the drama, theatricality and mystery of shell shock. All these factors have combined in a powerful synthesis, the result of which has been the progressive centralisation of shell shock in the neuropsychiatric landscape.

This is not to say that shell shock was not significant as a war neurosis. Published only a year after the Southborough Committee had complained about the scarcity of shell shock casualty figures, the official history of the medical

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<sup>6</sup> Southborough Report, p.7.



services stated that, during the period August 1914 to December 1917, 28,533 cases of shell shock were recorded.<sup>7</sup> Leaving aside questions as to whether these were actually 'shell shock' as defined in the Southborough Report, this thesis does not set out to deny its importance. The main aim is to clear away some of the literary and theatrical overgrowth surrounding shell shock, to re-discover other mental and nervous disorders unjustifiably neglected by previous studies and, in the process, to re-locate shell shock as one component part of a much more extensive and diverse neuropsychiatric context.

## 12.2 Conflation, confusion and neurasthenia

The sample cases investigated in this thesis highlighted a number of issues, the first of which was the role played by neurasthenia. This now forgotten condition - a complex syndrome of mental, nervous and emotional signs and symptoms - was found to have been diagnosed in almost a quarter of the 500 cases analysed. Patients initially diagnosed with neurasthenia frequently deteriorated, developing more serious mental conditions. Using illustrative examples from the '500 Cases' study, and drawing on a range of Great War and modern secondary sources, the thesis has investigated the medical, clinical and social historiography of neurasthenia. This has led to a clearer understanding of the disorder, thereby establishing how and why it played such an important role in diagnostic policy and practice during the war.

As a result of this investigation, the thesis contends that the prevalence of neurasthenia, and the fact that its complex symptomatology

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<sup>7</sup> Macpherson, *Medical Services, Diseases*, p.6. No explanation is given for the incomplete state of the record.



included many of those to be found in other conditions, added to the general confusion surrounding the history of the war neuroses. Failure on the part of the authors of modern shell shock theses to understand the complexities of neurasthenia, led to its being thoroughly confused with shell shock. Analysis of the limited information available in the Official History shows that, while it is legitimate and necessary to regard neurasthenia as an important constituent of the overall neuropsychiatric discourse of the Great War, it is an error to conflate neurasthenia and other nervous disorders. Neurasthenia was not the same as anxiety neurosis, nervous exhaustion or nervous breakdown, and it was not, as has been all too frequently implied, synonymous with shell shock. An authoritative description of neurasthenia published immediately before the Great War was of a 'a clinical Colossus in the shape of a sphinx.'<sup>8</sup> In dealing with neurasthenia, especially during the Great War, this must be kept constantly in mind.

Another important outcome of the investigation is the serious doubt it throws on the veracity of the official record. As the official history itself confesses, neurasthenia was routinely diagnosed, not because medical officers recognised its signs and symptoms and acted in accordance with their training and experience, but because neurasthenia was a conveniently imprecise and all-embracing entity. It was also the only officially listed diagnosis capable of embracing many of the conditions thrown up in quantity by the novel

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<sup>8</sup> *The British Medical Journal*, 23 November 1912, p.1458.



conditions of the Great War.<sup>9</sup> The final, and perhaps most historically significant outcome of the investigation is that, for a number of interdependent social, political, cultural and military disciplinary reasons, neurasthenia was deliberately misdiagnosed in order to disguise the incidence of more serious mental disorders in the officer class.

#### 12.4 The sample cases.

As explained in Chapter Three, the 500 case histories recovered from the Napsbury collection represented a compromise between the desire to create the broadest possible statistical database and the constraints of time and financial resources. With the experience of the present study as a guide, the computer programme used to generate the data presented and analysed in the thesis is capable of practically unlimited expansion and refinement. This is especially significant in respect of any further collections of medical case histories that may come to light. The methodology devised for the '500 Cases' study can be applied to other types of neuropsychiatric medical records such as Medical Board Reports, of which the Public Record Office has substantial holdings. Using the same analytical matrix, this process can be made to generate standard data sets, readily assimilated into the existing database.

Even with the advantages of modern computer technology, however, the process is laborious and time-consuming, a fact which perhaps helps to account for the neglect from which this particular field of study has suffered

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<sup>9</sup> Macpherson, *Medical Services, Diseases*, p.6.



in the past. Carefully conducted, however, such research is capable of supplementing the meagre store of statistical information presently available, and would go some way towards repairing the damage done by the wholesale destruction of medical records in the past. In addition to the important computer database compiled in the course of the present work, the 500 case histories - some containing as many as 15 documents - are far from exhausted as a source, and would reward further analysis.

These new primary sources allowed the present thesis to establish with much greater certainty than before, the nature and extent of the treatment given to mental and nervous casualties of the Great War. This is especially true of mental disorders, the treatment of which has been largely ignored. As the war progressed and as medical facilities became permanently located, records of treatment at field ambulances, casualty clearing stations and hospitals began to accompany patients on a more regular basis. The chronological completeness of the case histories analysed in the course of the present study significantly qualify the claims often made in respect of the Great War, namely, that it marked the point where British psychiatry moved decisively away from the principle of protective incarceration and embraced the doctrines of the 'New Psychiatry'

It is certainly true that, as far as the war neuroses were concerned, their psychological basis became widely accepted, and treatment relied increasingly on psychological methods. Those suffering from mental disorders, however, derived little if any benefit from new psychiatric



thinking. In following cases of mental disorder from the front line trenches to their final disposal, the overwhelming impression is one of a holding exercise. There was certainly no lack of care for the mentally disordered, and it must be said that some of the more comprehensively documented cases are models of clinical observation. No matter how focused and exhaustive, however, clinical observation is no substitute for effective treatment. The sombre fact is that, of the 299 cases diagnosed as suffering from mental illness, 99 (33.1%) were sent to public asylums.

This is undoubtedly one of the most important findings of the present thesis and, it is suggested, one that must be taken into account in future investigations. In the light of the factual evidence presented here, it is no longer valid to speak of 'Great War psychiatry' as if it were a seamless, all-embracing entity from which all neuropsychiatric casualties to a greater or lesser extent drew benefit. The progress made in understanding the psychological basis of shell shock and other war neuroses had no equivalent in the ranks of those who became mentally disordered. For them, the military medical services offered, for a time at least, a more generous, compassionate and considerate regime than in the civilian asylum system. When their case became hopeless, however, the asylum claimed them as before.



### 12.5 The concept of the 'Comradely Group'.

The '500 cases' study also illustrates the frequency with which delusions of persecution formed part of the symptomatology of neuropsychiatric disorders. It was particularly striking how often patients claimed that they had been rejected by their comrades and that this rejection had initiated their mental troubles. Richard Holmes in *Firing Line* (1985) stresses the importance within the military hierarchy of small group solidarity, pointing to the strength and intimacy of the bonds which form in the face of shared danger and hardship. This led to speculation as to whether rejection by his comrades - for example following some socially unacceptable activity - had been a contributory factor in causing the patient's mental disorder or, conversely, whether the patient's aberrant mental behaviour had initiated the process of rejection from the comradely group.

This thesis examines the relationships within what is termed here the 'Comradely Group'. Drawing on evidence from the '500 Cases' study, Chapter Five concludes that the early symptoms of mental or nervous disorder introduced tensions into the 'Comradely Group', straining the natural bonds created by shared vicissitudes, and prompting exclusion of the sufferer. Even in situations where danger from enemy action was not a factor, the uniquely interdependent nature of Army life, it is maintained, rendered the individual singularly vulnerable to the consequences of exclusion from his particular 'Comradely Group'. As this thesis has demonstrated, the sense of isolation



and deprivation felt by the rejected soldier led, in extreme cases, to serious attempts at self-destruction.

With the concept of the 'Comradely Group' as a focal point, and an expanded body of evidence taken from the clinical case histories in the '500 Cases' study as a corollary, the relationship between the neuropsychiatric casualty, the 'Comradely Group' and the wider military society promises scope for further research.

## **12.6 The Asylum War Hospitals Scheme: effects and implications.**

An aspect of the neuropsychiatric history of the Great War which has been entirely overlooked in previous studies is the Asylum War Hospitals Scheme. Under it a total of twenty-four asylums were eventually taken over and used as military hospitals, ten of which were devoted to the treatment of neuropsychiatric casualties. As Chapter Nine pointed out, the change of title from 'alienist' to 'psychiatrist' did little to advance the claims of the asylum doctors to be regarded as heirs-apparent to the new psychiatric territories being opened up by Freud and his followers. Under the Asylum War Hospitals Scheme most asylum Medical Superintendents were made Commanding Officers of these War Hospitals. By default, therefore, asylum doctors gained access to a large and varied body of neuropsychiatric raw material, and unprecedented opportunities for testing the efficacy of the 'new psychiatry'. What emerges from the present study however, is that in the great majority of cases, no effort was made to take advantage of the situation.



As a final comment on this theme, it is worth pointing out that the original medical and nursing personnel of the requisitioned asylums remained largely in place. For them, operational conditions differed fundamentally from those obtaining in peace-time. Where they had been used to a gender-segregated, quiescent and mostly elderly population, they now had to cope with large numbers of physically healthy males, suffering from every degree of mental and nervous disorder. Although the Board of Control retained a considerable interest in the administrative aspects of these hospitals, they were nevertheless part of the military medical infrastructure, the basic aim of which was to return soldiers to duty as soon as possible. Free from the medico-legal invigilation and local authority intervention characteristic of the the civilian asylum system, they were instead subject to military discipline and inspection. With the knowledge that they were part of a nationwide military medical network, the atmosphere in the War Hospitals must have stood in sharp contrast to the isolated pre-war asylum conditions. What is of greater interest, however, is whether these experiences, (particularly those of the Medical Superintendents, the great majority of whom became Commanding Officers), were translated into changes in the asylum ethos in the post-war years. Harold Merskey has suggested that the forced development of psychiatric services during the Great War and the treatment clinics set up by the Ministry of Pensions, paved the way for Britain's later psychiatric health services.<sup>10</sup> As far as can be ascertained, however, modern writers have entirely overlooked the involvement of the

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<sup>10</sup> Merskey H. 'Post-traumatic Stress Disorder and Shell Shock', in Berrios G. and Porter R. (Eds.), *A history of Clinical Psychiatry*, Athlone, (London 1995), pp.490-4.



asylum system in the treatment of neuropsychiatric casualties through the Asylum War Hospitals Scheme. Yet it is the case that a considerable number of those who played leading roles in the treatment of neuropsychiatric casualties - Rows at Moss Side, William Brown at Craiglockhart, Arthur Hurst at Seale Hayne and David Eager at the Lord Derby War Hospital, Warrington - were all ex-asylum medical officers and pre-war advocates of reform. This raises the obvious question of what influence, if any, these and others with similar experiences exerted on the post-war development of mental health services in Britain.



## GLOSSARY

### Explanatory note:

During the past 100 years, the language used to refer to mental and nervous disorders, like the language of medicine generally, has undergone many changes. At the start of the Great War, for example, 'psychic', was in common use to refer to matters of the mind. 'Psychical' was used synonymously with 'psychological' to describe mind-oriented methods of treatment, especially where these involved, as many did at the time, the use of hypnotism. Today, its meaning is strictly confined to the language of the paranormal.

Throughout the present thesis it has been necessary, particularly in direct quotations, to use the technical language of the period. In the glossary below, however, the definitions are those of modern understanding. Where appropriate, potential confusions between Great War usage and that of the present day are briefly explained.

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#### ABASIA

Inability to sit up.

#### ABREACTION

Weakening or elimination of anxiety or distress by 're-living' the painful events, actually or in the imagination.

#### ANOSMIA

Loss of sense of smell. Frequently a symptom in functional hysterical disorders.

#### APHASIA

Loss of speech.

#### APHONIA

Loss of voice.

#### ASTASIA

Inability to stand.

#### AUTOMATISM

Any act performed without conscious thought or reflection.

#### COENASTHESIS

Lit. 'common feeling'. The ordinary sense of being alive and aware of oneself. (Often absent in serious mental disorders).

#### CONATIVE

In psychology, an obsolete term for that aspect of the mental processes associated with volition, effort and will.



**CRETINISM**

A syndrome variously of restricted physical growth and mental retardation. Signs are coarseness of hair, skin and facial features, due to lack of thyroid hormone.

**DELUSIONS OF REFERENCE**

Misinterpretation of comments as critical of oneself.  
An extreme form of 'taking things the wrong way'.

**D.P.**

Frequently encountered clinical shorthand for Dementia praecox.

**DEMENTIA PRAECOX**

Lit. Premature dementia. Obsolete term for schizophrenia.

**DISSOCIATION**

The process whereby unwelcome thoughts, while remaining intact, are separated from the conscious mind. (Distinguish from the *disintegrative* state of D. praecox).

**ECHOLALIA (ECHOPHRASIA)**

The obsessive repetition of words spoken by another, esp. at the end of a sentence.

**IDEATION**

Pertaining to ideas.

**IDEOGENIC**

Of mental, as opposed to physical origin.

**INSANE/INSANITY**

1. In modern usage, confined solely to use as legal terms for a state of involuntary irresponsibility, most often as defences against serious criminal charges.
2. In the discourse of the Great War period, a general medico-legal state, rendering the sufferer liable to certification and confinement in a lunatic asylum.
3. With qualifications, ('delusional', 'confusional' etc.), recognised diagnoses in military medical nosologies during the Great War period.

**INSTINCT STATUS**

A standard of instinctive behaviour, for example catching a thrown object, flinching away from a pretended blow, reaction to unexpected noise or physical contact.



**LUNATIC**

1. A person certified as insane under successive Lunacy Acts and confined in an asylum.
2. Pejorative term implying irrational or dangerous activity.  
(Historically, lunatic behaviour supposedly waxed and waned with the lunar phases).

**LUNATIC ASYUM**

An institution for the involuntary confinement and treatment of persons certified as insane under legislation. During the Great War period, the term was very slowly being replaced by 'mental hospital', but the legal status of these institutions and of patients/inmates remained unaltered until much later.

**NEURASTHENIA**

Obsolete term for a complex syndrome which included lassitude, chronic fatigue, mental exhaustion and depression. Typically accompanied by digestive, genito-urinary, excretory and sexual dysfunction.

**NEUROSIS**

1. Obsolete term for a disease of the nerves.
2. Personality or mental dysfunction not caused by an identifiable neurological or organic condition. The term has a complex technical, professional, popular and literary history which is constantly evolving.

**PAROSMIA**

Any disorder of the sense of smell.

**PSYCHASTHENIA**

Pierre Janet's term for a disorder characterized by anxiety, obsessive behaviour (often of a repetitive nature) and fixed ideas.

**PSYCHOSIS**

1. Obsolete term for the whole mental condition of an individual.
2. A group of mental disorders including schizophrenia, manic-depressive and paranoid states, and organic mental disorders. Psychoses are characterized by loss of contact with reality, and generally manifest themselves through delusions, hallucinations, exaggerated mood changes, severe loss of insight and grossly disorganised thought processes.

**PHTHISIS**

Obsolete term for

1. any condition involving wasting and loss of flesh
2. pulmonary tuberculosis.

**SOMATOGENIC**

Of physical (as distinct from mental) origin.

**REFERENCE (Ideas of)**

See: 'delusions of reference'.



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(See entry under 'Miscellaneous'. The above article is an edited version of Salmon's earlier and more comprehensive report)

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Typescript, 8pp. plus corresp. Imperial War Museum. (1921)

Salmon T.W.

'The Care and Treatment of Mental Diseases and War Neuroses in the British Army'

War Work Committee of the National Committee for Mental Hygiene New York U.S.A.

Wellcome Institute London, Typescript, 68pp. plus appendices.

(N.B. See also entry under 'Articles'. The texts of the two documents differ materially: the above typescript contains information on hospitals, their location and their purpose, not given in the *Mental Hygiene* article.

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## BIBLIOGRAPHY PART TWO: PROFESSIONAL MEDICAL PRESS

As part of a preparatory literature review, the articles, editorials, correspondence, etc. listed below were extracted from the professional medical press of the Great War period. The aim was to provide a comprehensive bibliography, enabling material relevant to the thesis to be more easily located. A secondary aim was to provide a brief analysis of the content, allowing the relevance or otherwise of the source to a specific aspect of the current topic to be more readily assessed.

With respect to *The Lancet* and *The British Medical Journal*, the lists are believed to be comprehensive: this was made possible by the availability locally of complete sets of these publications. Those from *The Journal of Mental Science* and *The Journal of the Royal Army Medical Corps* are limited and selective, and are taken from holdings at the Wellcome Library.

### **THE LANCET**

#### **ARTICLES, LETTERS, EDITORIALS ETC., REFERRING TO MENTAL AND NERVOUS DISORDERS IN THE BRITISH ARMY 1914-1919.**

(Including material of general interest relating to contemporary neuropsychiatric medicine).

### **1914**

L. 3 October 1914 p.862

Article:

'A French Military Hospital at Dieppe'

By a R.A.M.C. doctor visiting a French base hospital.

Describes the nature of injuries, infections and treatment. Gives brief details of a case of what was later to be called shell-shock, although the actual term is not used. This is the first reference to the condition found in the professional medical press. 'Another [interesting case] was that of a young man who some ten days previously had received a shock from a bursting shell which had killed his comrade but had not touched him; there was not even a bruise to be found on any part of his head or body, but he had completely lost his memory and speech, and was in a condition of amentia.'

L. 17 October 1914 pp.935-40

Article:

The position of psychiatry and the role of General Hospitals'

C.Hubert Bond D.Sc., M.D., Edin. M.R.C.P. Lond.

Commissioner of the Board of Control and Emeritus Lecturer in Psychiatry at Middlesex Hospital Medical School.

An introductory address delivered at the Middlesex Hospital 1 October 1914. Major review of the contemporary civilian medical scene particularly the relationship between the public asylum system and general hospitals. Valuable as a benchmark for the considerable amount of material then being published



on this subject. Bond was notable *inter alia* for his authorship, with Marriott Cooke, of the official *History of the Asylum War Hospitals Scheme*, Cmnd. 899 (HMSO 1920). (See entry in bibliography Part One).

L. 3 October 1914 p.873

Editorial:

'The War'

At this time, editorials appeared regularly under this heading. They featured a miscellany of news of the establishment of hospitals, ambulance units - or 'ambulances' as they were termed at the time - important military medical appointments, etc., etc. This particular issue contained details of interesting wound cases including one of 'concussion of the spine' - adumbrating views held strongly by the influential neurologist, F.W. (later Sir Frederick) Mott. Mott published frequently throughout the war, modifying his views somewhat during that time to allow room for the psychological causation of functional hysterical conditions. In his *War Neuroses and Shell Shock* (1919) he reviewed his experiences at the Maudsley Hospital (part of the 4th London General Hospital) during the war, and still argued for cerebral and spinal micro-lesions as a primary cause of shell shock.

## 1915

L. 23 January 1915 p.210

Editorial:

'Soldiers' Dreams'

A correspondent 'in charge of a field ambulance' gives details of recurring dreams of patients. 'Neurotic subjects as one would expect', he states, 'react in a most striking fashion to the shock of explosions'. Goes on to describe many of the symptoms of shell shock. The correspondent appears to be unaware of the implications of his report. Gives no details of the nature of treatment given.

L. 23 January 1915 pp.189-90

Editorial:

'The War and nervous breakdown'

Reviews the experiences of battle neuroses to date. Notes that officers appear to be more affected than men, and that arrangements made are primarily for the former. Expresses the hope that difficult cases will not too readily be consigned to asylum regimes.

L. 23 January 1915 p.194

Editorial:

'Post-litigation results in the traumatic neuroses'

Reports on American experience in respect to the outcome of traumatic neuroses following settlement of claims. Has a bearing on the psychology of malingering and the effect of war pensions settlements.



L. 30 January 1915 pp.231-3

Article:

'Fear and Disease'

E.T.Jensen M.B.Lond., M.R.C.S., L.R.C.P. Physician to the Special Hospital for Officers, Kensington Palace Green.

Argues that mental states can wholly or partly account for the presence of toxins in the human organism.

L. 13 February 1915 pp.316-320

Article:

'A Contribution to the Study of Shell Shock'

Being an account of three cases of loss of memory, vision, smell, and taste admitted into the Duchess of Westminster's War Hospital, Le Touquet.

Charles S. Myers M.D., Sc.D.Camb., Captain, R.A.M.C.

Extended reports of three cases: details of histories prior to admission, of treatment, and eventual transfer. With tables of comparative symptomatology, vision charts (fields, maculae, etc.) Conclusion notes *inter alia* that '(These cases) appear to constitute a definite class among others arising from the effects of shell shock ...the close relation of these cases to those of "hysteria" appears fairly certain'. Introduces the term 'shell shock' in print.

L. 20 March 1915 pp.583-90

'The New Psychiatry'

Lecture One: 'Fundamental Psychical Mechanisms'

W.H.B.Stoddart M.D.Lond., F.R.C.P.Lond.

Lecturer in Mental Diseases, St.Thomas's Hospital etc.

First of three major (Morisonian) lectures delivered to the Royal College of Physicians of Edinburgh.

L. 27 March 1915 pp.639-43

'The New Psychiatry'

As above: Lecture Two: 'Psycho-analysis'

L.27 March 1915 pp.663-4

Editorial:

'Shell Explosions and the Special Senses'

Comment on Stoddart's Morisonian Lectures.

L. 3 April 1915 pp.589-92

'The New Psychiatry'

Lecture Three as above: : (no subsidiary title - continuation of Lecture Two)

These three lectures provide arguably the most comprehensive and certainly one of the most readable overviews of the state of British psychiatry in the early months of the war. They give valuable insights into the attitudes and



clinical approaches of some of the leading figures in the field. This piece should be read in conjunction with Hubert Bond's address on the asylum medical service, (17.10.14. above). Stoddart's lectures also provide a clear picture of the contrasting approaches of the established carceral system and the increasingly vocal and influential psychocentric caucus.

L. 3 April 1915 698-701

Article:

Traumatic ambylopia following the explosion of shells'

J.Herbert Parsons D.Sc., F.R.C.S.Eng., Ophthalmic Surgeon, University College Hospital, London;

Surgeon to the Royal London (Moorfields) Ophthalmic Hospital.

Discusses a wide range of observed and conjectural causes of the title and related conditions. Notes that the 'shooting eye' is very often the last to recover, and that some patients 'candidly admit to being in a "blue funk"' at the prospect of being sent back to the trenches.

L. 24 April 1915 pp.848-9

Article:

'Some physical defects met with when raising an army'

Sir Thomas Oliver M.D.Glasg., F.R.C.P.Lond.,

Honorary Colonel (Tyneside Scottish), 20th Battalion, Northumberland Fusiliers.

Notes that 30% of potential recruits are rejected on medical grounds of various kinds. No mention is made of mental or nervous disorders posing a problem in these early days, but the writer complains of a lax regime in some areas (particularly mining districts) and the consequent overlooking of obvious physical disabilities.

L. 10 July 1915 pp.63-6

Article:

Loss of personality from shell shock'

Sir Anthony Fielsing M.D.Cantab., M.R.C.P.Lond.,

Temporary Assistant Physician and Casualty Physician to St.Bartholemew's Hospital; Assistant Physician to the Metropolitan Hospital and the Hospital of Epilepsy and Paralysis, Maida Vale.

Based on the protracted treatment of a particularly difficult case, for which a variety of clinical techniques were employed, notably hypnosis and psycho-analysis. The loss, following the trauma, of skills such as the ability to play musical instruments, and their being regained only under hypnosis are dealt with at length. At the time the article was written the case had not responded to treatment.



L. 24 July 1915 pp.199-200

Letter:

'Hospital Treatment v. Lunacy Treatment'

S.E.White M.B., B.SC.Lond.

Draws attention to the increasing numbers of 'nerve-shattered' soldiers who need sympathetic and effective treatment. The writer points out that many who are both physically and mentally wounded are treated with considerable success in general military hospitals, where rest, ample food and being treated as other wounded has brought about a complete recovery. Maintains that society has all too often shut mental disease away in asylums, a practice which a civilized nation cannot contemplate in respect of those whose health has been sacrificed in war. Is dubious about the quality of treatment which mentally ill soldiers might receive if sent to asylums since, she\* claims, the same medical staff are put in charge of these 'war hospitals' as were in charge of them as asylums.

A civilian, before being confined in these places, would have to be the subject of a formal certification process. Soldiers are being sent to them for no other reason than that their condition is not readily covered by existing criteria. Maintains that none of those now being arbitrarily confined would voluntarily enter an asylum. Is scathing about the education and general competency of mental nursing staff. The letter throws light on contemporary attitudes towards the asylum philosophy and of the divergent opinions on the treatment of mental disorders. An ardent campaigner for reform in the treatment of mental disorders, Dr.White uses the plight of those whose only wounds are of the mind to urge a different approach to treatment for both military and civilian sufferers.

\*'S.E.White' was in fact Dr.Sarah Elizabeth White, although her gender was not referred to in the protracted exchanges that followed (q.v.).

L. 24 July 1915 pp.178-9

Article:

'A Case of Hysterical Paraplegia'

Adolphe Abrahams, M..D., B.C.Cantab., M.R.C,P.Lond.,

Medical Registrar to the London Temperance Hospital;

Chief Assistant, Medical Out-Patients, St.Bartholemew's Hospital.

Temporary Lieutenant, R.A.M.C.

Gives details of the background to and treatment of a case of total paraplegia below the hips following a near explosion, with partial anaesthesia.

L. 31 July 1915 p.250

Letter:

'Hospital Treatment v. Lunacy Treatment'

(Sir) George H.Savage, London.

Comments on previous correspondence (see entry for 24 July above) from S.E.White. Defends the asylum system. Cites the lack of success of previous attempts to treat mental disorders in general hospitals. Recognises the stigma



attached to the word 'asylum' and notes that 'the newest institutions are called mental hospitals'. Claims that little has been added to the understanding of mental diseases by those outside the asylum system, and that the recent involvement of the neurologists has not bettered the results achieved by the 'alienists' such as those at Claybury and Cardiff.

In the course of a long career, Savage had been at various times Medical Superintendent of Bethlem Hospital and Editor of the influential *Journal of Mental Science*, (previously *The Asylum Journal*). In October 1912 he became the first President of the new Section of Psychiatry of the Royal Society of Medicine.

L. 31 July 1915 p.250

Letter:

'Hospital treatment v. Lunacy treatment'

Edwin Goodall.

Welsh Metropolitan War Hospital, Cardiff (previously the City Asylum).

The Welsh Metropolitan was one of the institutions praised by Sir George Savage as being models of good asylum practice. Goodall collaborated with Savage in writing what became standard texts on the pre-war care of the mentally ill. Goodall was that rarity amongst asylum Medical Superintendents; supportive of reform of the asylum system and the improvement of conditions for medical staff. He clearly resented what he regarded as ill-informed and inaccurate comments by S.E.White. Deals systematically with White's points and refutes her claims. Significantly, Goodall uses the male pronoun in several places.

L. 31 July 1915 p.250

Letter:

Hospital treatment v. Lunacy treatment'

R.H.Steen, City of London Mental Hospital, near Dartford, Kent.

Also attacks White's letter for its inaccuracies. Draws attention to a considerable number of voluntary patients in his (Steen's) hospital: defends the 'self-denying and capable men and women' of his nursing staff. Concludes by suggesting that the kindest comment on White's views might be that they are representative of someone who 'has only a limited experience in this class of work'.

L. 14 August 1915 pp.348-9

Editorial:

'Nervous manifestations due to the wind of explosions'

Refers to the major article of 27 March 1915, 'Shell explosions and the special senses' by W.Stoddart. Stoddart, however, is more concerned with the effects of near explosions on the senses of smell, taste, touch and hearing, whereas this editorial draws attention to French reports of internal damage to the respiratory, urinary, gastric and intestinal organs caused by 'vent du projectile'.



L. 14 August 1915 pp.359-60

Letter:

Hospital treatment v. Lunacy treatment'

Response from S.E.White to criticism of her letter of 24 March 1915.

L. 4 September 1915 pp.569-70

Letter:

Hospital treatment v. Lunacy treatment'

A new participant in the controversy, Major W.A.Chapple M.P., in support of Dr. White. Scathing attack on what he regards as the vaulting ambitions of the alienist and his desire to drag every kind of mental disorder behind the asylum walls. Notes the sense of power he experiences 'when ...cases are brought to him for treatment.' Chapple's other main concern is the 'ineradicable stigma' which attaches to asylums whether in the guise of War Hospitals or not.

L. 11 September 1915 pp.613-4

Editorial:

'The sudden greying of the hair'

Comments on the fact that the sudden greying (or whitening) of the hair is a phenomenon so remarkable that, while imperfectly understood, it seldom fails to excite curiosity and comment. Some theories are advanced, including that sudden shock, as for example being blown up or buried by an explosion, can precipitate sudden decolouration.

L. 11 September 1915 p.622

Letter:

'Hospital treatment v. Lunacy treatment'

(Sir) George Savage

Refers to the 4 September issue and a letter from Major W.A.Chapple on the subject. Points out that, in opposition to some opinions on the subject, the 'condemned (sic) alienist' as he wryly describes himself, appreciates that, in the early stages at least, it is not always possible to separate the curable from the incurable. Despite the recent change in perception and practice (asylums to mental hospitals, mad doctors to alienists etc.), there will still be the need for professional resources to identify, house, treat and care for the incurably insane, (presumably including those driven mad by the experiences of war).

L. 18 September 1915 pp.672-3

Letter:

'Hospital treatment v. Lunacy treatment'

W.A.Chapple.

Response to Savage's letter of 11 September. Examines the nature of the stigma attached to mental illness. For example, to have 'been in an asylum'.is 'indelible evidence' that the subject is unfit to be at liberty, and has been medically and legally consigned to a regime of confinement for the public good.



As such, Chapple argues, it is difficult to reverse the process to the stage where society can accept the subject as 'cured', in the same sense as physical ills can be cured. In mental illness, the suspicion that a dangerous relapse may occur is ever-present, obstructing any attempts at grading mental illness.

L. 20 November 1915 pp.1155-7

Editorial:

'Special hospitals for officers'

Gives a very full account of the setting up, following an appeal by Viscount Knutsford P.C., of three special hospitals for the treatment of officers suffering from mental and nervous disorders. Hospital I deals with cases broadly described as 'fatigue of the central nervous system', Hospital II as a convalescent home for Hospital I, and Hospital III for the cases with organic lesions'. A fourth planned hospital will deal with 'definite cases of mental disorder'. The article describes in detail the furnishing of each of the hospitals, stressing, for example, the austerity of the environment at Hospital I, with plain grey walls and no pictures or ornaments to distract the tired men, to whom complete and absolute rest of body and mind is the first essential of recovery'. A list of the medical staff is given, some of whom, like W.Aldren Turner, were to be among the first to write on the problem of neuropsychiatric disorders in the Great War. (See entry dated 27 May 1916 below for Turner's article describing the general arrangements for reception, accommodation, diagnosis and treatment).

L. 27 November 1915 pp.1201-2

Editorial:

'Lord Knutsford's special hospitals for officers'

Discusses the background to the emergence in modern times of neurasthenia, 'unknown by name at least to the medical student of 30 years ago'. stresses the differences between the present conflict and those of history, particularly the development of high explosives, the length and intensity of artillery bombardments, aerial attacks, and the unique strains imposed by these and other factors in combination with trench warfare. 'The [human] organism, not having had previous experience of such overwhelming stimuli, does not always adapt itself adequately to its environment, hence a long series of homecoming cases labelled more or less indefinitely as "nervous breakdown," "collapse," "shell shock," "shell concussion," "traumatic hysteria," [and] "traumatic neurasthenia," where the symptoms are insomnia, battle dreams, disturbances of the special senses "functional" palsies and anesthesias, emotional over-reaction, defects of mental synthesis, mental instability and disequilibrium, even paramnesia and hallucinations.'



L. 11 December 1915 1317-8

Letter:

'Nerve-strain and war'

S.E.White M.B. B.Sc.Lond.

Refers to the special hospitals for officers set up by Viscount Knutsford and hopes 'that within a short time ...treatment of a similar nature may be provided for those soldiers of the rank and file who have been similarly disabled'. Dr.White also points out that, although these cases are currently being treated in special annexes to county asylums, there is the danger that once there, they may be certified as insane on no greater authority than that of the asylum doctor and commanding officer. The kind of 'timely attention and the provision of suitable preventive measures' afforded by the Knutsford initiative, White argues, avoid the danger of those who have fought bravely for their country being certified as lunatics. Appropriate early treatment will prove invaluable' both in avoiding the stigma of lunacy and in 'promoting their restoration to health'.

In this letter White returns to an argument she first advanced in the issue of 24 July 1915, and which sparked off the exchanges between those who believed the day of the asylum had passed, and those 'alienists' such as Sir George Savage who felt that their curative record was being overlooked. He and other interested parties - Medical Superintendents in their previous incarnations - objected to the assertion that the capabilities of both medical and nursing staffs in asylums were inferior, and that in short, asylums were the gateway to oblivion, and their custodians little better than turnkeys. Some of the comments made by correspondents on this issue - White being openly hostile - give credence to this complaint.

L. 25 December 1915 pp.1399-1403

Article:

'Functional Nerve Disease and the Shock of Battle'

A study of the so-called traumatic neuroses arising in connexion with the war

David Forsyth M.D., D.Sc. Lond., F.R.C.P. Lond.

Physician to out-patients Charing Cross Hospital; Physician to the Evalina Hospital.

Traces the history of 'traumatic neuroses' from their original diagnosis by Erichsen in 1875, their refutation by Page in 1883 and the various opinions leading up to the modern view of this and related conditions. The fact of 'unprecedentedly numerous' casualties exhibiting all the symptoms described by earlier writers, Forsyth contends, has effectively countered assertions that much of the problem accompanied the introduction of the Workmen's Compensation Acts. Soldiers, Forsyth observes, can hardly be accused of attempting to extract compensation from the enemy, therefore some other explanation must be sought.

Describes how the suppression of the 'fight or flight' instinct affects even the most well-balanced mind if prolonged. Gives a number of examples of disorders of varying severity, including those who had not been under any significant



shelling. Describes various therapies from enforced bed rest for the milder cases, to extended courses of psycho-analysis. Forsyth believes the latter should be undertaken only for the minority who suffer from the more intractable disorders.

L. 25 December 1915 pp.1407-21

Editorial:

'The Annus Medicus 1915'

Detailed review of all branches of medicine, surgery, etc., in both the civil and military sectors. The review begins with a summary of the more significant developments during the year, in which the following appears (on p.1409).

'Affections of the nervous system: Nervous fatigue'

An increase in the number of nervous troubles is naturally to be anticipated during the time of war. Officers and men have been exposed to nerve-strain probably without precedent. Long hours of watching and responsibility, with deprivation of proper sleep, the intensity of artillery bombardments, and the degree to which mechanical devices for slaughter have been elaborated - all these and other factors combine to produce an effect which cannot fail to produce a deleterious effect. The symptoms are in some way similar to those which have been included under the term "traumatic neurasthenia", but certain phenomena are particularly prominent such as insomnia, nightmare generally associated with the horrors of battle, want of power of concentration of attention, loss of speech or hearing and in the more severe cases, mental irritability and even paramnesia and hallucinations. This condition occurs more frequently among the officers than in the ranks, perhaps because of the intense sense of responsibility experienced by the former. Various terms have been employed in naming these cases, but the expression "shell shock" is perhaps as appropriate as any other. Fortunately many cases show a tendency towards recovery, but until observation has been made 'the accurate ultimate prognosis cannot be determined'.

Under the heading of 'Neurology' (pp.1412-3), the following also appears:

'Not the least of the neurological questions raised has been the exact nature, diagnosis and treatment of cases of shell shock so-called, and the influence of shell concussion generally on the special senses and the central nervous system as a whole. We have already touched on the subject in an earlier section. Myers\* has published a valuable study of shell shock; (the item concludes with brief references to earlier *Lancet* articles, as well as French and other sources on this topic).

\* See entries dated 13 February 1915 *et seq.*

The above suggests that, after little more than a year of war, the question of mental and nervous disorders caused by battle conditions remained far from clear in the minds of the medical profession. There is a discernible and growing sense in the journals that the phenomena described above may have their causes in a wider range of conditions than are rehearsed here. There is also evidence in the reports already published in *The Lancet* - particularly those from R.A.M.C. officers in the field - that the 'open door' recruitment policies



under which the physical condition of applicants was almost the only concern, may have admitted considerable numbers of men with a predisposition to mental instability, or even an undisclosed history of mental illness. This implication is confirmed by an entry in the post-war Report of the War Office Committee of Enquiry on Shell Shock' (1922), (p.155), which recognises that some men were more susceptible than others and that the recruitment policies of the early days were not designed to identify them. Many of the cases analysed as part of the present study show this suspicion to be well-founded.

These same reports also suggest that mental disorders are not confined to the tens of thousands of enthusiastic volunteers. Members of the Regular forces, who might have been expected to withstand better the stresses and strains of modern warfare, are also seen to be succumbing in worrying numbers.

L. 25 December 1915 pp.1427-8

Letter:

'Crime and legal insanity'

Chas.A.Mercier

Refers to a previous issue of The Lancet (18 Dec.1915) and to an editorial regarding the criteria to be applied in deciding whether a plea of insanity is justified. Mercier states that 'in the ten years that have elapsed since my book was published .... I have evolved my ideas, and i could now elaborate a better formula...' This item is listed for its bearing on the continuing controversy regarding soldiers shot for alleged capital offences during the war, but who were allegedly suffering from mantal disorders which ought to have precluded the death penalty.



## 1916

L.8 January 1916 pp.65-9

Article:

'Contribution to the study of shell shock.

Being an account of certain cases treated by hypnosis.'

Charles S. Myers M.D., Sc.D., F.R.S., Major, R.A.M.C. (T.C.)

Continuing Myers' series of articles.

Gives details of case histories, treatment and disposal of shell shock treated by hypnosis in which the major symptoms were respectively total amnesia, mutism, stupor, spasmodic movements and rhythmic tremor.

L.15 January 1916 pp.163-4

Editorial note:

'A Regimental Medical Officer in Gallipoli'

Refers to a letter (written some time previous to publication) from a Lt.Col.F.E.Fremantle R.A.M.C. (Deputy Assistant Director of Medical Services) concerning his experiences during the Dardanelles campaign. Gives details of the extreme conditions faced by his division... 'fresh troops, straight out from a life of healthy training but with no experience of war'. Comments on the various wounds and sicknesses of the campaign, and the strain under which his front line medical officers had to work. These included cases of 'exhaustion, capped by a shell explosion within a few feet; the third, a jolly young giant from a prosperous suburban practice, finally succumbed to the shock of being called to attend to four of his best pals, laid out by a single shell'.

L. 15 January 1916 p.167

Note on Parliamentary proceedings:

'Accommodation for wounded in asylums'

(a) Ministerial reply to the effect that ten asylums in England and Wales and isolated parts of two others have been placed at the disposal of the War Office for use as hospitals, and accommodation has thereby been provided for over 14,000 sick and wounded soldiers.

(b) Minister confirms that female nurses are being used in male wards of asylums, where recruitment into the armed forces makes this necessary. States that 'appropriate safeguards' are in place, but does not specify their nature.

N.B. This announcement was in fact a year out of date. The Asylum War Hospitals Scheme was planned in late 1914 and implemented from early 1915 onwards. The first 'vacated' asylum to receive military patients was the West Sussex County Asylum, Chichester (renamed 'Graylingwell War Hospital') on 11 May 1915. The new but unoccupied Moss Side State Institution at Maghull near Liverpool) had already been loaned to the military under the Scheme and received its first patients on 21 December 1914. (Cooke and Bond, 1920). See entry under 'Official Publications', Bibliography, Part One.



L. 22 January 1916 p.212

Letter:

'Loss of speech and shell shock'

J. McLaughlin M.D., Lieutenant-Colonel (late) R.A.M.C.

The writer claims that in 22 years of service he treated five cases of speech loss reportedly due to shock. He states that 'they were all cases of malingering and recovered their voice under an anaesthetic.

[...] 'keep the patient under it for half an hour, and he will have plenty to say when he recovers.'

L. 5 February 1916 p.318

Letter:

'Functional nervous disease.'

H. Bryan Donkin

Attacks the 'evils' of psycho-analysis: argues that its dangers are not addressed by re-naming psycho-analysis 'autognosis' as William Brown has advocated.

L. 5 February 1916 pp.206-7

Editorial note:

'A discussion on shell shock'

Refers to a 'special discussion on functional neuroses caused by shell shock which had taken place at the Royal Society of Medicine on 25 and 27 January 1916. The 'keynote' address was given by F.W.Mott, whose Lettsomian Lectures deal with the subject at length (and are reported in subsequent issues of The Lancet). 'Much variety of opinion on origin, symptoms and treatment came to light. Indeed, Dr. Henry Head was not even content to allow the separate existence of the subject under discussion, holding it to be a heterogeneous collection of different nervous affections from concussion to sheer funk, which have merely this much in common that nervous control has at last given way. To him it would be just as reasonable to sweep up the various fruits which fall from the trees in a strong wind and then to discuss them without first stating that some fell from an apple and some from a pear tree. The article goes on to outline other and contradictory opinions and personal experiences in treating cases, ranging from mild to severe.

L. 18 March 1916 pp.608-13

Article:

'Contribution to the study of shell shock,  
being an account of certain disorders of cutaneous sensibility'  
(Lecture III)

Charles S. Myers, M.D., Sc.D., F.R.S.

Lieutenant-Colonel, R.A.M.C. (T.C.)

In this, the third lecture of his series, Myers records a number of cases that have come under his care, including those of hyperaesthesia, anaesthesia and hemi-aesthesia. He examines the influence of personal and family histories of mental disorder, and the effects on patients of protracted examination.



L. 18 March 1916 pp.627-8

Editorial:

'Neurasthenia and Shell Shock'

Recalls that in the early days of the war, men sent back from the front reportedly suffering from nervous disorders brought on by the stresses of combat, were treated as if they were either insane or malingerers. Sufferers were either consigned to asylums, sent back to the fighting, or were discharged as being unfit for further military service 'with an inadequate pension.' The differing approaches of recognised experts are noted, in particular those of F.W.Mott and C.S.Myers, (q.v.) The former believed he has detected actual structural or pathological changes in the central nervous system,' as the result of exposure to violent explosions, burials etc. Myers, on the other hand, prefers a more psycho-centralised explanation, stressing the effects of predisposition.

The editorial concludes with the observation; 'Medical men may feel in entire agreement with Major MOTTS concluding remark: "We will need a brand-new Dictionary." There are numerous new as well as old terms employed. With "a newly earned meaning" by both Major MOTT and Colonel MYERS; whether they will remain as premanent aquisitions will probably depend on the general recognition of their utility, of which the future must be the judge.'

L. 15 April 1916 pp.813-817

Article: (Part One)

'Shock and the soldier'

G.Elliott Smith M.A., M.D., Sydney and Adelaide, F.R.C.P. Lond., F.R.S., Professor of Anatomy and Dean of the Faculty of Medicine in the University of Manchester.

The article was published following a period in the summer of 1915, when the author, together with his colleague Thomas Pear, spent his vacation from the University of Manchester working as a temporary member of the medical team at the Moss Side Military Hospital at Maghull, near Liverpool. Moss Side was the first special centre to be opened for the treatment of mental and nervous disorders in the 'other ranks' of the Army. For most of its wartime existence, Moss Side was under the direction of R.G.Rows.

In addition to Elliott Smith and T.H.Pear, William Brown and W.H.R.Rivers were at various times part of the medical team.

This first part of Elliott Smith's article deals mainly with a description of the neuropsychiatric problems of the war, and with a general review of the many mistakes the writer believes have been made in formulating British Army policy and practice. Is especially critical of the practice of sending neuropsychiatric casualties to general hospitals, where there is a severe shortage of medical officers with the necessary experience. The article is most useful in giving an overview of the situation as perceived by a non-specialist in neuropsychiatric medicine.



L. 22 April 1916 pp.853-5

Article: (Conclusion)

'Shock and the soldier'

G.Elliott Smith M.A., M.D., Sydney and Adelaide, F.R.C.P. Lond., F.R.S., Professor of Anatomy and Dean of the Faculty of Medicine in the University of Manchester.

Examines the situation of discharged military mental and nervous patients, noting a general uncertainty on the part of the authorities as to their ability to cope with civilian life. The problem of readjustment is likely to be greater for the ex-Regular than for 'hostilities only' soldier, because in most cases the Regular has been used to the comparative insularity of Army life for much longer.

L. 13 May 1916 p.1006

Editorial:

'The medical examination of recruits'

Points to a number of shortcomings in the way recruits are examined, claiming that failure to detect ill,health at the earliest possible moment leads to breakdown in service and to waste of resources.

L. 20 May 1916 pp.1048-9

Editorial:

'The diseases of active service'

Reviews the history of the conflict, contrasting experience with that of earlier wars. Notes the tendency to regard certain diseases as 'peculiar to service in the field' demonstrated by the adoption of relevant descriptive terms such as 'trench foot', 'trench fever', 'trench nephritis' and 'shell shock'.

L. 27 May 1916 pp.1073-5

Article:

'Arrangements for the care of cases of nervous and mental shock coming from overseas'

William Aldren Turner M.D.Edin., F.R.C.P. Lond.

Lt.Col. R.A.M.C.(T) Physician to King's College Hospital and to the National Hospital for the Paralysed and Epileptic, Queen Square London.

Wide-ranging review of the Army's arrangements from the earliest months of the war. Conveys a comforting view of a highly organised, responsive and expert system, a view which is not wholly borne out by the facts



L. 27 May 1916 pp.1080-2

Article:

'Warfare neuroses of the throat and ear'

John F. O'Malley, F.R.C.S.Eng., Captain (Temporary), R.A.M.C., Surgeon for Diseases of the Ear, Nose and Throat, Royal Herbert Hospital, Woolwich, and Evelina Hospital for Sick Children; and Surgeon, Royal Ear Hospital, London.

Briefly describes the physiology of the ear nose and throat and the treatment given to a number of cases of wounds therein. The title is misleading in that the cause of some of the cases described was wholly physical, e.g., bullet wounds of the neck. The writer claims to have effected rapid cures, largely by use of the laryngeal mirror to observe the behaviour of the vocal cords, while at the same time inducing the production and expectoration of mucus by friction with the mirror.. The consequent restoration of the ability to cough and hence to make sounds, convinced the patient that his latent ability had been restored, and this in turn brought about rapid improvement. The element of psychological suggestion in the treatment of these cases is thus very marked: in none of them was surgical intervention attempted.

L. 17 June 1916 pp.1207-12

Article:

'A contribution to the etiology of shell shock'

Harold Wiltshire M.A., M.D.Cantab.,

Assistant Physician, King's College Hospital, London.

Late Temporary Captain, R.A.M.C.

Puts forward the view that the nervous disorders of the present war are no different to those of civil life. The experience now being gained should therefore be 'of great value helping to elucidate problems connected with the etiology of functional nervous disease in general'. Wiltshire also notes that 'up to the present, more has been done to deny than to disprove the universal application of the "sex" theory by Freud and his followers. It is obvious that these cases of so-called "shell shock" should be invaluable for the latter purpose. At the present time, however, the etiology of "shell shock" is buried in confusion, owing to three main difficulties, namely:-

- (a) Bad terminology.
- (b) Dubious clinical histories.
- (c) Rapid changes in clinical condition.

Each of the above headings is discussed at length.

L. 24 June 1916 pp.1268-9



Editorial:

'Paralysis from fright'

Recounts the case of a soldier admitted to the Canadian Hospital in France suffering from boils and facial paralysis'. The patient, a very young bugler, had apparently been put on his first guard duty at a building being used as a temporary mortuary. Part of his duty was to kick at the door at 15 minute intervals, to discourage the rats from attacking the corpses. Although extremely nervous, he performed this task assiduously for some time, gaining a little courage each time. Unknown to him, however, the guard commander had ordered a drunken soldier to be put in the dead-house to sober up, presumably in the hope that the awakening might serve to dissuade him from further transgressions. As the fumes of alcohol dispersed, the drunk partially recovered his senses, only to hear the guard's thunderous kicking at the door. "What the hell are you kicking about?" the drunk inquired plaintively. The rest of the anecdote follows a wholly predictable path.

L. 12 August 1916 pp.264-8

Report of an address:

'The psycho-pathology of the war neuroses'

Delivered at the Malta Medical Conference April 9th 1916

M.D.Eder, B.Sc.Lond., M.R.C.S., L.R.C.P.Lond. Temporary Captain, R.A.M.C.

Late Medical Officer in Charge, Psycho-Neurological Department, Malta.

Notes the tendency to refer to the present conflict as 'industrial warfare'. From the medical standpoint a more accurate description would be 'nerve warfare', since the most outstanding novel characteristic has been the incidence of nervous and mental disorders with which the medical profession has had to contend. Describes a number of cases dealt with including functional ambylopias, contractures, irrational incapacitating fears and phobias etc. Discusses the merits of various treatments including hypnotism and suggestion.

L. 19 August 1916 p.343

Letter:

'The psycho-pathology of the war neuroses'

G.Burton-Brown M.D.

Criticises Eder on the grounds of alleged inaccurate observations. Eder records that in Case 7, a young sailor states that he rang down for 'full speed ahead' when the correct terminology is 'full steam ahead'. On that basis, Burton-Brown casts doubt on the whole of Eder's findings, stating that; ...'if it is so in this case it is probably so in others'.

L.

9 September 1916 pp.461-3

Article:

'Contributions to the study of shell shock'

'Being an account of certain disorders of speech, with special reference to their causation and their relation to malingering.'

Charles Myers M.D., D.Sc., F.R.S., Lieutenant-Colonel, R.A.M.C. (T.C.)



Continuing Myers' series of articles. Reviews speech disorders under three main headings, aphonia, dysarthria and mutism. Gives detailed case histories under each of the headings.

N.B. Myers was appointed Consulting Psychologist to the B.E.F. in August 1916.

L. 21 October 1916 pp.707-9

Article:

'A series of military cases treated by hypnotic suggestion'

J.Bennett Tombleson, M.B. B.Ch., Oxon.

Lieutenant (Local Captain) R.A.M.C.

Gives in tabular form details of 60 cases of nervous and physical disorders treated by the title means. Specifies case number., rank, age, disease, disability, duration, history, date of admission, days treated, degree of hypnosis, and result.

L. 18 November 1916 pp.860-2

Article:

'The psychology of malingering and functional neuroses in peace and war.'

Thomas Lumsden M.D.Aberd., Deputy Chief Medical Examiner,

London County Council etc.

Puts forward a number of physicalist explanations for neuropsychiatric disorders. In respect of neurasthenia, maintains that individuals have a reserve of 'ergogen' varying from person to person. The exhaustion of this results in neurasthenia. In this at least, Lumsden's ideas find some support in those of F.W.Mott whose later Lettsomian lectures expound similar 'nerve bank account' ideas. Discusses 'combined' cases e.g. the section entitled "traumatic neurasthenia and "shell shock"...the case then becomes a combination of all the three disorders mentioned above - hysteria, neurasthenia and malingering. After a shock, for instance being blown up on a ship which is torpedoed, a sailor or passenger may lose his nerve so much that he shudders 'at the sight or even at the thought of a ship at sea. This state (in so far as it is unreasonable) I look upon as clearly hysterical, a result of disordered emotions; it is true that it may induce neurasthenia if the man's livelihood entails voyaging, as he will worry for the loss of his occupation and pay, but the condition is not essentially neurasthenic.

L. 30 December 1916 pp.1095-9

Article:

'Warfare on the brain'

E.Farquhar Buzzard, M.D.Oxon., F.R.C.P.Lond., Captain, R.A.M.C.(T);

Physician to Out-patients Department, St,Thomas's Hospital and National Hospital for the Paralysed and Epileptic; Honorary Physician, King George Hospital, etc.

Provides a wide-ranging review of the causation and treatment of those mental and nervous disorders, most importantly shell shock and traumatic epilepsy, now so prevalent. 'There can be no medical man in this country at the present



time who is not constantly being brought in contact with these psychical and physical injuries and who does not appreciate the difficulties which surround their proper interpretation and their proper treatment.'

L. 30 December 1916 pp.1107-15

Editorial:

'The Annus Medicus 1916'

The section on shell shock (p.1108) begins: 'Much has been written and various discussions have taken place during the year on the condition known as shell shock. Ever since the term has been introduced there has been a tendency to consider that the cases might be divisible into two classes. One class has been assumed to include various exaggerations of pre-existing forms of mental deficiency, the second has been held to be akin to hysterical manifestations. The number of cases now investigated appears to afford conclusive evidence that the subject of shell shock is not likely to be disposed of on either hypothesis.' The section goes on to discuss the contributions of two of the more important writers on the subject, F.W.Mott and C.S. Myers. The former, who in 1916 was a Major in the R.A.M.C. had during the year given the Lettsomian Lectures on the topic of 'Effects of High Explosives on the Central Nervous System', details of which can be found in earlier entries. Myers was a comparatively prolific writer on shell shock, having had published the first of several items under the title 'A Contribution to the study of shell shock' as early as 2 February 1915. In it, Myers introduced the term 'shell shock' although he later criticised its misuse, nor did he claim to have actually coined it.

The section on 'soldier's heart' (pp.1106-9), emphasises the involvement of the central nervous system, and the marked mental and nervous symptoms such as irritability, depression and obsessive hypochondria which typically accompany this condition. pp.1111-2 refer briefly to 'nervous affections' and 'neuroses' respectively.



1917

L. 17 February 1917 pp.269-70

Editorial note:

'A rare form of war neurosis'

Comments on a report in the French *Nouvelle Econographie de la Salpêtrière*, No.1 (1915-1917) in which the author, one Madame Rosanoff Saloff, describes 'a curious and uncommon condition', which she has observed in certain of the cases coming under her care. In it, the sufferer develops an extreme anterior curvature of the spine, i.e., literally strives to bend over backwards, in a manner the editorial describes as reminiscent of 'The Man with the Muck Rake'. The reference is clearly to an image - possibly a cartoon, sufficiently well-known to be common currency among readers of *The Lancet*. The condition is the more puzzling in that patients are fully capable of lying flat on both back and face.

L. 24 March 1917 pp.452-3

Article:

'The nervous factor in relation to ophthalmic conditions'

T.E.Harwood, B.A.Oxon. ,M.B.,Ch.B.Edin., Resident Ophthalmic Officer, The King George Hospital, London,S.E.

Notes that:

'The war is the greatest nervous strain the world has ever known and has brought the nervous element in disease into prominence again. It is impossible to remain long in a large military hospital at the present time without seeing the essential similiarity between the effects of fatigue, shock, and traumatism and the results of intoxication, glandular deficiencies, dietetic errors, and psychic influences.'

L. 8 June 1917 pp.867-72

Article:

'The treatment of some common war neuroses'

E.D.Adrian, M.R.C.P.Lond., Temporary Captain, R.A.M.C., Superintendent, Connaught Hospital, Aldershot and;  
L.R.Yealland, M.D., Resident Medical Officer, National Hospital for the Paralyzed and Epileptic, Queen Square, London.

The authors describe the treatment of some of the 250 cases with which they have been concerned, and in which there is an objective disorder, such as paralysis, loss of speech etc., without showing signs of organic change in the central nervous system.' They must be distinguished from the 'neurasthenic and psychasthenic conditions, where patients have subjective complaints, headaches, feelings of exhaustion and depression, and very little in the way of physical signs. At the same time it is a difficult matter to find a suitable name for them. Were it not for the stigma attached to the word, one would not hesitate to class them as hysterical'.



L. 16 June 1917 pp.907-10

Article:

'Neurasthenia in soldiers of the Home Forces'

F.W.Burton-Fanning, M.D.Cantab., F.R.C.P.Lond.,

Lieutenant-Colonel, R.A.M.C.(T).

(Report to the Medical Research Committee).

The stated aim of the report is to draw attention to the 'predominance of neurasthenia as a cause of going sick among our newly recruited soldiers.' The writer, now serving overseas, refers to a time prior to his transfer when for 10 months he had charge of beds in the 1st Eastern General Hospital, Cambridge. 2240 patients had been admitted during the period, of which 1600 had come from the Home Forces. Sub-headings include 'The Story of the Neurasthenic Soldier', 'Symptoms and Signs', 'Patients' Complaints', 'The Heart', 'Prevention' and 'Treatment - Prognosis'.

L. 16 June 1917 pp.912-4

Article:

'Freud's psychology of the unconscious'

W.H.R.Rivers, M.D., Lond., F.R.C.P.Lond., F.R.S. Temporary Captain, R.A.M.C.

(Text of a paper read to a meeting of the Edinburgh Pathological Club, 7 March 1917).

Outlines the basis of Freud's theories including:

- (1) Theoretical scope
- (2) Unconscious experience (personal and inherited)
- (3) Mental conflict (Dissociation, sexual experience)
- (4) Evidence afforded by the war\*
- (5) Line of treatment to be followed\*

\* Rivers sees it as deeply ironic that the advent of the Freudian theories of psychology should have been followed so closely by the outbreak of war, and the consequent unique opportunity to study the mental strains of conflict in their light. He also sees it as an opportunity overwhelmed by the immediate crisis of having to cope with the large numbers of men suffering from mental disorders.

L. 23 June 1917 p.974

Report of Parliamentary proceedings:

'Treatment of Shell Shock'

The Under-Secretary for War was asked whether it could be made possible for soldiers 'suffering from shell-shock and other convalescents' to be employed in agriculture and horticulture, or to be allowed to cultivate any spare land that might be conveniently available, 'so as to afford the men some relief from the



monotony of their existence and give them an interest in life'.The reply was that this was already being done.

L. 4 August 1917 p.163

Book review:

*Malingering, or the simulation of disease*

A.Bassett Jones, M.B. and Llewelyn J.Llewellyn, M.B.

With a chapter on malingering in relation to the eye by W.M.Beaumont.

Wm.Heinemann, London. 1917

Deals with the subject exhaustively and, according to the reviewer, with a high degree of literary ability and admirable scholarship. Refers only to civilian experience, but useful in that the book specifies various techniques used by patients. In view of its late date the book, by ignoring the topic of wartime malingering and simulation, has a somewhat detached, not to say unreal sense about it.

L. 1 September 1917 pp.352-3

Editorial:

'The effect of war upon psychiatry in England'

Notes that the enormous scale of the present conflict has thrown up unprecedented numbers of cases of mental and neurological disorders. Comments on the large number of articles, etc., published about these subjects in the professional press since the war began, expressing the view that this must have had the effect, if not of quickening interest in neurology and psychiatry, then at least of making the profession aware of their existence, and of bringing them in closer contact with the mainstream of medicine. A recently published book by G.Elliott Smith and T.H.Pear, *Shell Shock and its Lessons*, Longmans Green & Co., (London 1917) is cited.

L. 8 September 1917 p.407

Letter:

'Psychiatry in England'

L.A.Weatherly M.D., Bournemouth.

The writer comments on the editorial of 1 September, and on the book by Elliot Smith and Pear cited therein. He criticises what he sees as a regrettable tendency to view shell shock as a single category of disorder. Each case needs to be treated individually; priority must be given to the provision of 'a happy environment', agreeable companions and cheerful, well-trained nursing staff having a positive approach. Weatherly is convinced that given these conditions a cure is not only possible, but assured. This, he argues, restores the patient's self-confidence, fostering the all-important will to recover. Weatherly contends that Elliot Smith and Pear place too much emphasis on the role of the physician, and not enough on the 'team' philosophy which he himself claims to have found most effective.



L. 22 September 1917 pp.456-7

Article:

'Blood pressure and surface temperature in 110 cases of shell shock'

Edith N.M.Green, M.B.Lond., Research Scholar under the medical Research Committee, working as Assistant to Major F.W.Mott at the Maudsley Hospital.

Gives details of the examination and treatment of patients, and of the comparative results obtained by the administration of pituitrin and thyroid extracts. Some detailed case histories are recorded.

L. 22 September 1917 p.478

Editorial Note:

Medical Boards for functional nervous disorders'

Relays and supports a call from the Ministry of Pensions for medical practitioners to volunteer their services as members of boards sitting to assess the eligibility for pensions of men discharged from the Army for neurasthenia and functional nervous disorders'.

L. 20 October 1917 pp.600-2

Article:

'Gastric atony and war neurasthenia'

J.Campbell McLure, M.D.Glasg., Captain, C.A.M.C. Physician to Out-Patient's, French Hospital and to Red Cross Clinic for the Physical Treatment of Officers, London.

Outlines the method by which the body deals with intake of food, and describes some of the 'large number' of cases suffering from chronic disorders of the digestive organs commonly identified with war neuroses. These were treated by a variety of methods including baths, manipulation, douches and electrical stimulation of various kinds.

L. 20 October 1917 pp.612-3

Editorial:

'The problem of the insane sailor and soldier'

Adumbrates considerable problems in caring for Servicemen 'who have become insane or who are otherwise mentally afflicted' as the result of their war experiences. 'It may be taken for granted that the Government and the country desire that all who have broken down while wearing the King's uniform should be treated justly and even generously'. Contends that cases of insanity due to syphilis or other cases where an element of self-inflicted injury is proven should be excluded, and only receive that treatment they would normally have been given in civilian life.



L. 20 October 1917 p.621

Letter:

'Spiral fields of vision and neurasthenia'

W.M.Beaumont, Bath.

Refers to a book review of 4 August issue and states that, in his experience, spiral fields of vision are routinely associated with the neurasthenic condition.

L. 27 October 1917 p.659

Letter:

Insane sailors and soldiers'

R.H.Stern, Royal London Mental Hospital, Dartford, Kent.

Refers to previous correspondence on this subject, particularly the arguments for special military asylums and against putting insane servicemen in civilian asylums, as shameful reward for having sacrificed their sanity in the country's cause. Stern points out that there are many private patients in public asylums. Few people outside the asylums themselves can distinguish between public and private inmates. The fear that ex-servicemen will be automatically identified as paupers is therefore unfounded.

L. 17 November 1917 pp.768-9

Letter:

'Spiral fields of vision in hysteria, malingering and neurasthenia'

C.H.Browning and David Ligat, The Middlesex Hospital, London.

(On the same page there is a contribution to this debate from Arthur F.Hurst).

The debate is inconclusive.

L. 24 November 1917 p.797

Editorial:

'The treatment of war neuroses'

Refers to a scheme put forward by Dr.Thomas Lumsden in The Times of recent date known as the "Country Host Institution" scheme. Under it, 'patients of a suitable character' would be billeted in country areas, where they might be expected to benefit from the 'peaceful environment'. It seems that the scheme, supported by the President of the Special Board on Neurasthenia and also by the 'highest military authorities', is languishing for lack of sufficient volunteers, and through a less than enthusiastic Government attitude.

L. 24 November 1917 p.804

Letter:

Thomas Lumsden

Sets out in detail his proposals for a 'Country Host Institution' (see item above). Lumsden refers to the War office conference on neurasthenia and the proposed establishment of special urban institutions which he believes are planned 'for



convenience of management' and not in the anticipation of cure of mental disorders, much less the happiness and well-being of the sufferers.

N.B. This, and the preceding item on the same subject, are notable for the freedom with which the terms 'shell shock' and 'neurasthenia' are used synonymously.



## 1918

L. 5 January 1918 pp.25-6

Book review:

Military medical manuals

Reviews the first six volumes of the 'Horizon' series of French primers, 'translated into English under the general editorial control of Sir Alfred Keogh', (Director-General of Army Medical Services). The volumes cover a number of topics, including *Hysteria or Pithiatism* by J.Babinski & J.Froment, edited by Dr.Farquhar Buzzard, and *The Psychoneuroses of War* by G.Roussy & J.Llehermitte, edited by Dr.W.Aldren Turner. (Both Buzzard and Turner had been actively engaged in treating mental disorders in the Armed forces since the outbreak of war, and had been published extensively in *The Lancet* and elsewhere).

L. 12 January 1918 p.63

Book review:

*The Psychology of War*,

John T. MacCurdy M.D., Heinemann, (London. 1917).

The author, a lecturer in medical psychology at Cornell University, takes the entry of the United States into the war as an opportunity to publish his views on the reasons why nations go to war, and to examine how these motives can be accounted for by reference to current psychological theories. In particular, he attempts to reconcile those of Freud and Trotter by suggesting 'that Trotter's "herd instinct" is in fact the repressive force behind Freud's "unconscious, primitive instincts" of selfish violence. The reviewer does not record his views on how far, in the space of 68 pages, MacCurdy succeeds in his self-appointed task.

An extremely perceptive and comprehensive work, but rendered much less useful than it might be by the frustrating lack of an index.

Foreword by W.H.R.Rivers

L. 26 January 1918 pp.127-9

Article:

'War psycho-neurosis:

(1). Neurasthenia: The disorders and disabilities of fear.'

Address before the Harveian Society of London, (16 December 1917)

F.W.Mott, M.D., LL.D., F.R.S., F.R.C.P.

Brevet Lieutenant-Colonel, R.A.M.C.(T), Maudsley Extension, 4th. London General Hospital.

Contains a useful definition of neurasthenia taken from Djerine. 'Neurasthenia consists of the ensemble of phenomena which result from the non-adaptation of the individual to a continuous emotive cause and the struggle of the individual for this adaptation'. The problem in using such a definition, Mott implies, is that the 'ensemble' is itself so diffuse and ubiquitous as to make definitions themselves superfluous. Mott also maintains strongly that neurasthenia is being



widely misapplied in order to 'cloak ignorance, to help deception, and to aid fraud...almost every form of insanity has been designated neurasthenia.'

L. 2 February 1918 pp.169-72

Article:

'War psycho-neurosis'

F.W.Mott

(2). The psychology of soldier's dreams.

Address before the Psychiatric Section of the Royal Society of Medicine (8 January 1918).

This is the second in a series of lectures given by F.W.Mott around this time, (see item above). In this, he cites a number of case histories to illustrate the factors which lead to the onset of neurosis. Describes the various developmental stages to the point where dreams become part of the experience, and the point where a reaction intervenes. This is where dreams, (usually of a terrifying nature) exert varying influences on the development of the neurasthenic condition.

L. 2 February 1918 pp.177-9

'The predispositioning factors of war psycho-neuroses'.

Captain Julian M. Wolfsohn, M.S., M.D., M.R.C.,

Assistant Professor Nervous Diseases, Leland Stanford Jr. University, California.

The Maudsley Extension, 4th London General Hospital.

Notable for being the first paper to be published in *The Lancet* by an officer of the United States Army Medical Corps. A number of these were attached to the Maudsley and other U.K.hospitals in advance of America's entry into the war on 6 April 1917. Predisposition as the result of family history, previous mental illness and the failure of Medical boards to weed out unsuitable recruits was a continuing debate. Wolfsohn worked closely with F.W.Mott. The results of this study were incorporated into Mott's 1917 Shell Shock and War Neuroses, and Mott cited Wolfsohn's findings as evidence to the 1922 Southborough Committee on shell shock.

L. 9 February 1918 pp.233-4

Letter:

'War psycho-neuroses'

(Temporary) Major R.Worth and (Temporary) Lieutenant T.A.Ross,

R.A.M.C. War Hospital, London.

Robert Armstrong-Jones, Harley Street, London.

The former correspondents take issue with Wolfsohn's contention that neurotic patients should be removed from air raid zones as a matter of urgency. Their experience is that to do so would create a situation in which any noise, however inoffensive in the normal sense, being identified as a problem and a bar to recovery. Much better to explain to the patient why the noise frightens him, reinforcing their fortitude and making light of the event. Armstrong-Jones is concerned with terminology, pointing out that 'psycho-neurosis' has been in use for 40 years. In view of the 'opprobrium' recently attached to the term



'hysteria' the writer proposes its replacement by Babinski's term 'pithiatic', giving the Greek provenance for this word.

L. 9 February 1918 p.238

Report of Parliamentary proceedings:

'Shell shock cases in London hospitals'

(Re air raids) The Under-Secretary of State for War, answering a Question, confirmed that patients suffering from shell shock were being transferred to safe areas and that 450 'have just left' (5 February 1918).

L. 2 March 1918 p.349

Letter:

'War psycho-neurosis'

David Drummond, Newcastle-on-Tyne.

Writes approvingly of Mott's two addresses on the title subject, and wishes to add a further aspect of importance, namely, the patient's will to recover. Drummond fiercely critical of those who fail to maintain a positive attitude to their malady, associating such attitudes with malingering, which in turn he sees as 'deserving of our condemnation'.

L. 2 March 1918 p.354

Report:

A meeting of the Medico-Psychological Society of Great Britain, held at the 4th London General Hospital, 21 February 1918. The main business of the meeting was an address by Col. F.W.Mott, on the the subject of 'War psychoses and psychoneuroses'. He said that there were 'two conditions in connexion with shell shock, and in the old days when a soldier came into hospital, and we had to learn from him what happened, it was all "shell shock". But since the use of the new Army form, one knew whether the man was blown up or not. He had often had his suspicions that many of the cases were "shell-shy". True shell shock casualties had been blown up and lost consciousness. There was evidence of a condition having arisen 'which might produce organic change.' This conforms very much to Mott's emphasis on the 'commotional' effects of high explosives, what Roussy and Llehermitte had described graphically as the 'vent du projectile'. It was also a subject on which he had earlier delivered the Lettsomian lectures, and on which he was to publish soon after the war.

(See biliography Part One)

L. 9 March 1918 p.394

Editorial note:

'Shell shock and alcoholism'

Refers to a New Zealand report based on research carried out at N.Z. institutions to the effect that:



- (a) Total abstainers are more likely to suffer from shell shock
- (b) Sufferers from shell shock are adversely affected by alcohol.

L. 20 April 1918 p.587

Report of Parliamentary proceedings:

'Pleas of shell shock at courts-martial'

The Secretary of State for War confirmed that when a Medical Board is convened as the result of a plea of shell shock forming part of the defence, the Board is instructed to:

- (a) Determine whether the accused is suffering from shell shock.
- (b) Give an opinion whether the accused was suffering from shell shock at the time of the alleged offence.

L. 4 May 1918 p.643

Editorial note:

'Hospital treatment v. Asylum treatment'

Refers to a debate which took place in its columns in October 1917 regarding the policy of sending insane sailors and soldiers to County Asylums through the Poor Law Infirmaries. Complains that men in need of asylum treatment are being delayed in the infirmaries.

L. 8 June 1918 pp.795-6

Article:

'So-called functional symptoms in organic nerve disorders'

John S.B.Stopford, M.D.Manch., Lecturer in Anatomy,  
University of Manchester.

(Report to the Medical Research Committee.)

Investigates the relationship between physiological damage and nerve disorders. Concludes that, in minor wound cases, complaints of nerve disorders are either missed through ignorance or inexperience on the part of the medical officer, or dismissed as trivial in comparison to the organic damage. As the healing progresses, there is a tendency for the nerve disorder to become more marked, by which time the best opportunity for cure may have been lost. Advocates 'patience and diligence' in treating these cases.

L. 8 June 1918 p.827

Report:

A meeting of the Medico-Psychological Society of Great Britain and Ireland on 28 May 1918 at which Dr. John Turner presented early results of his post mortem research on the brains of the insane. Describes some anomalies found in the architecture and cellular structure of the brain in specific areas and between the sexes, but is unable to draw firm conclusions from them.



L. 20 July 1918 p.82

Editorial note:

'The treatment of functional nervous disorders in the Army'

Refers to the conscription of doctors into the R.A.M.C. and, in the case of the more experienced, to their possible desire 'to do work that has some bearing on the less mechanical aspects of medicine'. Points to the 'vast field' of useful and interesting work in the treatment of those functional nervous disorders usually classed together under the heading of 'shell shock' which the war has revealed. Those interested are urged to request special training as soon as they are called up, to ensure 'that the treatment of functional nervous disorders should fall into the hands of those competent to give it with the necessary sympathy and enthusiasm'.

N.B. This item was claimed by Charles Myers to be the result of his representations to the London Conference of senior medical officers of which he was a member. See: Myers C.S., *Shell Shock in France*, Cambridge University Press, (Cambridge 1940), p.126.

L. 27 July 1918 pp.97-9

Report of lecture:

'Remarks on the Pathology of War Neuroses'

An Address given to the officers at the Lord Derby War Hospital, Warrington.

Judson S. Bury M.D.Lond., F.R.C.P.Lond.

Major, R.A.M.C.(T), Consulting Physician to the Manchester Royal Infirmary.

Gives details of observed symptoms of war neuroses. Useful explanation of terms, and a list of references of contemporary literature on the subject by the author and many others, including F.W.Mott and W.H.R.Rivers.

L. 27 July 1918 pp.100-1

Article:

'Gunshot Wounds of the Peripheral Nerves'

C.Noon F.R.C.S.Eng., Temporary Major, R.A.M.C.;

Officer in Charge of the Surgical Division of the Norfolk War Hospital.

Gives details of 364 cases of title wounds admitted between June 1915 and March 1918 to the N.W.Hosp., and of the treatment given.

L. 27 July 1918 p.111

Editorial:

'The Fifth Year of War,

Review of the War to date: notes that fighting is unabated and numbers of casualties rising. Exhorts medical profession to maintain efforts and to think also of the task of rehabilitation of casualties.



L. 27 July 1918 p.131

Report of Parliamentary proceedings:

'Treatment of nerve strain'

The Parliamentary Secretary to the Ministry of Pensions told the House that for functional nerve disorders, six 'homes of recovery' had been established as listed below;

|               |              |
|---------------|--------------|
| London        | 120 patients |
| Leicester     | 60           |
| Nr.Manchester | 100          |
| Edinburgh     | 30-60        |
| Dublin        | 33           |
| Belfast       | 62           |

The Secretary stated that his Departmental records did not show how many cases had been admitted since the homes had been opened (date?). He confirmed that the homes had 'no connexion with lunacy administration or lunacy staff'. (An obvious reference to the controversy surrounding the transfer of insane servicemen to county asylums without the safeguards of the statutory certification procedure).

See entry for 24 July 1915 et seq.

L. 3 August 1918 pp.139-41

Article:

'The rapid cure of hysterical symptoms in soldiers'

A.F.Hurst M.A., M.D.Cantab., F.R.C.P., Temporary Major R.A.M.C., Physician and Neurologist, Guys Hospital; Officer in Charge of Seale Hayne Military Hospital, Newton Abbot, and J.L.M.Syms M.A., M.D.Cantab. Captain, R.A.M.C.(T) Neurologist, Seale Hayne Military Hospital.

Claims that added experience in the treatment of the hysterical symptoms which form one of the largest classes of war neuroses has led to the gradual simplification of methods and increasing certainty and rapidity of cure'. Article gives several case histories.

L. 3 August 1918 p.153

Letter:

'M'

'The treatment of functional nervous disorders in the Army'

The anonymous correspondent supports the call for members of the profession to volunteer themselves for this important work. Points out that there is a wide range of therapies available including electricity, manipulation, isolation and and the more purely psychological methods of analysis, suggestion and hypnosis each have their value in appropriate cases'.



L. 3 August 1918 p.160

Report:

A meeting of the Medico-psychological Society of Great Britain and Ireland 23 July 1918 at which papers on "The prevention and treatment of neurasthenia and other nervous breakdowns" by Dr.Claude F.Fothergill, and "The infective factors in some types of neurasthenia" by Dr.W.Ford Robertson. No details of these presentations are given.

L. 10 August 1918 pp.168-72

Article:

"The 'Instinct-Distortion' or 'War Neurosis'".

Donald E.Core M.D.Manch., M.R.C.P.Lond.

Honorary Assistant Physician, Manchester Royal Infirmary;

Physician, Ancoats Hospital. Captain, R.A.M.C.(T).

Suggests groupings for the functional nervous disorders. The present article considers various types of hysteria.

L. 10 August 1918 pp.177-8

Editorial note:

'A Year's Work at a Mental Section'.

Refers to an article in *The Journal of Mental Science* written by Major R.Eager R.A.M.C. under the above title; The Lancet note is a brief analysis of the title paper. Reviews twelve months from 17 June 1916 to 16 June 1917 at the Lord Derby War Hospital, Warrington, where the author was in charge of the mental division. (It is noted elsewhere that, in response to the numbers of mental and nervous casualties, such sections were set up in the majority of military general hospitals). Reviews the admission, treatment and discharge of some 4000 soldiers suffering from mental disorders. Advocates early identification and 'streaming' of the various categories of complaints. Implies that the arrangements, even at this late stage of the war, are not wholly satisfactory. (The J.M.S. paper is listed in the relevant section).

L. 17 August 1918 pp.197-200

Article:

'The treatment of cases of shell shock in an advanced neurological centre'

William Brown M.A. M.D.Oxon, D.Sc.Lond. Reader in Psychology

in the University of London, King's College Hospital;

O.C. Craiglockhart War Hospital.

The author was in charge of an advanced neurological centre in France during the period November 1916 - February 1918, when he 'had to deal with between two and three thousand cases of psychoneurosis (neurasthenia, hysteria and psychasthenia). Most cases were hospitalised 'within 48 hours of their breakdown'. Claims that 70% of those seen were returned to duty: gives some further statistics. Analyses the effectiveness of the clinical methods used and makes recommendations for preventive strategies.



L. 17 August 1918 pp.218-9

Letter:

'War Deafness'

Arthur F.Hurst, Seale Hayne Military Hospital, Newton Abbot.

Comments on the previous article by Judson Bury (27 July pp.97-99). Takes issue with his strictly organic basis for treatment of war deafness, arguing that his approach fails to take account of recent work by the writer and others which demonstrates that, in respect of concussion deafness, there are many cases which respond rapidly to psychotherapy. (We) have not yet failed to cure by psychotherapy a single one among a very large number presenting all the signs and symptoms of so-called reflex paralysis or contracture. Implies that Judson Bury and others are constrained by pre-war experience... 'If we had believed, like them, that the majority of cases of concussion deafness are organic in origin we should never have attempted psychotherapy, whereas in our experience many are completely cured by re-education and suggestion'.

L. 17 August 1918 p.219

Letter:

Thomas Lumsden

'Treatment of War Neuroses'

Congratulates Hurst and Symns on the results obtained. (See item above dated 3 August 1918 pp.139-41) By implication, questions the permanency of the cures to which they lay claim. Argues for a 'halfway house between full discharge and continued hospitalisation', contending that a period of outdoor work in a convalescent centre would favour a better long-term prognosis. Notes that the Naval medical authorities have acted on this suggestion and is awaiting decision of the Army .

L. 24 August 1918 p.242

Book review:

*Hysterical Disorders of Warfare*

Macmillan (London 1918).

L.R.Yealland M.D., Resident Medical Officer, National Hospital for the Paralysed and Epileptic, Queen Square London.

Reviewer very approving of Yealland's methods and dismissive of psychotherapy.

L. 7 September 1918 p.328

Book review:

*A Plea for the Insane*

L.A.Weatherly M.D. 288 pp. Grant Richards London 1918.

Broad review of the current state of care under the 1890 Lunacy Act: identifies many disadvantages and abuses and makes recommendations for reform.

L. 7 September 1918 pp.341-2



Letter:

'Treatment of War Neuroses.'

Hurst and Symns

Response to criticism of their methods at Seale Hayne. They refute suggestions that their cures are temporary, claiming that men are 'never sent away until (they) are fit to earn a living in civil life'. They further claim that 'not a single man... has relapsed.'

L. 7 September 1918 p.335

Editorial note:

'Systematic instruction in war neuroses'.

Details of the syllabus of a course on shell shock and war neuroses organised by (Colonel) F.W.Mott on behalf of Sir Arthur Keogh, the Director-General of Army Medical Services, held at the 4th London General Territorial Hospital (the Maudsley Hospital in peacetime).

L. 17 September 1918 pp.341-2

Letter:

Arthur F.Hurst and J.L.Symns

Seale Hayne Military Hospital, Newton Abbot.

Attacks Lumsden's 'Country Host' scheme mainly on the grounds of its assumption that the physician is not necessarily the best person to assist the convalescent military mental patient back into civilian life. Outlines their own regime which they claim has been outstandingly successful.

L. 14 September 1918 pp.370-1

Letter:

'The treatment of war neuroses'

Thomas Lumsden

Response to Hurst and Symns: doubts their claims of permanent cures; 'I can only attribute this to their not having had the time or opportunity to follow so many of their discharged cases, for I have seen relapsed and uncured cases from every neurological centre in Great Britain, including Netley.'

L. 21 September 1918 pp.433-4

Letter:

'Hypnosis in Hysteria'

William Brown, Major, R.A.M.C. Craiglockhart War Hospital, Edinburgh.

Comments on Thomas Lumsden's letter of 17 August 1918 regarding the permanency of cures claimed by Hurst and Symns. Questions the real efficacy of hypnosis in cases of hysteria, referring to the fact that the majority of earlier claims for the technique have been seen to (be) mistaken'. Brown expands on the arguments put forward in his earlier article concerning his experiences at an Advanced Neurological Centre in France in 1917-18. Argues that hypnosis is a useful tool in the treatment of hysteria but must be regarded as only one in a range of techniques to be used by the informed practitioner.



L. 28 September 1918 p.433

Letter:

'Hypnosis in Hysteria'

William Brown, Major, R.A.M.C. Craiglockhart War Hospital, Edinburgh.

Replies to further correspondence on the title issue. Discusses the theories of prominent neuropsychiatrists and repeats Brown's belief that hypnosis - in Brown's case only 'light' hypnosis - can be a valuable aid to uncovering repressed emotions which may be a cause of hysteria.

L. 5 October 1918 p.470

Editorial:

'New hospital for shell shock cases'

Notes the opening of a new Ministry of Pensions hospital at Bray Court, Maidenhead, providing 50 places for discharged neurasthenic sailors and soldiers and including facilities for re-education and the teaching of 'suitable trades'.

L. 5 October 1918 p.471

Letter:

'Hypnosis in Hysteria'

Donald Core, Captain, R.A.M.C. (T.C.)

Takes issue with Brown: emphasises role of education and upbringing in the establishing of emotional control, and consequently of suggestibility and susceptibility to hypnosis.

L. 12 October 1918 p.505

Letter:

'Hypnosis in Hysteria'

William Brown, Major, R.A.M.C., Craiglockhart War Hospital, Edinburgh.

Response to Core's letter. Stresses (again) that hypnosis is not the whole answer, and that his (Brown's) method in the majority of cases relies on 'free association and (carefully) explaining to the patient as to how his symptoms have originated'. Labels his method 'autognosis' since it is 'knowledge of self which makes a psychoneurosis or psychosis impossible.'

L. 9 November 1918 pp.613-6

Article:

'Neuroses and psychoses of war'

The Bradshaw Lecture.

Delivered before the Royal College of Physicians of London,  
7 November 1918.



William Aldren Turner, C.B., M.D.,

Temporary Colonel, A.M.S., and Consulting Neurologist.

Wide-ranging and very useful review of many aspects of the title conditions, with case histories illustrating developments from the early days of the war to the present.

L. 8 November 1918 p.653

Report of Parliamentary proceedings:

Under-Secretary for War is asked for, and provides, a list of all the institutions, 'provided by the War Office for the care and treatment of uncertifiable soldiers who had been mentally unhinged in consequence of the severity of the strain through which they had passed'.

L. 23 November 1918 pp.703-4

Article:

'Neurasthenic and hysteric cases in general military hospitals'

R.H.Trotter, M.D.Manch., Major, R.A.M.C.(T.C.);

Officer in Charge, Medical Wards, Huddersfield War Hospital.

Outlines the methods of admission, diagnosis and treatment of the title conditions, and the criteria adopted for transferring cases to Special Hospitals such as that set up at Craiglockhart, near Edinburgh, solely for the treatment of neuropsychiatric disorders in officers.

(See entry above - 21 September 1918.)

L. 17 May 1919 pp.833-6

Article:

'War Neurosis: a comparison of early cases seen in the field with those seen at the base.'

William Brown, M.A., M.D. Oxon., D.Sc. Lond.

Reader in Psychology in the University of London, King's College.

Contrasts the nature and forms of treatment applied in cases dealt with in France, and those treated at base hospitals in the U.K. Observes the 'great difference' in severity and perseverance brought about by elapsing time, further evidence of the need for disorders to be dealt as soon as possible.

Some of the officer casualties met with in France later came under his care at Craiglockhart. Describes different mental and nervous disorders and a variety of symptoms - Amnesia, paraplegia, mutism, tremors of varying intensity, and the methods adopted in each case 'as Dejerine advocated and Rows, Rivers and others practised in England'.



**BRITISH MEDICAL JOURNAL****ARTICLES, LETTERS, EDITORIALS ETC., REFERRING TO MENTAL AND NERVOUS DISORDERS IN THE BRITISH ARMY 1914-1918.****1914**

BMJ. 7 November 1914 p.802

Editorial note:

Mental and nervous shock among the wounded'

Refers to an appeal by Lord Knutsford for £10,000 in order to secure and equip 'a large, quiet, house in London and a convalescent home in the country'. Although the note does not say so, the facilities were intended exclusively for officers. When the hospital became a reality this fact caused some comment. Social conventions of the time, however, precluded overt protest, but the hope was expressed that similar provision might be made before long for other ranks. The ensuing correspondence also sparked off a sometimes heated debate about the treatment of. Army mental illness in general. A particular area of concern was the fate of those more serious cases sent to the 'special annexes' of County Asylums that had been set aside for them, and where, it was contended, they could be certified as insane without the protection of the statutory certification process. Much later still, the fact that insane soldiers were put into pauper clothing was strongly condemned.

See The Lancet entry for 24 July 1915 et seq. as well as the BMJ entry about the Daily Graphic campaign on the issue.

BMJ. 5 December 1914 p.995

Editorial note:

Refers to a French study carried out 'on the outbreak of the present war' by Dr.Vaillard, Medicin-Inspecteur of the French army, and Professor Gilbert Ballet. The study concluded that there were 'a few cases of delirium due to alcoholism in mobilized troops who had celebrated their departure rather too joyously', and that these had all recovered quickly and had been sent to the front. Vaillard and Ballet conclude that the war has so far not produced insanity'.

BMJ. 12 December 1914 pp.1005-6

Article:

'Transient paraplegia from shell explosions'

T.R.Elliott M.D., F.R.S., Lieutenant, R.A.M.C.

Describes the salient features of a condition 'which has already led to mistakes in diagnosis in its early stages, and which will be even more difficult to recognise in the men who are invalided home with only the history that they can give as a guide to a correct opinion.' Four cases described; three of which



involved burial or partial burial by high explosive shell bursts. In Case II the nature and extent of the injuries revealed post mortem - kidneys, lungs, spine, abdomen etc. - make it clear that death was caused by the crushing action of the mass of earth on the victim, and that the observed paralysis, particularly of the legs, was a consequence of this. The remaining cases appear to involve psychological and emotional trauma - 'horrible sights' etc., - typical of shell shock. Although the term is not actually used, this account clearly describes cases of what Charles Myers was to report as shell shock, beginning with his first 'Contribution' in *The Lancet* of 3 February 1915.

## 1915

BMJ. 8 May 1915 p.820

Parliament:

'Pensions available for soldiers mentally incapacitated'

Confirms that pensions will be paid to those disabled by mental illness and that for employment and similar purposes, the degree of disability would normally be regarded as total. Also confirms that there are powers to increase the amounts where the recipient is incapable of managing his own affairs.

BMJ. 15 May 1915 pp.833-5

Article:

'Cases of nervous and mental shock'

William Aldren Turner, M.D., F.R.C.P.,

Physician to King's College Hospital and the National Hospital for the Paralysed and Epileptic, Queen Square;

Temporary Lieutenant Colonel R.A.M.C.

Reviews the history of the title conditions, their frequency and symptomatology. The writer accepts without question the existence and aetiology: 'It was soon recognized that one type of case was due to the explosion of big shells in the vicinity of the patient, who did not himself receive any detectable physical injury or bodily wound.'

BMJ. 22 May 1915 p.905

Parliament:

'Nerve strain and mental disturbance'

(Hospital treatment v. asylum treatment)

Question raised as to the arrangements for the reception, diagnosis and appropriate treatment of those 'of the rank and file' suffering from nerve strain 'before being placed in charge of medical officers (Royal Army Medical Corps) who had been taken over from the asylum service.' The questioner points out that the French government had ensured that specialists 'not alienists' were available at their clearing hospitals to sort out the various degrees of nervous and mental disorder. But the real point of this question was to bring further pressure to bear on the Government, and the implication is that mentally ill



soldiers who might respond to treatment in general hospitals are being too hastily consigned to asylums.

BMJ. 29 May 1915 pp.941-2

Parliament:

'The medical service of the army'

A section of this report is headed 'Provision for insane soldiers' and is another round in the 'Hospital v. Asylum treatment' controversy. The Under - Secretary for War is asked whether, ... 'in the event of wounded soldiers becoming insane, they are dealt with as pauper lunatics and conveyed to the workhouse of their place of settlement; whether demonstrences have been received from Boards of Guardians on the subject; and whether arrangements could be made by means of which such men would be dealt with by the Red Cross Society and be eligible for pensions as disabled soldiers, thus avoiding the taint of pauperization.' Members cited a number of cases where men had allegedly been discharged from the Army into workhouse asylums.

BMJ. 19 June 1915 pp.1060-1

Parliament:

'Army casualties (Mental Strain)'

A further and lengthy exchange on the subject of soldiers in lunatic asylums, and one in which the conflation of 'nervous' and 'mental' illness persists. By this time, however, the Government was able to point to the existence of newly opened special hospitals such as those at Maghull, Liverpool, and the Red Cross Hospital at Denmark Hill, as well as the special 'neurological sections' at selected Territorial Force General Hospitals. Even so, there is clearly still doubt in some M.P.s minds as to the ability of erstwhile asylum doctors to adequately treat nervous and mental illness, as well as a continuing fear of the 'opprobrium associated with having been treated in a lunatic asylum.'

BMJ. 19 June 1915 p.1072

Letter:

Nervous and mental shock in the Base Hospitals in France'

Dr.J.Reid, London.

Refers to Dr.W.Aldren Turner's paper of 15 May 1915. Reid puts forward an argument which was to be frequently reiterated, that the cases of shell shock and other mental and nervous disorders being reported were nothing new. Reid recalls treating members of a farming family in 1885 following a 'buggy accident' in which the victims briefly displayed symptoms similar to those of shell shock.



BMJ. 10 July 1915 p.64

Editorial:

'Nerve shock in war'

Reports on the 'large crop of papers appearing recently in the German medical press, dealing with the organic and functional nervous disorders provoked by modern warfare.' The majority of the German writers, it is reported, agree with some opinions in the U.K. in refusing to recognize the disorders as unique to warfare. Predisposition in the form of a previous history of nervous illness, or at least a tendency to 'nerviness' and /or timidity, aggravated in many cases by exhaustion, ill-feeding and the lack of opportunity for cleanliness, are held to be the important factors in determining an individual's liability to suffer a breakdown.

BMJ. 17 July 1915 p.115

Editorial:

'Edinburgh hospital accommodation for soldiers suffering from mental shock'

Notes the setting aside of 45 beds in the Royal Victoria Hospital 'for soldiers suffering from mental shock and nervous exhaustion [...] The Red Cross Society, which is running the hospital, has confirmed that the patients are being treated on the same basis as 'ordinary wounded soldiers'. Some, however, develop permanent mental disturbance: in such an event the patient is transferred to an ordinary asylum.

BMJ. 31 July 1915 pp.185-6

Report:

'The commotional syndrome in war'

Reviews a French report in the Bulletin de l'Academie de Medicine Paris, (1915 3s.,lxxiii, 654); describing the treatment of 8 cases of 'commotio cerebri'. The authors, (Mairet, Pieron and Bouzansky) divide the nervous signs and symptoms into six groups, each of which is described in detail.

BMJ. 31 July 1915 pp.187-8

Parliament:

'Soldiers in asylums'

Report of questions in the House of Lords on the title subject, and accommodation for cases of nerve strain not certifiable under the Lunacy Acts'. These, it was stated, were treated in the neurological sections of the military hospitals. In addition, accommodation was available at two institutions which were formerly responsible to the Lunacy Board of Control.

Neurological cases had been divided into four classes:

- (1) nerve injuries caused by wounds
- (2) men who were quite insane
- (3) cases of a minor character
- (4) cases of epilepsy.



The treatment for each of these classes, Lord Newton said, was special: there was no foundation for the allegation that all cases were to be treated as 'ordinary lunatics'. Furthermore, there was no truth in the allegations 'which had been made in various quarters against the War Office on this particular question'. Lord Knutsford said that the arrangements for the treatment of 'nerve and organic shock' were particularly good. [...] 'It had been made a grievance that at certain hospitals soldiers were treated by men who had made mental disorders their special study, but these doctors bitterly resented that which had been got up against them and the representation that because they were alienists every man who went to them was necessarily insane.'

N.B. This controversy was being aired elsewhere, not least in the columns of *The Lancet*. The above is, however, the most direct reference yet found. See also the reports concerning Lord Knutsford's appeal for a mental hospital solely for officers, which may have clouded his judgement. There was some oblique criticism of this at the time.

BMJ. 14 August 1915 p.265

Editorial:

'The pathology of shell concussion'

Notes that the present war 'has considerably added to our knowledge of injuries caused directly or indirectly by high explosives, but there are some mysterious occurrences of which no satisfactory explanation is as yet forthcoming.' Goes on to rehearse the type of case that achieved almost mythical status, particularly in the early period, where men were reportedly found set in the actions they were performing at the instant of death. Stories were told of men sitting around tables playing cards, holding mugs of tea, all without a mark on them. The effect of such tales on impressionable young men, no doubt embroidered in the telling and re-telling, can be readily imagined. That said, it is the case that no thoroughly satisfactory explanation emerged. Almroth Wright claimed to have found evidence in the brains of violently concussed soldiers, and was to publish widely on the topic during and after the war, but there was no systematic collection and examination of evidence at the time of the deaths: everyone was no doubt far too busy surviving.

BMJ. 21 August 1915 p.308

Report:

'Notes on some cases under treatment at the 2nd Eastern General Hospital, Brighton'

Gives details of how different kinds of wounds are treated. One short section deals with the subject of 'wind contusion', i.e., 'injuries ...without any sign of contusion or injury of the skin'. Quite how such injuries were identified in the absence of external evidence is not made clear, but was probably inferred from the history given by the patient. In any case, the report makes it clear that the diagnoses of such injuries were an error of former times', which would not be repeated now. Refers to a book by Stevenson\* - *Wounds I War* or similar. The section is very dismissive of 'vent du projectile' as an actual war injury.

\* Surgeon-General W.F.Stevenson.



BMJ. 28 August 1915 pp.338-9

Letter:

'A note on "wind contusion" in war'

Surgeon-General W.F.Stevenson, C.B.

Stresses that 'wind contusion' caused by the close passage of shot is quite different from the close bursting of modern high-explosive shells. The former were largely internal injuries to bones and soft tissue inflicted by the 'vent du projectile'. The latter involve 'interference with the special senses' which in turn are manifested as dysfunctions of vision, hearing, locomotion, speech etc.

BMJ. 18 September 1915 p.450

Letter:

Surgeon-General W.F.Stevenson, C.B.

'Note on the cause of death due to high-explosive shells in unwounded men'

Continues the debate surrounding cases of sudden death due to close explosions where the bodies are untouched by missiles and are found in life-like attitudes.(See entry for 21 August). Stevenson refers to the work of Arnoux, a French civil engineer who had repaired and repressurized an aneroid barometer found on one such victim. From this, Arnoux had calculated that the dynamic pressure on the bodies was 'over 10,000 k/m<sup>3</sup> - instantaneously followed by massive decompression'. Stevenson, however, still prefers the 'commotio cerebrii' theory and the line followed by F.W.Mott.(q.v.)

BMJ. 25 September 1915 p.481

Parliament:

'Mental and nervous cases'

Replying to several questions, the Under-Secretary of State for War confirmed that '...uncertifiable cases sent to buildings attached to county asylums were not in any way dealt with under the Lunacy Acts, but were under the control of the Under-Secretary of State for War. Each case was the subject of special consideration by general physicians and neurologists, and was placed under the care of the most appropriate specialist in the institution. Although not stressed, the fact that the questions were addressed to the Under-Secretary of State for War indicates that this was a further effort by activists to air the 'soldiers in asylums' matter.

BMJ. 2 October 1915 p.515

Parliament:

'Military mental and nervous cases'

Confirmed that 'Military mental and nervous cases were treated in the neurological sections of the twenty-three military hospitals in the United Kingdom.' Additionally, accommodation for this type of case was provided at the Springfield House Hospital, Wandsworth, and at the Red Cross Military Hospital, Maghull, near Liverpool. The question of the more serious cases had been receiving consideration and 'had caused the authorities



considerable anxiety'. The increased numbers of incurable cases, therefore, would no longer be retained under the care of the Army, but would be put into the civilian Lunacy Act system.

BMJ. 9 October 1915 p.545

Parliament:

Military mental and nervous cases'

This is a sequel to the questions put during the debate reported on 2 October, and clearly, the questioners were not content with the Government's response on this issue. On this occasion, the Government spokesman stated that 'so long as accommodation was available, hospital treatment was provided to soldiers suffering from nerve disturbance and loss of mental balance in the neurological sections of the twenty-three military hospitals in the United Kingdom in which uncertifiable cases amongst the rank and file were treated.' Mr. Tennant, the Government spokesman, also stated that he Springfield House Hospital 'was a block of the Middlesex County Asylum at Wandsworth, and was under the same management as the rest of the institution.' It was also stated that, unlike military personnel, any civilian admitted to the Asylum would necessarily have been certified under the relevant sections of the Lunacy Act.

BMJ. 23 October 1915 pp.615-6

Parliament:

Mentally injured soldiers'

Government spokesman stated that the three classes of patients it was intended to certify 'could not properly be described as mentally injured soldiers, if it was to be understood by that term that the mental injury was originated by the hardships of active service.' The debate clearly turned, as had previous discussions on this subject, on the suspicion in the minds of some M.P.s that the Government was cutting corners in respect of care for the mentally injured. This development reveals a move by the authorities to regulate the language being used to describe mental disorders. It would seem that any soldier who could be shown to have had a mental or nervous history of any kind and of any degree, could be said not to have acquired his disability through the exigencies of active service, even if he had been under weeks of heavy bombardment, or had undergone the most horrific experiences. There is also continuing concern over the actual procedures for certifying soldiers as insane. Appeal against decisions to do so under King's Regulations is, for example, to a general officer and not to a civil magistrate as would be the case under the Lunacy Acts. The 'top brass', it is feared, will inevitably support the military ethos

BMJ. 23 October 1915 p.618

Editorial:

'The work of the 2nd Eastern General Hospital, Brighton'

A general review of the hospital's work, with a description of the wounds and conditions treated, including neurasthenia, psychasthenia and in some few



instances, actual mental disease, with suicidal tendencies.' Records that if the patients were from the Expeditionary Force they were transferred to (the Royal Victoria) hospital at Netley .... 'otherwise they were handed over to the guardians of their parishes' i.e., to be put into their local county or workhouse asylum.

BMJ. 30 October 1915 p.654

Parliament:

Mentally injured soldiers'

Government spokesman stated that those parts of county and other asylums to which mentally injured soldiers were admitted were 'under the full control of the War Office'. The arrangements now in force, it was stressed, 'adequately safeguarded the interests of uncertifiable soldiers.' Treatment was for 'nerve shock' and was given on the assumption that recovery was either possible or probable. One of the continuing points of disagreement in this controversy was that such cases were better treated in general hospitals. It seems, however, that none of the M.P.s present were moved to ask why, when there was accommodation for such cases in the neurological sections of the military General Hospitals and at Netley and Liverpool, these cases had been sent to an asylum.

## 1916

BMJ. 3 January 1916 pp.41-2

Article:

'Absence of proper facilities for the treatment of mental disorders in their early stages'

Delivered at a meeting of the Yorkshire Branch of the British Medical Association.

Bedford Pierce, M.D., F.R.C.P.Lond., Medical Superintendent, The Retreat, York. President of the Branch.

Draws attention to the fact that, in attempting the early treatment of mental disorders, there is in the United Kingdom no statutory system other than that of certification as insane and consignment to an asylum. Generally approves of what is being done for mentally disturbed servicemen: refers to the special hospitals at Liverpool and other places and to the neurasthenic sections of the military General Hospitals.

N.B. Bedford Pierce was a strong advocate of reform of the asylum system to provide early treatment for incipient mental disorders. He had been instrumental in the immediate pre-war period in carrying out a major survey of pay and conditions of asylum medical officers in other European countries. See The Lancet 13 April 1912 and subsequent entries above.



BMJ. 15 January 1916 p.105

Parliament:

'Asylums as military hospitals'

The Under-Secretary of State for the Home Department stated that 'ten asylums in England and Wales and isolated parts of two others had been placed at the disposal of the War Office for use as hospitals, and accommodation had thereby been provided for over 14,000 sick and wounded soldiers. Arrangements were in contemplation for converting into hospitals two more asylums. In addition an asylum which at the outbreak of war was nearly completed but not yet occupied was taken over by the War Office, and a similar course would be adopted with another new asylum now approaching completion. nearly all the civilian patients displaced by these arrangements had been distributed over the remaining asylums, with the result that most of these asylums had at present more inmates than would be considered advisable by the Board of Control in normal times. Every effort was being made to minimize the inconveniences of the arrangement, which was only justified by the exceptional circumstances of the present time.'

BMJ. 22 January 1916 p.148

Report: (Scotland)

'Soldiers in asylums'

In his annual report Dr. Henry Carre, Medical Superintendent of the Glasgow District Mental Hospital, notes that the 436 patients admitted during 1915 represented an increase of 92 over the previous year (69 males and 23 females). The total also represents an increase of 117 over the average for the past ten years, and can be accounted for by the Stobhill Hospital being taken over by the military authorities. 'The transfer to Burnhill Hospital of the old people upset many of them so much that they had to be certified and sent to the two asylums under the Board.' Dr.Carre also reports that only 14 cases admitted could be attributed to war conditions, 5 females and 9 males. Of the latter only one man was actually in the firing line, one broke down in the excitement of mobilization, and two during military training.'

BMJ. 18 March 1916 p.436

Letter:

Dr, S.E.White, London.

Refers to the address by Dr. Bedford Pierce (see BMJ 8 January 1916). Disagrees with Pierce, contending that the problem of 'nerve-shaken' soldiers does not require a change in the law to provide an alternative to lunacy control, but only 'a cheering atmosphere, such as will steady, quiet and help the troubled mind'. Points to the excellent results already being obtained at the Base and Territorial Force General Hospitals by treating mental disorders as illnesses for which a cure is not only possible, but probable, and by assuming from the outset that the detention and repression inherent in the lunacy system are inappropriate measures in the treatment of mental disorders.

See also Dr. (Sarah Elizabeth) White's participation in the controversy over the same subject in *The Lancet*, starting in the issue of 25 July 1915.



BMJ. 25 March 1916 pp.441-3

Article:

'Mental conditions following strain and nerve shock'

R.G.Rows, M.D., Temporary Major, R.A.M.C.

Describes the work of the Red Cross Military Hospital at Maghull, near Liverpool, where he has gained the experience outlined. Concurs with much of what has already been written on the subject of mental and nervous shock, particularly the work being done in France. Believes that although the cases described will add little to what is already known about the conditions, the war provides a unique opportunity to study a large number of cases in their early stages, and with the patients' co-operation.

BMJ. 10 June 1916 pp.830-2

Editorial report:

'Nervous and mental shock'

William Aldren Turner, M.D., Lt.-Col.(Temp.) R.A.M.C. and describes 'arrangements for the care of cases of nervous and mental shock among soldiers coming from overseas.'

This lengthy report also appeared in The Lancet of 27 May 1916 on pp.1073-5.

BMJ. 15 July 1916 pp.73-4

Article:

'A method of treatment of "shell shock"

E.T. Milligan, M.D., B.S.Melb., Captain R.A.M.C.

Discusses the 'well-known fact' that, during the administration of chloroform anaesthesia, a stage is reached 'before the involuntary struggling stage' where the patient is highly susceptible to suggestion. Anaesthesia as a therapeutic procedure has been used to treat hysteria in selected cases of what is now diagnosed as "shell shock". The results of this treatment have been so satisfactory, Milligan claims, 'that I desire to give some account of the details of the same in this brief note'. Cases involving discoverable organic lesions of the special sense organs, the central and peripheral nervous system, and organic lesions of the above accentuated by hysteria, are not given this treatment. Its use is essentially as a soporific during the 'struggling stage', and as an aid to suggestion.

BMJ. 5 August 1916 pp.179-80

'Mental disabilities for war service'

Report of 75th Annual meeting of the Medico-Psychological Association, 27 July 1916.

Addres by Sir George Savage. Describes some of the cases he has seen of men who were obviously unfit through mental instability, some with a documented history of attacks of insanity - had found their way into the army and had quickly broken down in training or when they had reached the front. When in the rearly days of the war asylums had had to be vacated to make room for military patients, some men had been released and had then enlisted. Savage



accepts that in some cases enlistment had done good (for example in cases of hypochondria) these were rare and ought not to be taken as reliable evidence for any purpose.

BMJ. 5 August 1916 p.201

Letter:

Treatment of "shell shock"

P.R.Cooper, M.D., B.Sc. Lond., F.R.C.S.Eng., etc. Bowden. Cheshire.

The writer confesses to being 'deeply interested' in Milligan's article of 15 July, having routinely administered minimal doses of chloroform to relieve pain and anxiety and to assist suggestibility to instruction in many difficult pregnancies. Points out that few doctors have mastered the techniques of hypnotism, but most are quite capable of administering chloroform. Advocates the use of what he terms chloroform hypnosis, 'in all cases of traumatic hysteria, as well as "mere shell shock"(!)

BMJ. 12 August 1916 p.242

Letter:

Treatment of "shell shock"

Unidentified correspondent

Draws attention to the publication of his paper in the Journal of Laryngology (8/15), describing the use of chloroform hypnosis' to treat shell shock victims, especially those suffering from aphonia as the result of being buried by near explosions.

BMJ. 19 August 1916 p.267

Parliament:

'Nerve-shaken soldiers'

The Parliamentary Secretary to the Local Government Board stated that...'questions...with regard to the medical treatment of disabled soldiers should be addressed to him...' A committee (of the L.G.B.) was looking into the question of institutions or some alternative means of treating luncertifiable) nerve-shaken soldiers' who were presently treated at military hospitals.

BMJ. 14 October 1916 p.537

Parliament;

'Gratuities to neurasthenic soldiers'

Reports that a Royal Warrant issued under Army orders 'makes special provision for soldiers discharged on account of neurasthenia, functional nerve disease, or functional paralysis.'



BMJ. 21 October 1916 pp.548-9

Article:

'Practical tests on functional disorders'

M.Culpin, M.B., F.R.C.S., Captain (Temp.) R.A.M.C.,  
Surgical Specialist, Alexanddra Hospital, Cosham.

Complains that many 'psychical disabilities' go unrecognized because of field medical officers' inability or unwillingness to apply simple tests of function such as the application of faradic current to establish the presence or absence of neural pathways when diagnosing the effects of limb and other injuries. Lists a number of cases in which mental disorder has followed such incorrect diagnoses.

BMJ. 21 October 1916 p.14 para. 28

(Epitome to Vo1.2)

'Shell shock'

Reports on French observations of shell shock, contained in a thesis presented to Lyons University by Charles Grandecolade. Describes the general symptoms observed at the onset, and concurs with some British opinion that the milder forms often respond to rest and diet in a very short time. More intractable cases are caused by massive near explosions and particularly those causing burial.

BMJ. 28 October 1916 pp.584-6

Article:

'Shell shock and its treatment by cerebro-spinal galvanism'

Wilfrid Garton, Captain R.A.M.C.

States that; 'The term "shell shock" is made use of to describe two distinct conditions: one a severe type of traumatic neurasthenia, and the other bearing no resemblance to a neurasthenic condition, but characterized by hysterical manifestations.' Cerebro-spinal galvanism treatment is of use only for the first type of disorder, its application being based on the assumption that neurasthenia is an organic disorder. There is, the author contends, 'no reason to expect any favourable results to follow its use in a condition of functional disorder.' He does not say whether such an approach has been tried and has failed, by himself or some other. Lists the symptoms of neurasthenia as;

- (1) Headache (always aggravated by thundery weather)
- (2) Insomnia
- (3) Mental depression
- (4) Loss of memory
- (5) Nervousness
- (6) Bad dreams
- (7) Fatigue (without exertion)
- (8) Tremors
- (9) Wasting
- (10) Loss of appetite



Paralysis of limbs and/or groups of muscles has been observed in a number of cases. The resemblance between this and the symptoms of neurasthenia following severe illness is, the author states, 'so striking that that a similarity of origin is exceedingly probable.' Gives details of cases treated, strengths of current applied, techniques for overcoming patient fears of electricity, etc., etc.

4 November 1916 p.631

Parliament:

'Uncertifiable discharged soldiers,

'Mr. Forster stated on October 25th that the total number of men discharged from the army owing to the effects of uncertifiable loss of balance was 396, excluding cases in no way due to war service.'

BMJ. 11 November 1916 p.653

Report:

'Shell shock and traumatic epilepsy'

Report of a paper read to a meeting of the Harveian Society by Dr. E. Farquhar Buzzard entitled 'Warfare on the brain'.

The author states that:

'Shell shock, a much abused and unfortunate term, covered ...a number of groups of cases (a) cases of pure exhaustion; (b) cases in which exhaustion had excited inherited neuropathic and psychopathic tendencies into activity; (c) cases "martial misfits" who passed as normal individuals in civil life but were quite unable to stand the strain of military service; in these groups direct exposure to shell explosion might be absent, or at most merely a culminating factor in the production of symptoms; (d) normal individuals affected by close shell explosion who showed symptoms similar to those following a blow on the head. In making a diagnosis care must be taken to exclude the presence of organic changes in the skull or brain. The symptoms of mutism, etc., were hysterical and signified mental disorder and not a localized cerebral injury.

BMJ. 23 December 1916 p.752

Editorial:

Notes from German and Austrian medical journals. 'Disciplinary treatment of shell shock'

Edited notes from the *Munch.med.Woch.* of 30 May 1916. F. Kaufmann is the accredited author of a system of treatment which even some of his fellow countrymen have considered inhuman. He has recently published an account of it which begins with the general statement that the "psychical disturbances produced by the war are essentially the same as those observed in peace, but their frequency is out of all proportion greater". His treatment consists mainly of suggestion, accompanied by painful electric shocks to reinforce the message that recovery is advisable or imperative. This treatment, according to the BMJ, has been 'stigmatized' by eminent practitioners in the more conventional methods of treating mental disorders.



1917

BMJ. 3 March 1917 pp.301-3

Editorial: (Report of Scottish medical matters)

'War and other causes of insanity'

Refers to the annual report of the Royal Edinburgh Mental Hospital at Morningside. The report shows that '...the statistics at (the medical Superintendents) disposal afford no evidence that there was any increase in insanity in the civil population last year, either as compared with 1915 or former years.' Presenting the report, Dr. George Robertson sounded a warning to those bereaved by the war, and who might be tempted by grief and longing to embrace spiritualism in its popular forms. Dr. Robertson reminded his audience that those anxious to meet people who see visions of angels or who claim to be visited by the spirits of dead family and friends, 'need only to go to a mental hospital to find them.' Dr. Robertson congratulates the military authorities on the resourceful way in which they have coped with the various problems connected with the care and treatment of the 'large numbers of neurasthenic soldiers.' The public rightly desires that such men should have a good chance of recovery without acquiring the stigma of certification as insane, and there is no insuperable difficulty in a mentally deranged patient being kept under observation and treatment in a special hospital for six months, if the case be notified to the Board of Control and medical certificates showing the necessity of the step be issued. In Scotland a mental case can be kept at present for six months in any private house for gain without notification, and the question may well be asked why he should not equally be placed in a well-appointed mental hospital specially organized for the care of such cases, kept not for private gain, under the strict regulations of the Board of Control.

The answer would seem to be that even a short residence in a mental hospital, which is more commonly called a lunatic asylum, impresses on him a stigma not felt in the case of those who have been inmates of hostels for neurasthenic patients, but Dr. Robertson that the promoters of such hostels are doing a public disservice by speaking unfavourably of the useful and excellent work done in asylums; there ought to be no antagonism between such hostels and mental hospitals, for both are necessary for appropriate cases. 'He boldly asserts that whereas no case of neurasthenia has been sent to an asylum, the converse is not true, and that a man admitted to a hostel may find himself side by side with patients obviously suffering from mental disease.'

N.B. This item summarises in a detached way the essence of the 'Asylum v. Hospital treatment' controversy which began almost as soon as neuropsychiatric casualties began to be reported. If Robertson's analysis of the legal position is reliable (and there is every reason to think it so), much of the conviction that certification was necessary to obtain treatment was misplaced.



BMJ. 14 July 1917 pp.39-42

Article:

(The Chadwick Lecture)

'Mental hygiene and shell shock during and after the war'

F.W.Mott, M.D., LL.D., F.R.S.,

Major R.A.M.C.(T.F.)

Mott refers to 'a new epoch in military and medical science...' having arisen as the result of... 'high explosives, combined with prolonged trench warfare, in this terrible war.' Gives some figures of the power of explosions and refers to the widely canvassed stories of men being found dead, but in the very acts they were performing when the explosion occurred. Describes the effects of various bodily states on the likelihood of shell shock - tiredness, lack of sleep or food, etc., and the different ways in which shock may be sustained such as near explosion, trench and dug-out burial, 'contemplative fear' etc. Ends by describing the various treatments given during the war so far, and their efficacy in the early and later stages of the condition.

N.B. Unlike some of his contemporaries Mott, as his opening remark shows, had no doubt that shell shock was an actual and novel mental disorder, warranting the closest professional attention.

BMJ. 14 July 1917 p.47

Book review:

*Shell shock and its lessons*

G.Elliott Smith M.A., M.D., F.R.C.P., F.R.S. and T.H.Pear, B.Sc., University of Manchester, Longmans, Green & Co., (London 1917).

Notes the 'lamentable' neglect of what the reviewer calls 'psychopathy as apart from definite insanity.' By this he means the practices of both psychology and psychiatry, and points to the fact that Germany has shown itself to be paradoxically both advanced in these fields and yet inhumane in its conduct of the war. Hopes that Elliott and Pear's book will be a sharp spur', but believes the goad to be a necessary one if the aftermath of war is to be competently managed.

BMJ. 21 July 1917 p.81

Report of a meeting of the Royal Society of Medicine:

'Shell shock'

Reports on a meeting of the Section of Medicine of the Royal Society of Medicine in Dublin on 11 May 1917, at which Dr. F.C.Purser read the title paper. He grouped the cases met with in this country into three classes:

- (1) Shell shock proper;
- (2) Traumatic neurosis and;
- (3) Mental alienation.



The symptoms of the first class were:

(a) Headache; (b) insomnia; (c) dizziness, probably mental confusion; (d) tachycardia; (e) tremor; (f) general physical and mental depression. Most cases recovered fairly well with rest, warmth, quiet, and occupation. Other symptoms which made the outlook less favourable were: (g) loss of memory; (h) mental confusion; (i) epileptiform attacks; (j) petit mal; (k) profuse sweating. The President, Dr.H.C.Drury, said that "family stock" was an important factor in these cases. It must be concluded that the shell shock cases had less stable nervous systems than normal persons.' Other members recounted their personal experiences of treating shell shock cases.

N.B. The question of predisposition was often raised in respect of mental disorders generally. The most comprehensive discussion of this belief found so far is in Roussy and Lhermitte,

*Les Psychoneuroses de Guerre* (as translated) University of London Press (London 1917).

BMJ. 23 July 1917 pp.127-8

Parliament:

'Treatment of sufferers from shell shock'

Mr. Barnes was asked whether his attention had been drawn to an appeal for money being currently made, signed by "Frederick Milner" and intended, it was claimed, to facilitate the setting up of recuperation hostels' for sufferers from nerve strain discharged from the Forces. The appeal literature further claimed that these men were being discharged in large numbers with no prospect other than the workhouse, the asylum, or a miserable existence as a burden to themselves and their relations; and whether this statement represented the position of the men. Mr. Barnes replied that he had ascertained that the appeal had 'not been seen by Sir Frederick Milner. Goes on to describe the actual arrangements for the granting of pensions or gratuities to those discharged because of shell shock or neurasthenia.' Those necessarily sent to lunatic asylums were paid for at a special rate which fully met the costs of maintenance and ensured their being treated as, 'private patients free from the taint of pauperism.' The wives and children of such patients were provided for on the widows and children scale.

BMJ 15 September 1917 pp.361-2

Book review:

*Les Psychoneuroses de Guerre*

G.Roussy et Jean Lhermitte

Masson, Paris.1917

The authors maintain that 'the vast majority of psychoneurotic subjects are predisposed by heredity or personal antecedents, such as bad education or alcoholism, and in a combatant neuropath, the repetition of emotional shocks induces an anaphylactic mental state for such stimuli. Treatment is in essence a contest between the physician and the patient, with the former holding the more powerful weapons of suggestion, prolonged interviews, and 'unhesitating



direction' by the physician as to correct and socially acceptable patterns of behaviour.

BMJ. 22 September 1917 p.402

Letter:

'*Shell shock and its lessons*'

G.Elliott Smith

(Co-author with T.H.Pear of *Shell shock and its lessons*).

(See book review dated 14 July 1917 above)

Elliott Smith refutes the conclusions attributed to him by the (unidentified) reviewer of Roussy and Lhermitt's book *The Psychoneuroses of War*, namely that he accepts that 70% of shell shock cases possessed personal or family histories of mental instability. Accepting that heredity is one causal factor, Elliott Smith maintains that 'any man, whatever his family history or antecedents, can fall a victim to "shell shock" if he is subjected to sufficiently intense, prolonged, and relevant anxieties and emotional disturbances.'

BMJ. 22 September 1917 p.403

Letter:

'Discharged soldiers and sailors'

Criticises government policy on pensions for invalided servicemen, alleging that no new money is to be made available as a national provision.

BMJ. 29 September 1917 pp.409-14

Article:

'The etiology and treatment of war neuroses'

Arthur F. Hurst, M.D., F.R.C.P., Temporary Major R.A.M.C.,

Physician and Neurologist to Guy's Hospital; Neurologist to the Royal Victoria Hospital, Netley.

A very detailed and well-informed review of the author's experiences at the main U.K. military hospital at Netley, Southampton,, a hospital that had been treating army mental illness since before the war. Lists the significant mental and nervous conditions and their treatment.

BMJ. 27 October 1917 p.566

Note of Government statement:

'Discharged neurasthenic soldiers'

Notes that the Local Government Board has issued, at the request of the Minister of Pensions, a memorandum to Boards of Guardians of Poor Law hospitals in respect of discharged neurasthenic soldiers. The gist of the memo is that some of these cases, subject to "automatic wandering" and loss of memory, have found their way to Poor Law institutions, where they have been detained for observation in the mental wards. In some cases they have eventually been sent to lunatic asylums. The memo goes on....'it is suggested that where any such men are received ....an inquiry might be addressed to the Special Medical Board for neurasthenics, at 78, Lancaster Gate, W., to ascertain whether



neurasthenia was the cause of discharge from the army, and that Board's reply might be awaited before arriving at a definite conclusion as to the class of case to which any particular man may belong, and especially before any steps are taken to send the cases to a lunatic asylum.

N.B. The wording is suspiciously lukewarm. 'May' when 'must' would have been more appropriate. 'Might be awaited', when a man's liberty was at stake, and the stigma of the lunatic asylum a distinct possibility, would seem the least of precautions.

BMJ. 3 November 1917 p.595

Parliament:

'Nerve shocked soldiers and sailors'

Stated that men of the army and navy invalided out suffering from "nerve strain" were examined by a special medical board, essentially to assess their degree of disability for pensions and also their treatment needs. (There were) 'thirteen Scottish and Irish doctors serving on these boards, of whom three held posts connected with lunacy.' The Minister's statement goes on to assert (somewhat mysteriously) that the government's view was that special knowledge of mental disorders did not disqualify doctors from serving on these boards.(!)

BMJ. 3 November 1917 p.601

Editorial note:

'London County Asylums'

Reports that the Asylums and Mental Deficiency Committee of the London County Council had approved proposals by the Board of Control for the kind provision to be made at asylums for disabled sailors and soldiers, patients who have been discharged on account of mental disorder due to or aggravated by war service. These men, it is stated, will not be classed as paupers but as 'service patients', being placed on the register as such when notice is received from the Ministry of Pensions.' Service patients would be on the same footing as private patients, except that the cost of their upkeep was being met by the government. There would be an extra 2s.6d. a week allowed for additional 'comforts' for those patients 'able to appreciate them.'

BMJ. 10 November 1917 pp.612-7

Article:

'The microscopic examination of two men dead of *commotio cerebri* (shell shock) without visible external injury'

F.W.Mott, M.D., LL.D., F.R.S., F.R.C.P.,

Pathologist to the London County Council Asylums, Maudsley Hospital, Denmark Hill.

Gives history of the events leading up to both deaths, summaries of the *post mortem* examinations, the methods of preserving the brains (not wholly satisfactory from the standpoint of Mott's later examinations) and the detailed methods of general pathological and of microscopical examination. These and



similar cases were to form a substantial part of Mott's post-war work, *War Neuroses and Shell Shock*, Henry Froude, Hodder & Stoughton, (London 1917).

BMJ. 10 November 1917 p.618

Report of BMA meeting.

'Neurasthenia and allied conditions'

At the Autumn meeting of the Dorset and West Hants. Branch of the BMA on 17 October 1917, Dr.F.C.Forster read the title paper. He stated that 'neurasthenia is a complex of symptoms induced by nerve exhaustion and associated with, if not actually causing, a change in nutrition. It is nearly always due to a combination of mental overwork and worry. It is the mental shock that accompanies a physical injury which gives rise to traumatic neurasthenia or shell shock.'

N.B. Note the confusion, even in those with medical training, between neurasthenic (exhaustion) and shell shock (hysterical) states.

BMJ. 17 November 1917 p.665

Parliament:

'Shell shock and neurasthenia'

A suggestion was made that the condition of shell shock and neurasthenia patients at the 4th. London General Hospital and at the Special Hospital at Golder's Green was being aggravated by the fear of air raids. In response to another question, it was stated that the condition of neurasthenia patients varied greatly, and it had not been thought appropriate to lay down a specific time for treatment, after which a neurasthenic should return of duty. In the light of experience gained in recent times, however, this policy was now under review.

BMJ. 17 November 1917 p.655

Book review;

A manual on mental diseases for practitioners and students

*Psychological medicine*

Maurice Craig M.D., F.R.C.P.

Third edition, London, J.and A. Churchill 1917.

This new edition contains a chapter on the 'functional neuroses and psychoneuroses which have become prominent since the outbreak of war.' The author warns against regarding the 'manifestation of war shock' as malingering, since... 'this old view is true in but a few cases and should then be easily detected.'



BMJ. 24 November 1917 p.767

Letter:

'Treatment of war neuroses'

Thomas Lumsden, M.D., London.

Lumsden complains of the War Office's rejection of his 'Country Host Institution' Scheme under which he proposes that the 'nerve-shattered' men now housed in central London should be transferred to the peace and quiet of the countryside. Quotes from a graphic eye-witness account of the effects of a German night air raid on mental and nervous patients in a nearby hospital, and accuses the authorities of thinking only of convenience and not the men's well-being.

BMJ. 1 December 1917 pp.713-5

Article:

'The treatment of neurasthenia and psychasthenia following shell shock'

R.T.Williams, M.D.Lond., F.R.C.P., Consulting Physician, Manchester Royal Infirmary.

Reviews the putative causes and symptomatology of the mental disorders of war, noting that many of the milder cases improve dramatically after only a short rest. In the more severe cases, patients are not occupied in any systematic way, and are allowed ample time in which to think about their experiences, contemplate their future, and in particular, brood on their impending return to the front. Outlines suitable forms of treatment based on rest, hypnosis, suggestion, structured occupational therapy and the reinforcement of self-confidence. Emphasis, however, is firmly on non-psychological therapies.

BMJ. 22 December 1917 p.840

Editorial note:

'Service patients in asylums'

Refers to a circular from the Local Government Board regarding the arrangements for the care in lunatic asylums of servicemen disabled by mental disorder.' These will in any case be classed as private patients, but, additionally, in the event that the Medical Superintendent, after investigation, classes them as 'Service patients', they will receive supplementary privileges. Details are given of the conditions under which a patient may be classed as a Service patient, conditions under which they may be allowed out of an asylum "on trial", the type of clothing to be provided for them etc.

BMJ. 29 December 1917 p.870

Parliament: 'Neurasthenic soldiers'.

The Government spokesman was asked to confirm that, before any soldier who had been receiving treatment 'for shell shock or other nervous troubles' was sent back to the front, he would be examined by a medical board which included at least one specialist in nervous diseases. This confirmation was not



forthcoming, but it was stated that 'under the new arrangements it is hoped that this desirable end will be obtained.'

## 1918

BMJ. 2 February 1918 p.158

Parliament:

'Nerve-strained soldiers'

Question whether soldiers suffering from nerve strain would be kept in the army until they were cured or certified insane. In the former case whether special institutions would be provided properly staffed with specialists. Confirmed that premises were being sought: no comment on the other topics.

BMJ. 9 February 1918 p.193

Editorial:

'Medical news'

The London County Council has determined that the London Lunatic asylums shall in future be mental hospitals, except in legal documents, where an alteration in the name would require an Act of Parliament.'

BMJ. 2 March 1918 p.270

Parliament:

'Treatment of nerve-strained soldiers'

Statement that eight institutions for the care of nerve-strained soldiers were already organized. The names of the medical officers in charge were;

|                  |  |
|------------------|--|
| Lieut.Col.Mott,  | Maudsley Section, 4th London General Hospital. |
| Major Rows,      | Red Cross Hospital, Maghull.                   |
| Major Worth,     | Springfield War Hospital, Upper Tooting, S.W.  |
| Lieut.Col.Fox,   | 4th Southern General Hospital, Plymouth.       |
| Major Hurst,     | Royal Victoria Hospital, Netley.               |
| Major Mackenzie, | Glen Lomond War Hospital, Fife.                |
| Capt. Culpin,    | 1st Southern General Hospital, Birmingham.     |
| Capt. Clements,  | Bradford War Hospital, "Abram Peel" Section.   |

BMJ. 2 March 1918 p.271

Report:

Insanity and the war'

In his annual report, Dr,Oswald, Physician - Superintendent of the Glasgow Royal Infirmary, drew attention to the present situation regarding lunacy. Some new forms of mental disorder had appeared among soldiers exposed to the rigours of warfare, but for these 'ample provision had been made.' Insanity due to alcoholism had decreased and due to syphilis had shown a regrettable though small increase. These, Dr.Oswald stated, were the more to be deplored



in view of the greatly improved conditions of the working classes since the outbreak of hostilities.

BMJ. 9 March 1918 pp.299-300

Report of a meeting (Scotland):

'Early treatment of mental disturbances due to war strain'

In his report for 1917, Dr.George M. Robertson stated that there was no evidence of an increase in the frequency of insanity among the working classes since the outbreak of war. There had been, Dr.Robertson reported, a decrease in the amount of insanity among the younger male population, but this was no doubt attributable to the absence of so many on military service, where the problem was being dealt with by the military authorities.

BMJ. 23 March 1918 pp.345-6

Reports of societies:

'War neuroses'

At a meeting of the Section of Neurology of the Royal Society of medicine on 12 March 1918, major A.F.Hurst, M.D., F.R.C.P., R.A.M.C., 'gave a cinematograph demonstration illustrating the essentials of treatment of soldiers and discharged soldiers suffering from functional nervous disorders.The series of films shown had been taken during the last nine months at the Royal Victoria Hospital, Netley, under the auspices of the Medical Research Committee in order that a permanent record of some of the remarkable neuroses which had developed in soldiers should be obtained to form a part of the medical history of the war.' The report goes on to give details of the treatments and the growing experience of the clinical, nursing and technical staff in dealing with various forms of paraplegia, contractures, etc.

BMJ. 6 April 1918 pp.403-4

Editorial:

'Neurasthenic pensioners'

Breakdown of the nervous system , due to the effect on certain temperaments of the strain of active war conditions, may manifest itself in several different ways, and there seems some danger of confusion of ideas as to the proper method of treating such cases in their various forms and stages.' Discusses the term 'neurasthenic' and its limitations, and to 'an invaluable letter to the Times from Professor Elliot Smith', referring to a series of informal conferences held at the War Office, at which it had been "unanimously agreed that neurasthenic patients should not mixed with other patients, but should be sent to large hospitals specially set apart for the treatment of nervous and mental ailments". The item goes on to set out the essentials of a controversy surrounding the policy adopted by the Ministry of Pensions with respect to discharged 'shell shock and nerve-strain' patients, which is that they should be treated alongside others suffering from a variety of physical and other disabilities. The ministry's argument is that the prospect of fellow patients



suffering from apparently much more severe disabilities would tend to convince the sufferer from mental illness of the comparatively trivial nature of their ailments. The argument advanced by Elliot Smith, Hurst, Aldren Turner\* and the 'segregationists' is that skilled and experienced clinical care and the encouragement of fellow patients who have themselves been through the recovery process, are infinitely more effective methods of treatment. N.B. This is an important item, with a number of leads to other sources which throw light on the controversies of the time.

BMJ. 13 April 1918 pp.421-2

Article:

'Observation on shell shock and neurasthenia in the Western Command'

Ernest W.White, M.B.Lond., M.R.C.P., Temporary Lieut.- Colonel,  
R.A.M.C. ,Consultant in Mental Diseases to the Western Command;  
Emeritus Professor of Psychological Medicine, King's College, London.

As 'inspector of shell shock and neurasthenic patients in the Western Command', the author states that he has examined and taken notes of more than 800 cases of shell shock and neurasthenia treated in the general, sectional, auxiliary, military, Red Cross and V.A.D. hospitals throughout the Command. Describes the symptoms of various classes of disorder and the specific treatments applied. Gives a list of practical hygiene and health routines for the shell shock sufferer to follow.

BMJ. 13 April 1918 pp.422-5

Article:

'War psychoses occurring in cases with a definite history of shell shock'

Major R.Eager, R.A.M.C., Medical officer in charge, Mental Division, the Lord Derby War Hospital;

Senior Assistant Medical Officer, the Devon County Asylum.

States that the opinions expressed are based on the examination and treatment of over 4000 cases where the patient had a definite history of having been in close proximity to a shell explosion. Lists case histories under the headings of amnesia, melancholia, delusional states, hallucinatory states.

BMJ. 13 April 1918 pp.425-6

Article:

'The early stage of hysteria'

M.Culpin, M.B., F.R.C.S., Captain, (Temp.) R.A.M.C.

The author states that in the three years he has been interested in the diagnosis of functional nervous disorders, he has identified three classes which he regards as basic. These are:

A. The malingerer, who has determined to attain a definite end by the simulation of disease. This is not a large group and does not call for special attention here.



B. The man who goes sick with feigned or exaggerated symptoms without any more definite object than to avoid a route march or an unpleasant fatigue.

C. The hysteric, who differs from the members of Groups A and B in that he has a belief in the reality of his disability. The article expands on the above headings, giving details of methods of exposing malingerers and of treating hysteria.

BMJ. 4 May 1918 p.513

'Aortic reflux due to shell shock'

Gives details of three cases reported in the French and (German/Austrian/Swiss?) literature, in which men suffered traumatic rupture of the aortic valve after being blown up by shell or grenade explosion.

BMJ. 26 May 1918 pp.601-2

Report of a meeting:

'Neurasthenic soldiers'

At a meeting of the Scottish Joint Institution Committee, it was reported that the extension of Craigend neurasthenic home to house 50 or 60 patients was proceeding satisfactorily. 'Dr. Fletcher Porter stated on behalf of the Ministry of Pensions that, owing to new arrangements made by the Army Council, these cases would in future be treated in special hospitals before discharge. It seemed probable, therefore, that no soldier would be discharged who required institutional treatment for any functional nerve disorder.'

BMJ. 8 June 1918 pp.649-50

Editorial:

'The nervous temperament in war'

'Much interest has been excited recently in France by Professor Ernest Dupre's description of a type of psychoneurosis which would sharply distinguish from neurasthenia on the one hand and hysteria on the other.' Goes on to say that Dupre's work, which was apparently initiated before the war, attracted little attention at the time. Now, however, the recognition of a clinically validated condition related to, but clinically distinguishable from either of the two conditions, 'will prevent injustice, especially among soldiers'. The neurasthenic/hysterical condition, to which Dupre gives the 'not very happy' name of '*constitution emotive*' is characterized by some of those symptoms often confused with abject fear and cowardice, which to the civilian may be embarrassing, but which to the soldier may be damning.

BMJ. 22 June 1918 p.710

Letter:

'The nervous temperament in war'

'Late Civil Surgeon'

Casts serious doubt on the novelty of Dupre's findings, claiming that the condition which he calls *constitution emotive* has been 'thoroughly described



by several British writers' as "neurasthenia minor", "neurasthenoid", and "pre-neurasthenia". Because of the strong element of predisposition in these cases, the writer prefers the term "congenital neurasthenia".

N.B. Although an accepted medical entity, neurasthenia was inherently controversial, featuring as it did a wide and complex symptomatology. In the face of that fact, the article does little more than add to the complexities surrounding the condition.

BMJ . 3 August 1918 pp.119-20

Editorial:

'Home of recovery for neurasthenics'

Announces the opening by the Rt.Hon.John Hodge, M.P., Minister of Pensions of the 'Home of Recovery for neurasthenic and other functional nervous disorders'. The home, which is able to accommodate seventy patients, is situated near Leicester, and is under the medical direction of Dr. Astley Clarke. The whole enterprise has been provided from the Leicester Disabled Warriors' Fund, set up by Alderman Jonathan North, the Mayor of Leicester, and the costs of maintenance are met by the Ministry of Pensions. The report goes on to note that the home has actually been in operation since February 1918, and has already built up a good record of cures and discharges. However, the fact that all the patients are ex-servicemen (and therefore not subject to military discipline) had, Dr.Clarke reported, 'led to some of the patients discharging themselves, and others being discharged for misconduct.'

The Base Hospital of the 5th Northern General Hospital at Leicester (now the main administration building of the University) had a lending library donated by a local charity, the West End Association. There is a catalogue of the library on file in the County Record Office at Wigston Magna, which gives details of the donation. Under the same reference (14D35 Box28) a note on the inside front cover of the catalogue states that libraries were similarly donated to the North Evington War Hospital (now the General Hospital), the military wards of the Royal Infirmary, the Gilroes Hospital (Glenfield Road) and the 'Leicester Frith Home for Neurasthenics', clearly the institution referred to in the BMJ extract. The note goes on to say that 'At the latter home a special Gymnasium has been provided by the Association under the personal direction of Col.Astley Clarke.'

BMJ. 14 August 1918 pp.269-70

Report of French publication:

*Les Neurologie de la Guerre*

Reports on a special double number of the French Neurological Society's Review, dealing at length with the title subject. The contributors include names of investigators and clinicians pre-eminent in the field, including Dejerine, Schwartz, Roussy, and Babinski. The report is of special interest in that a number of the contributors had already established reputations outside France. It also reflects the often unsentimental attitudes of French practitioners such as Roussy, who thought that any diagnosis of simulation



should be entered on the personal record of the patient, '...and let him suffer the consequent military penalties.'

BMJ. 5 October 1918 p.390

Editorial:

'Hospital for neurasthenic men'

Notes the opening of a new hospital for 'discharged neurasthenic servicemen' at Bray Court, Maidenhead. As with the Leicester hospital noted above, the emphasis is on re-education and training in 'suitable trades.'



**JOURNAL OF MENTAL SCIENCE**  
**ARTICLES, ETC., RELATING TO THE TREATMENT OF MENTAL DISORDERS.**

JMS. Vol. 27 July 1881 pp.166-188

Article:

'The Study of Insanity'

Charles Mercier M.B., Lond. F.R.C.S.

Senior Assistant Medical Officer

Leavesden Asylum, Herts.

Good summary of the state of 'alienism' in Britain before the effects of Freudian theory and practice were widely felt. Outlines how alienism got from religion to science (sic) but argues that the specialism is still firmly rooted in the spiritualistic, concerned as it is with mind and body, and not with processes. To say, for example, that 'insanity is a state in which the mind has departed from an anticipated norm is the same as saying that a broken leg is a state in which the leg has departed from the norm to be expected in the leg of a normal healthy person. Such observations are entirely accurate, but add nothing of value to the sum of knowledge.

JMS. Vol.27 July 1881 pp.189-193

Article:

'On the early stages of Mental Disorder'

W.B.Kesteven M.D.St. Andr., F.R.C.S. Eng.

Lists the signs and symptoms of incipient mental illness. Blames the 'odium' of insanity for what he claims is an inherent tendency by the general public to euphemise and conceal mental illness. Highly moralistic view. Points to 'great men' such as John Bunyan, saved from the 'fate of the lunatic' by the grace of the Almighty driving out the Devil.

JMS. Vol.56 April 1910 p.272

Editorial:

Defends the choice of *The Journal of Mental Science* as a title, which had apparently attracted criticism from the medical profession generally. In the process makes some enlightening observations on the strong and weak areas of psychiatry at the time. Debates the advantages of adopting an all-embracing professional description, perhaps even 'psychiatry'...a term much favoured by our German brethren.'

JMS. Vol.56 April 1910 pp.273-6

Article:

'The Significance of Heredity and the Neuro-insane Constitution as important factors in the Production of Mental Disease, with an Examination into the History of 100 Consecutive Cases.'

G.Rutherford Jeffrey M.D.Glasg. M.R.C.P. Edin.

Senior Assistant Physician, Crichton Royal Institution,

Late Senior Assistant Physician, District Asylum, Ayr.



Sets out his views of 'hereditary taint', as well as a wide selection of appeals to history and social Darwinism, heavily overlaid with 'scientific' data consisting of not much more than invented terms for aspects of old disorders. The kind of article which mainstream medical science regarded as typical of the asylum system's preoccupation with wearisome taxonomy.

JMS. Vol.56 July 1910 pp. 418-422

'A theory of the Toxic and Exhaustion Psychoses'

W.H.B. Stoddart, M.D., F.R.C.P., Assistant Physician, Bethlem Royal Hospital.

Stoddart embraced the Freudian doctrine with some fervour, delivering three lectures on 'The New Psychiatry' in 1915. Like most British adherents, however, he had difficulty with the sexual side of the doctrine.

See The Lancet for 20 March, 27 March and 3 April 1915.

JMS. Vol. 59 January 1913 p.161

A series of reports presented to the Committee of the Medico-Psychological Association on the status of British Psychiatry and of Medical Officers.

These Reports were prepared at the request and under the authority of a Committee acting on behalf of the Council of the M.-P.A. Its purpose was to carry forward the debate on status and pay of asylum medical officers then in progress. The debate was cut short by the outbreak of war: its fate thereafter has not been researched.

'The Asylums and Clinics in France'

Report prepared by Henry Devine M.D., M.R.C.P.

'The Status of Asylum Medical Officers in Italy'

Report prepared by David Orr M.D.

'The Teaching of Psychiatry and the Status of Medical Officers in the United States of America'

Report prepared by J.Grimmond Smith M.D.

'The Facilities for the Teaching of Psychiatry afforded by Universities and Medical Colleges in England, Scotland and Wales'

Report prepared by Edward Gane M.D.

'The Status of Psychiatry and Assistant Medical Officers in Scotland'

Report prepared by Robert B.Campbell

'The Establishment of Psychiatric Clinics

and the Status of Assistant Medical Officers in Ireland'.

Report prepared by W.R.Dawson M.D.



Outlines the legal and practical structure under which Assistant Medical Officers live and work. In some respects, Dawson maintains, the Irish situation compares favourably with that in Great Britain.

JMS. Vol. 60 April 1913 pp.162-5

Report:

'State aid of research into mental diseases'

Report of a meeting held on 5 December 1912 at the Guildhall, London, to discuss pressing the Government for grant aid for research. Dr. James Soutar, President of the Medico-Psychological Association stated that he was present as a representative of one of the registered hospitals for the treatment of the mentally ill and not in his capacity of President of the M.-P.A. He admitted that the Association had not so far considered the question of research. Dr. Soutar questioned whether a conference such as this, called as it was by Visiting Committees of asylums and not by a medically qualified body, was best fitted to discuss such matters as 'the effect of heredity in the transmission of insanity.'

JMS. Vol.60 April 1913 pp.263-73

Article:

'Assistant Medical Officers in Asylums'

J.B.Spence, Medical Superintendent, Brentwood Asylum, Lichfield.

Long and very detailed examination of the many disadvantages under which junior medical staff in asylums laboured. Spence (untypically for a medical Superintendent) sympathetic to their plight and was influential in the move towards reform at this time

JMS. Vol. 59 July 1913 pp.583-595

Report of a lecture:

'Traumatic Neurasthenia'

H.Campbell Thomson M.D., F.R.C.P., Physician to the Department for Nervous Diseases, Middlesex Hospital, and to the Hospital for Epilepsy and Paralysis, Maida Vale.

The ensuing discussion features a contribution by Sir George Savage, expressing some of the prevalent reservations about neurasthenia, and citing Sir John Collie as 'the arch-investigator'. As the sniffer-out of fraud and malingering for the London County Council, Collie was notorious for his harsh and unsympathetic approach, particularly to functional nervous disorders.

JMS. Vol.59 October 1913 pp.688-694.

'The Status of British Psychiatry and of Medical Officers'

(Interim Report of a Committee of the Medico-Psychological Association)

Excellent comparative study of the conditions under which assistant medical staff in asylums and mental hospitals were employed in Germany, France and the United States, as well as an assessment of the relative state and status of



the psychiatric profession in those countries. Very useful 'double-column' comparative layout.

See also pp.699-706 of the same issue for a discussion held on the following day, when the Chairman of the Committee, Dr. Bedford Pierce, was able to be present and answered questions. Note the comments made by Dr. R.G. Rows on some of the cases that had been turned away from asylums where he had worked, describing himself as one who had 'been through the mill', i.e. had been in the assistant asylum medical officer ranks.

JMS. Vol.60 July 1914 pp.351-369

'The Biological Conception of Insanity'

John Turner M.B., Medical Superintendent, Brentwood Asylum

Examines the presence of various physiological symptoms and conditions in the kidneys, heart, and elsewhere of the insane. Has some interesting views on the Freudian and Pavlovian doctrines.

JMS. Vol. 60 July 1915 pp.453-6

'Occasional Notes' (Editorial material).

'Proposed Legislation in Cases of Incipient Insanity'

Discusses the disadvantages of the 1890 Lunacy Act and the form which new legislation might take. Useful for reflecting the contemporary view of the asylum sector, but obviously qualified by that sector's desire not to be the instrument of its own demise. Interesting also as reflecting the asylum sector's view of itself as the legitimate repository of knowledge regarding psychological medicine.

JMS. Vol.62 October 1916 pp.653-7

Article:

'Mental Disabilities for War Service'

Sir George Savage M.D., F.R.C.P.

Comments on typical cases seen at 'D' Block, Netley, when visiting there and (unusually) criticises the quality of younger officers seen at Viscount Knutsford's London hospitals for neuropsychiatric cases. Savage cites numerous cases of individuals who should never have been allowed into the Army, including a cavalry officer who, during the Boer War, had sent a 'very mad telegram' to Savage, demanding an end to an alleged persecution. This individual, Savage warns, was all too likely to obtain a command in the present war, with dire results.

JMS. Vol.63 July 1917 pp.346-389

Article:

'The Psychology of Fear and the Effects of Panic Fear in War Time.'

Sir Robert Armstrong-Jones M.D., F.R.C.P., RAMC.



Consulting Physician in Mental Diseases London Command

Gives historical and contemporary examples of how fear works on the mind, biological effects produced by the state of fear, etc.

JMS. Vol.63 October 1917 pp.467-488

Article:

'Mental Hygiene in Shell-Shock, during and after the War'

F.W.Mott M.D., LL.D., F.R.S., Major, R.A.M.C.T.

The Chadwick Lecture, given before the Medico-Psychological Association (26 April 1917).

Propounds at great length Mott's favourite theme - that shell-shock, properly described - was the result of massive near explosion, causing microscopic changes within the brain and/or the spinal cord. Mott was forced by the evidence to accept the psychological causation of shell shock, but never completely abandoned his physicalist stance.

JMS. Vol.64 April 1918 pp.165-189

'War Psychoses : an analysis of 202 Cases of Mental Disorder occurring in Home Troops'.

(Temp.) Capt. D.K.Henderson, R.A.M.C., Royal Victoria Hospital, Netley, Review of cases coming under the author's care during his time at the Lord Derby War Hospital, Warrington, Lancs. between June 1916 and January 1918. After that time, other arrangements for the treatment of mental cases were made. Detailed analysis of individual cases, with perceptive comment on the failings of the recruiting process, as well as proposals for improvement. Some useful tables (e.g. on p.166) showing how the 202 cases were divided - makes an interesting comparison with Napsbury.

JMS. Vol.64 July 1918 pp.272-295

'A Record of Admissions to the Mental Section of the Lord Derby War Hospital, Lancs., from June 17th, 1916, to June 16th, 1917.'

By R.Eager, M.D., Major, R.A.M.C. (T.) Officer in Charge, Mental Division, L.D.W.H. Warrington, and Senior Assistant Medical Officer Devon County Asylum.

Very detailed analysis, excellent statistical tables giving lists of mental disease classifications, etc. First rate and very useful as a comparison with Napsbury. See also a brief and approving summary of this article in *The lancet* of 10 August 1918, pp.177-8, and a further long and detailed article by Eager, 'The Early Treatment of Mental Disorders' also based on his experience as O.C. of the Mental Division of the L.D.W.H., *The Lancet*, 29 September 1919, pp.558-563.



JMS. Vol.64 October 1918 pp.365-377.

'The Psychoneurotic Temperament and its Reaction to Military Service'

E.Fryer Ballard, Capt. R.A.M.C.(T.), Registrar, Mental Observation Division,  
No.2 Eastern General Hospital.

Describes the kinds of temperamental predispositionary characteristics met with in those soldiers who have broken down mentally in the early stages of military service.

JMS. Vol. 64 July 1919 pp.152-180

'Mental Wards with the British Expeditionary Force:

a Review of Ten Months' Experience'

W.D.Chambers M.A., M.D., Senior Asst. Physician, Crichton Royal Hospital,  
Dumfries, Late Temp. Capt. RAMC

Covers 1 March 1918 to 11 January 1919, when the author was working as  
Mental Specialist in charge of the mental wards at Boulogne Base.



**JOURNAL OF THE ROYAL ARMY MEDICAL CORPS  
ARTICLES, ETC. RELATING TO THE TREATMENT OF MENTAL AND NERVOUS  
DISORDERS IN THE BRITISH ARMY.**

JRAMC January-June 1915 Vol. 24 pp.243-52

'Cases of Nervous and Mental Shock observed in the Base Hospitals in France'

William Aldren Turner, M.D., F.R.C.P.

Physician to King's College Hospital and the National Hospital for the Paralysed and Epileptic, Queen Square, London. Temporary Lieut.- Col. R.A.M.C.

Very careful descriptions of the various types of condition - hysterical, neurasthenic and mental - that were to become familiar as the war progressed. Turner was the senior neurological specialist in France at this time and was instrumental in appointing Charles Myers to the post in which he carried out the bulk of his work as Consulting Psychologist to the B.E.F. The article is disappointing in that, other than to observe that the milder neurasthenic cases recovered after complete rest, it fails to describe any forms of treatment.

JRAMC January-June 1915, Vol. 24, pp.471-3

Article:

'A Case of Hysterical Paraplegia'

Adolphe Abrahams, Lieutenant R.A.M.C.

Describes a case in which the patient was blown over by a near explosion which rendered him unconscious and seriously injured his comrade. Patient was completely paralysed in both legs. He was anaesthetised and the legs flexed. On regaining consciousness he was told that he had drawn up his legs without assistance. Recovery from that point was slow but generally positive. When transferred to an auxiliary hospital patient still complained of patchy anaesthesia on the right side.

JRAMC January-December 1916, Vol. 27, pp.619-626

Article:

'Arrangements for the care of cases of nervous and mental shock coming from overseas.'

William Aldren Turner, M.D., F.R.C.P., Physician to King's College Hospital and the Hospital for the Paralysed and Epileptic, Queen square, London. Temporary Lieut.-Col. R.A.M.C.

Reviews the Army's experience since September 1914, when the first cases began to arrive in England. They could be put into one of three categories; concussion due to near explosions, neurasthenic exhaustion due to shelling, general stress and strain, and mental disorder as shown by mania, confusional insanity, hallucinations and melancholia. Turner contradicts the Official History by claiming that such cases were 'coming over in considerable numbers in consequence of the severe fighting in September and October 1914'. The O.H. states (at p.8) that nothing serious in the way of neuropsychiatric casualties emerged until the autumn of 1915 at the battle of Loos. The O.H. goes on to say that the problem 'did not become acute until July 1916 during the battle of the Somme.'



JRAMC January-June 1916 Vol. 26, pp.525-544

'Neurasthenia: what it costs the State'

Hon. and Temporary Lieut.-Col. Sir John Collie, M.D., J.P.

Royal Army Medical Corps.

This very long article is only incidentally concerned with neurasthenia as it was recognised by other doctors, and much more to do with Collie's view of himself as the 'Witchfinder-General' of neuropsychiatric fraud. Contains a series of accounts of his success in uncovering exaggeration and malingering. Accounts for the alleged increase in recovery time to the passing of the Workmen's Compensation Act. A typical passage reads:

Hysteria has much in common with neurasthenia on the one hand and malingering on the other; all three, when associated with traumatism, are more or less curable by settlement of the legal claim.

For all its partiality and scarcely concealed contempt for the employed classes, the article is a valid corrective to the sometimes uncritical acceptance by some doctors of patients' claims. The main weakness of Collie's argument is that he suspects everyone of fraud, and is liable to resort to bullying and extreme measures such as electric shocks to bear out his prejudices. It is also important to know that, after the war, Collie occupied a prominent position in the Ministry of Pensions, where he strongly influenced the Government's generally unsympathetic post-war policies towards neuropsychiatric disability.