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Shell Shock in the First World War: An Analysis of Psychological Impairment in Canadian Soldiers.

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A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in History

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Abstract

This thesis explores the question of standardization in the First World War Canadian Army Medical Corps ideologies and procedures through a case study of fifty soldiers discharged for being medically unfit. In analyzing their service records, this thesis demonstrates that there was generalized diagnosis, treatment, and common experiences for Canadian soldiers being treated for mental health afflictions in the First World War. However, because of different medical ideologies, scientific-based beliefs in how humanity was hierarchically organized, the influence of class and rank, the impact of the opposing fields of neurology and psychology, and the need for military efficiency over individual wellness there were not and could not have been standardized practices in the medical field during the First World War.

Keywords

First World War

Case Study

Canada

Psychology

Men

CAMC

Neurology

Rank

Neurasthenia

Mentally Unfit

Shell shock

Standardization

Mental Health

Military

Health

Summary for Lay Audience

In this research project, the treatment of mental health in First World War Canadian soldiers will be examined to better understand the experience on the ground of being diagnosed with a psychological affliction after the turn of the century. Through the service records of fifty soldiers, this thesis will demonstrate that soldiers with shell shock, neurasthenia, or other mental health afflictations were not treated in a standardized system of care, but in a reactive system of care that was focused on maintaining unit strength and returning sick soldiers to the front as soon as possible. Different hospitals with different physicians held opposing beliefs about the cause of shell shock and other mental illnesses, and therefore how to treat them. Neurologists believed it was the result of physical lesions or an injury to the nervous system. Psychologists believed that mental illness was the physical manifestation of a mental weakness and strove to determine the genetic, intellectual, or individual weaknesses that resulted in this mental breakdown.

Rank and class affect how a soldier was diagnosed and treated. Officers were given the opportunity to take more time off the front to recuperate in private convalescent centers run by British elites and offering state-of-the-art treatments like electrotherapy. They were also more likely to be sent back to Canada for extended periods of time without having to be discharged from service. Physicians, who were officers, were noted as feeling more comfortable around fellow officers and could therefore perform better. That soldiers experienced different levels of care based on their class and their rank is indicative of a system of preferential treatment that could not have been standardized medically.

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Introduction

Private Charles Stevens was a 24-year-old London, England-born chimney sweep married to Florence and together they had two children. On 13 December 1915, he enlisted in the 72nd Canadian Infantry Battalion in Saskatoon, Saskatchewan. Two years later, he was admitted to No. 4 Stationary Hospital in Arques, France for “NYD [Not Yet Diagnosed] Shell Shock” after a shell exploded near him at Vimy Ridge and knocked him unconscious.¹ After allowing him time to convalesce, his physicians considered him cured of shell shock and neurasthenia and discharged him from hospital. However, on 2 June 1917, he “had a hysterical fit,” fell, and hit the back of his head on stone.² As a result, Pte Stevens would spend 1917 in and out of hospitals and convalescent stations for shell shock, neurasthenia, hysteria, convulsive delirium, mental observation, and general weakness as his doctors tried to get at the heart of what caused his seizures, and determined if he could be rehabilitated and returned to the front.³

A handwritten note dated July 1917 in his file indicated that Pte Stevens had confessed to murdering his wife and children while on leave in England.

I said I was fit, but she kept on saying that I was not fit I said I was going back to camp, but she kept on saying I was not fit and should not be in the army and she said, ‘why don’t you come home?’ I said I was going back to camp, but she kept on saying I was not fit and then she tried to prevent me from going by taking hold of me and in the struggle, I killed my wife and my two children.”⁴

¹ Library and Archives Canada, Personnel Records of the First World War, “Stevens, Charles.” RG 150, Accession 1992-93/166, Box 9283 - 5, Item Number 250672 Regimental Number 472815.

² Ibid.

³ Ibid.

⁴ Ibid.

A second handwritten note appeared in his file a few months later in November 1917, after he had been discharged back to Canada, from the Saskatchewan Military Hospital that read

Stephens does not remember making any such statements or signing any such confession. At present time – his wife and children are residing in Saskatoon. He is living with them and getting along well... His family have never been in England.⁵

Physicians looked at his medical and family histories for clues. His father, it was discovered, had died in an asylum; there was family history of insanity. It was also uncovered that Pte Stevens had seizures in his childhood and at the age of . His childhood seizures were relevant, but military physicians concluded that the seizures he had experienced at nineteen were been brought on by alcoholism, something he struggled with while in the military.

Stevens was moved between three military hospitals from 23 May 1917 to 28 September 1917 before a medical board determined that he would be discharged back to Canada for treatment in October of 1917: first, the 2nd Western General Hospital in Manchester where he was admitted for neurasthenia for 23 days; second, the Canadian Stationary Hospital in Epsom where he was admitted for neurasthenia and general weakness for 16 days; and third, the Canadian Military Hospital in Eastbourne where he was admitted for hysteria for 71 days. Here, it was determined that he was to be transferred to the Canadian Military Hospital in Liverpool from which he could be invalidated back to Canada. Because his seizures were the most overt symptoms of his illness, doctors focused on healing them and his shakiness and therefore diagnosed him with hysteria and shell shock; the haphazard note of “delirium” written earlier on in his file called no attention as those symptoms. With

⁵ Ibid.

his discharge back to Canada, his medical board determined that he would be able to return to civilian life and his work as a chimney sweep in Canada, but only after he received further treatment in Saskatchewan at a convalescent hospital. On 28 October 1917 his medical board met and confirmed that he should be discharged back to Canada.

The First World War brought a critical shift in the history of psychiatry as the sheer number of soldiers afflicted with shell shock necessitated improved hospital systems, care, and the revitalization and modernization of conceptions of mental health diseases, ailments, and illnesses. Tim Cook notes that official records list “at least 9000 Canadians were diagnosed with shell shock,” and one wartime physician suggested that the number should be at least 15,000.⁶ Ben Shepherd notes that, although the records do not provide complete numerical data, 16,000 soldiers were diagnosed with shell shock in British hospitals in 1916 alone, the numbers rising dramatically during large engagements such as the Somme offensive.⁷ The experience of shell shock in the First World War is a poignant and popular historical relationship to explore because it permits historians to superimpose the microcosm of the individual experience in battle onto the macrocosm of important tactical decisions made in First World War operational warfare; a soldier’s health was an individual experience and yet its organization and treatment was carried out through interconnected military institutions. War forced mental health from scientific ambiguity to the forefront of medical,

⁶ Cook, Tim. *Shock Troops: Canadians Fighting the Great War, 1917-1918*. (Toronto: Viking Canada, 2008). 243.

⁷ Shephard, Ben. *A War of Nerves: Soldiers and Psychiatrists in the Twentieth*. (Cambridge, Mass: Harvard University Press, 2001). 41.

military, and home-front realities; it demanded it be dealt with because it impaired the Allied forces' ability to wage war.

This thesis will explore the experiences of fifty soldiers discharged as medically unfit due to psychological afflictions. The purpose of this case study will be to use examples from points across the war, the continent of Europe, ages, ranks, and illness type to demonstrate that there were not standardized treatments of care for soldiers discharged for being psychologically impaired. This can be observed in inconsistent treatment methods and the reasons behind them, the hospitals to which the soldiers were admitted, how and when they were discharged, what they were diagnosed with, and the length of time they spent on and off the front. The differentiation of treatment and a lack of medical consistency will be the primary focus of this research that, ultimately, will contribute to a better understanding of the development of mental health treatments in Canada.

Historiography:

The historiography on the subject of Canadian soldiers diagnosed with and/or discharged for being medically unfit for psychological impairment is substantial. Historians have explored shell shock as another facet of the debilitating medical experience of war. A number of studies looked at shell shock in the Second World War, followed closely by comparative works of the two world wars.⁸ Revisionists have tackled psychological injury in war, revisiting the numbers to suggest that the afflicted could not actually be quantified.⁹ If

⁸ Shepherd, *A War of Nerves*; Copp, J. T., and Bill McAndrew. *Battle: Soldiers and Psychiatrists in the Canadian Army, 1939-1945*. (Montreal: McGill-Queen's University Press, 1990).

⁹ Copp, Terry, and Mark Osborne Humphries. *Combat Stress in the 20th Century: The Commonwealth Perspective*. (Kingston, Ontario: Canadian Defence Academy Press, 2010).

latent symptoms arose years later, were they not still due to wartime conditions? Were all reported wartime conditions the result of genuine experience of psychological distress? If psychological distress was not reported, was it pertinent to include their experience? How did class play into the diagnosis or lack of diagnosis in soldiers?

In recent years, authors have moved from an analysis of what shell shock was and how it emerged to what it meant to the war effort. Tim Cook and Mark Osborne Humphries have explored the experiences of these men in *Shock Troops: Canadians Fighting the Great War* and *A Weary Road: Shell Shock in the Canadian Expeditionary Force*. In Cook's *Shock Troops*, he discusses how shell shock was initially considered a physical ailment resulting from reverberations and atmospheric changes caused by shells exploding near the body.¹⁰ At the beginning of the war, men who were on the front lines and near exploding shells were the most common victims diagnosed with shell shock. However, as the war continued, only men who were close to shell accidents or involved in them were permitted to be diagnosed with shell shock by military medical officers. As men far from any shellfire or explosions were presenting with similar symptoms to men diagnosed with shell shock, it became apparent that something other than shock waves had to be behind what doctors were calling shell shock: "Prolonged exposure to stress was the culprit, and without rest or respite from the strain of war, most soldiers inevitably developed some form of this nervous disorder."¹¹ According to Cook, there was no one common symptom experienced by all those afflicted with shellshock. However, "for most men the effect began gradually and gained progressively in intensity."¹²

¹⁰ Cook, *Shock Troops*, 241.

¹¹ Ibid.

¹² Ibid.

Shock Troops examines how the men's and their physicians' understanding of shell shock changed over the course of the war. The variety in visible or notable symptoms is one of the reasons why standardization would have been so difficult; if men were presenting with different symptoms and physicians were not capable of discerning a common cause, the culprit would initially be determined to be different entities. Instead, the military opted for a general approach that could best tackle as many symptoms at once as possible.

Mark Osborne Humphries' *A Weary Road* looks at shell shock and asks questions about what it meant to the Canadian soldiers and how that affected the war effort more broadly. How did the large numbers of men afflicted with psychological issues affect the fighting units at the front? Did treatment differ from colonial to imperial soldiers? Humphries takes an expanded view of psychology, suggesting that shell shock was not simply a symptom of war, although its presence and treatment did become a determining factor in the outcome of war efforts. Whereas the historiography tends to characterize shell shock as byproduct of war, Humphries includes it as an active and determinist participant. He does this by framing military organization of medical treatment as a reactive institution that had to accommodate mass numbers of soldiers in hospitals with shell shock and other psychological disorders while simultaneously maintaining strength at the front.

Sir Andrew Macphail's 1925 book *History of the Canadian Forces, 1914-1919: Medical Services* explores the construction, experience, and realities facing the Canadian medical services during the First World War. Specifically, he highlights the experiences of a medical division dedicated to improving the health of soldiers while also serving the higher need of maintaining military strength on the front. It becomes clear that he wants readers to understand that the Canadian Army Medical Corps, or CAMC, operated under a system of

triage and rehabilitation in war that did not constitute a classical hospital rest-recuperate environment. Instead, it was an institution established to maintain military strength rather than to support individual lives. In pulling back from the individual experience, this book helps bring the historian out of the individual in the case files to the administration and realities of the war. This theme was taken up and expanded on by historian Richard Holt in his book *Filling the Ranks: Manpower in the Canadian Expeditionary Force*. Holt analyses the evolution of the Canadian Expeditionary Force, or the CEF, from a militia to a professional army, the main impediment to that process being establishing and maintain the manpower as well as the institutions to support that military system. Holt looks at the use of command depots to rehabilitate soldiers outside convalescent and general hospitals as a means of freeing up space, the Bruce Report and the government's response to an investigation that concluded the CAMC resources were being squandered by the British Empire, and the experiences of physicians and patients in the war. Holt takes a step away from the war front to look at its administration. The army was organized around acquiring and sustaining manpower and that had an influence on the medical treatment of soldiers as they were a resource to be reused as opposed to wasted. The dichotomy between medicine and the military, and the way the needs of one affected the other, permitted me to construct arguments around the problems associated with hospitalizing men who presented with mental illness in wartime.

Other historians move out of the First World War and into the Second, to compare and contrast them and to assess the evolution of medicine over that time. Ben Shepherd's *A War of Nerves* is an amalgamation of in-depth analyses about the experiences of the soldiers and their physicians over the 20th century, from 1914-1994. Shepherd examines shell shock and other nervous disorders that were rampant during the First World War, looking at the

soldier's experience and what the physicians brought to that relationship. He stresses that physicians were not neutral bodies acting outside of military needs, hospital needs, and their own ideological convictions. Shepherd analyses the evolution of different medical practices, military procedures, and the subsequent shifts in soldier treatment. He places the physicians' decisions to expand and restrict definitions of nervous disorders in the context of successive offensives that demanded medical advancements and resulted in varying soldier experiences. Like Macphail, Shepherd looks to the overarching relationships that affected the medical community and its decisions regarding soldiers' care, and the external influences that affected those layered decisions. Shepherd then moves into an interwar analysis of larger themes of mental health to discuss how perceptions and treatments of mental health changed. He addresses the lessons learned and the lessons ignored from the First World War, such as the institutional shift away from asylums towards hospitals and the expansion of the psychological specialty to include civilians. However, although the psychological specialty grew in popularity and respectability, the divide that existed between and within neurologists and psychologists during the First World War continued into the Second to the detriment of the men.¹³

Like Shepherd, Terry Copp and Mark Humphries explore the evolution of trauma in war over the 20th century in their book *Combat Stress*. While Shepherd focuses mainly on Britain's experiences, Copp and Humphries take their analysis to the colonies as well. *Combat Stress* helps connect medical ideas that were prominent in England to those in Canada and other Commonwealth countries. *Combat Stress* also details the downstream

¹³ Shepherd, *A War of Nerves*, 164-165.

problem of the psychological specialty being at odds not just with itself, but other medical specialties. Shepherd notes that there was contention in the interwar period but shifts quickly into a discussion about Second World War psychologists isolating heredity in weakness and using that to successfully work with the British military to implement a psychological test to potential soldiers before they enlisted. Copp and Humphries explore the divisions that existed going into the Second World War between the medical community and the military to point out that psychology was not equally considered effective, truthful, or beneficial to the military complex. As a result of this continued lack of medical agreement on what combat stress was, soldiers would needlessly suffer again in the Second World War.¹⁴

While Tim Cook and Mark Osborne Humphries have done exceptional work detailing more explicitly the experiences of shell shock among First World War soldiers, this thesis will explore the diagnoses and treatments that these men received to demonstrate that while the mental health field was evolving, it was not operating through standardized practices but generalized ones based upon military need rather than individual medical concerns.

Terminology:

The terms used to differentiate the various types of psychological conditions during the First World War were vague; what exactly constituted one psychological condition or separated one from the other was not definitively established nor consistently applied to patients across the CAMC. Shepherd notes that some physicians lamented the use of the term shell shock during the war because it was applied to anything and everything.¹⁵ It could be

¹⁴ Copp and Humphries. *Combat Stress in the 20th Century*. 143.

¹⁵ Shepherd, *A War of Nerves*, 13.

related to a shell explosion or it could have nothing to do with one; this contributed to its liberal use, and then to its subsequent restricted use. Over the course of the war, different terms emerged as a way to try and differentiate varied cases of shell shock. The differentiation process would include a reassessment of the symptoms to determine if they had changed, the triggering incident, and the individual's personal and family histories. Shell shock was associated with a pure case of psychological effect from an accident, whereas diagnoses like neurasthenia, neuritis, neuralgia, gastritis, and myalgia were applied to cases where classical shell shock symptoms were not be expressed or when they dissipated or changed.

Shell shock and neurasthenia were the two most common terms found in this case study; seventy-two per cent of the soldiers in this study were diagnosed with shell shock or neurasthenia, or both, over the course of the war. This number increases to eighty-two per cent if the diagnoses shell shock-wounded, shell shock severe, nervous, tremors, and neuritis are included. Other diagnoses were insanity, melancholia, mental deficiency, mental derangement, psychosis, and sick-mental.

Shell shock, while also linked to mental affectation, was specifically tied to symptoms of nervousness, shakiness, tremors, amnesia, dizziness, mutism, deafness, or any combination thereof. It was tied to men who were involved in physical incidents involving shellfire and then presented these symptoms afterwards. However, as the war progressed, men were appearing in hospitals with shell shock symptoms who had not been involved in a shell explosion. The number of soldiers being sent back from the front was so high that restrictions had to be placed upon diagnosing a patient with shell shock. According to military procedure, a soldier would first present to his unit's medical officer. There, the

decision would be reached about whether or not the soldier should be sent further back to a stationary hospital, or even back to England. Only once a soldier got to a hospital with signed statement from his superior officers that he had in fact been in a shell accident could that soldier be diagnosed with shell shock. Historian Mark Humphries discusses shell shock or traumatic shock as a result of a sudden and dramatic event that produced seemingly hysterical symptoms by causing functional organic lesions in the central nervous system, which mimicked hereditary defects observed in hysterical patients. It was an acute form of neurasthenia.

Neurasthenia was the second most common term to describe a psychological issue in a soldier. This term was created in the late 1820s and would come into widespread use during the 1870s.¹⁶ George M. Beard, one of the people who popularized the term, considered neurasthenia to be defined by symptoms of fatigue, anxiety, headaches, heart palpitations, high blood pressure, neuralgia or nerve pain, and a depressed mood. Beard connected nervous exhaustion of the civilized man with the civilized world. In his 1889 book *A Practical Treatise on Nervous Exhaustion*, he first states that

the symptoms of neurasthenia are largely of a subjective character. ... Unlike the existence of surgical and acute and inflammatory diseases, the phenomena of which the physicians can see and feel, and for the study of which he is little, if at all, dependent on the patient's intelligence or honesty, they do not appeal directly to the eye or ear or touch, and are in fact quite out of the range of all modern appliances...¹⁷

Here Beard establishes neurasthenia as a vague disorder, easily overlooked by the non-specialist. During the First World War, it maintained that vague definition, being used as way

¹⁶ Shepherd, *A War of Nerves*, 9.

¹⁷ Beard, George M. and A. D. Rockwell, *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment* (New York: E.B. Treat, 1889). 26-27.

to explain physical symptoms that were similar to shell shock when the incident could not be verified or was not a part of the diagnosis. It was a way to have an illness that was not necessarily the fault of the individual.

Other terms that arose in this study relating to shell shock and neurasthenia were insanity, hysteria, mental disorders such as derangement or deficiency, and psychosis. Insanity and hypnosis were typical pre-First World War medical terms to describe psychological disorders. Dr. Daniel Kitchen, chief of staff for the hospitals on Blackwell's Island in New York during the 1870s, considered insanity to be "a disease of the brain affecting the mind by which there is a change in the person's mode of acting, thinking, and doing things."¹⁸ While he acknowledged that this was a broad jumping-off point, he insisted that was the only place to start with diagnosing insanity. While mood can be altered in any normal individual, persistent changes in mood or constitution that do not reflect their environment or one's general disposition are also indicative of a state of insanity.¹⁹ Mania, depression, melancholia leading to pathological sleep, or dementia were the telltale signs of insanity for Dr. Kitchen. Hysteria was more complex: "The employment of the word 'hysterical' may sometimes be found indicative of the state of mind of the practitioner rather than those of the patient's health."²⁰ It was a way for a physicians to convey that something was fundamentally altered in a person's mentality, but that this alteration was "nothing very serious as to life." Hysteria was more closely linked to the nervous system of the individual: "a perversion or a complete annihilation of its functions or part of them, no matter whether

¹⁸ Daniel H. Kitchen, *Lectures on Insanity and Hysteria* (New York: Bellevue Press, 1876). 3.

¹⁹ *Ibid*, 3-4.

²⁰ *Ibid*, 89.

any physical changes are noticed in organs by instruments and other mean in our power.”²¹

Indications of altered organ states were either extreme happiness or sadness; the hysterical episode might also include excitement or irritability. Into the First World War, insanity would still be identified by excitability, dementia, mania, and depression. Apathy would be a newer marker for its diagnosis. It would also be connected to physiological changes within the brain as well as psychological changes.²²

The vagueness of the terminology used to define psychological conditions during the First World War is indicative of a system of medicine that operated on no standardized methods for classification, diagnosis, or treatment.

Methodology:

The primary source of material for this project will be fifty randomized personnel files of First World War soldiers available online through the Library and Archives Canada website. While all service files of soldiers from the First World War have been digitized, there is no means of keyword-searching the files. Therefore, the greatest impediment to acquiring an adequate and randomized sample to yield any kind of conclusions regarding their experience over the course of the war was first identifying and isolating fifty service files of men discharged for being mentally unfit from the 673,054 total service records digitized from the First World War.

²¹ Ibid, 93.

²² Hart, B. *The Psychology of Insanity* (Cambridge University Press, 1914). 24-25.

The first method of attempting to identify servicemen's files who were discharged for being medically unfit was through a randomized list generator that would select a service file between 1 and 673, 054 possibilities. This method yielded few soldiers who had been discharged for being medically unfit and most of those were not discharged for being mentally unfit.

The second method to find the names of soldiers discharged for being mentally unfit was to consult hospital war diaries, also digitized and available on the Library and Archives Canada website. Soldiers' names are occasionally specifically mentioned in the diaries, when they were away on leave, struck off strength, or sent to other facilities for treatment. Occasionally, this treatment was for psychological distress. However, these diaries are separated by unit and time. As a result, names found using this method would only be representative of soldiers in a specific unit and their cases would likely only reflect experiences after specific battles. For this case study, this process would not yield the desired randomized results.

A third option was to consult lists of soldiers who, throughout the war, were demobilized and sent home for various reasons. They were not sent home on the basis of unit, rank, city of origin, race, or level of injury and therefore might represent a fairly randomized amalgamation of soldiers from which I could derive representative data. Because demobilization took place throughout the war, there is a higher likelihood that the names listed are of individuals who were discharged for being medically unfit. This is, however, not guaranteed.

The final method that was pursued and located more than fifty soldiers who were discharged for being medically and mentally unfit was through newspapers' archives. Over

the course of the war, lists of names of soldiers who were discharged were released in newspapers across Canada. These lists of names included the reason why a soldier had been discharged. Through a keyword search of ‘shell shock’ during the years 1914-1919 in Canada on newspapers.com, I was able to locate ninety-one soldiers discharged for shell shock. In this list, only fifty were viable candidates for this study and even then, some were included who were discharged for being physically unfit, who were demobilized, or who committed suicide. These men all had instances of mental health affliction in their case files and most were being considered for discharge; in some cases, men were returned to duty or shifted to light duties for reason of mental unfitness. Ultimately, I identified fifty names that were used to create a working baseline for what it was like to be diagnosed and treated for psychological wounds in the First World War and what that discharge process looked like across class, region, time, and symptoms.

Chapter Outlines:

The first chapter examines the diagnostic process involved with treating First World War soldiers who were diagnosed with mental health issues to demonstrate that terms and practices were generalized rather than standardized. The system functioned on a case-by-case basis with follow-up procedures depending on which physicians were treating which patients, and what symptoms they were presenting with at the time. Before the war, medical theories about intelligence, superiority, and mental health all affected how soldiers were diagnosed. As the war progressed, the initially liberal definition of shell shock shifted to be less inclusive to offer some level of differentiation and guidance to medical officers. Other descriptive terms such as neurasthenia, gastritis, myalgia, mental derangement, and mental

deficiency were used in an attempt to ensure that fewer soldiers were classified as having shell shock.

This analysis will start with an examination of medical theories and practices operating before the First World War to discuss how they affected diagnostic processes during the war. The validity and efficacy of asylums were being questioned, as were the methods that had historically been used in them by the mid-1800s. Questions arose in British and North American psychology communities about the permanence of hysteria and insanity as investigations by psychologists from both continents suggested that keeping people locked up and treating them as if they were insane actually reinforced that behaviour as opposed to curing it. In fact, the problem that scientists and physicians were having with asylum workers was that their medical focus was not on curing their patients but keeping their diseased prisoners segregated from society to protect the general population. This was not so different from the assumption, widely held during the First World War, that mentally afflicted men had to be removed from their units temporarily, lest they infect other soldiers.

In the second chapter, treatment given to First World War soldiers affected with mental health illnesses will be examined to demonstrate that treatments were varied depending, not on the disease itself, but on which diagnosis a soldier received, what hospital he was in, what doctors he saw, his rank, and how debilitated he was. In three sections, this chapter explores how prioritizing military efficiency over individual care affected that care, how rank and classism affected treatment, and how the practices of psychologists and neurologists differed, to the degree that a soldier's treatment could depend on the hospital to which he was transferred, rather than anything inherent in his condition. These sections will demonstrate

together that care was situationally dependent on factors that were not, and could not be, standardized, resulting in differing levels of care over the CAMC.

The final chapter takes themes explored in the first two chapters and applies them to individual case files as a means of demonstrating that, within this case study, soldiers experienced differing levels of non-standardized care. It compares soldiers who were diagnosed with shell shock and then subsequently neurasthenia and the reasons behind diagnosing a person with one and then the other. It then looks at the experiences of officers and how those were different from men. Finally, it takes a look at a malingering soldier to reveal a truism of the history of shell shock: it was impossible to fake a bullet wound, but relatively easy to pretend to have psychological symptoms.

Ultimately, this thesis argues that in this period of war, change, conflicting priorities, and divergent theories, medical care could not have been standardized and could only have been generally applied situationally.

Chapter 1

1 Diagnosis.

Patient is a foreigner and never speaks.

Insomnia – Marked. Sleeps not more than 4 hours in 24 hours.

Appetite – Good. Bolts his food ravenously.

Temperament – Docile and obedient.

Habits – Childish, collecting articles such as pieces of wood, nails, tins, etc., and making mud balls with which he plays continuously. Has a habit of taking off socks when he puts on his cap.²³

Gerasim Stecenko was born in Russian Kiev on 4 March 1885. Married to Justina, he was trained as a blacksmith and, before immigrating to Canada, had served three years in the Russian Army. On 12 July 1915, Stecenko was living in Quebec and enlisted in the 15th Battalion, 1st Reinforcement Draft. He would move from there to the 14th Battalion and ultimately end up in the 23rd Reserve Battalion of the Canadian Expeditionary Force. Pte Stecenko trained for nine months in Quebec before making it to the front in France. Three months later, he was put into a firing trench where, after his first day at the front, he reported to his medical officer with a headache. It was not considered serious, and he was discharged back to his unit. The next day, “a shell exploded near him[...] killing his friend and knocking him down.”²⁴ After two fainting spells, he was sent to No. 3

²³ Library and Archives Canada, Personnel Records of the First World War, RG 150 “Stecenko, Gerasim.” RG 150, Accession 1992-93/166, Box 9251 – 14. Item Number 248781. Regimental Number 448219.

²⁴ Ibid.

Canadian Field Ambulance with the additional symptoms of insomnia, pain in his leg whenever his head ached, abnormal childlike behavior, and shell shock.²⁵ Over the course of his transfers in and out of hospitals, his diagnosis would change from shell shock to insanity. The decisions that led his physicians to this point will be explained here to demonstrate an individualized system of care based on specific interactions, symptoms, and history.

At No. 10 Canadian Field Hospital, Pte Stecenko was judged to be violent, disobedient, and with poor hygiene; it was noted that he rarely spoke as he was foreign. At Moore Barracks, a Canadian and British hospital otherwise known as the Royal Military Hospital in Shorncliffe, England, his physicians dug deeper, under the initial diagnosis of shell shock, to investigate the validity of his illness as he was not presenting with classic shell shock symptoms; by that time, malingering or pretending to have shell shock, was becoming a problem for to the military. Physicians reported that he was collecting small objects, like nails, with no clear purpose and that he had a family history that pointed to mental weakness as opposed to shell shock. Both Pte Stecenko's brother and his father had a history of debilitating headaches to the point where his brother had had to be operated on twice for them. Another symptom that caught his physician's eye was that Pte Stecenko's physical condition was unusually good. Physicians noted that he was well-nourished and therefore fit. The implication in his file was that physicians did not expect to see someone with his mental affliction to look like him; the fact that he was physically fit for service pushed them further from a diagnosis of debilitating nervous

²⁵ Ibid.

shell shock to one of insanity. Finally, the fact that Pte Stecenko had suffered similar head pain during his service in the Russian Army, in conjunction with him failing a neurological test, shifted his diagnosis from shell shock to neurasthenia and delusional insanity. Pte Stecenko had presented with head pain and was in proximity to a shell explosion, but he was neither injured by said explosion nor exhibiting any nervousness, shaking, or tremors. The leg pain he presented with as a symptom of the explosion was tested through endurance and physical pain stimuli. Doctors struck his leg and had him stand and walk, and Pte Stecenko reported feeling no more pain. In light of his history and absence of significant physical pain, a diagnosis of shell shock was no longer applicable to his case. What doctors used to help choose his diagnosis shifted to analyses of his personal hygiene, comportment, and mental state: “His habits are dirty and degraded”;²⁶ He suffered from “foul breath” and inflamed gums, indicative of a lower-class individual; “Patient cries once a day for at least ten minutes. He is, in fact now, never violent, always obedient, and clean since his admission.”²⁷ These symptoms in conjunction with his child-like behaviour and obsessive practices resulted in diagnoses of neurasthenia, then acute mania, and finally delusional insanity. His condition was ultimately considered aggravated by shell shock, but not created by it. The Medical Board reviewing his case could not determine the length of time his illness would persist, saying that with these symptoms and prognosis it was “impossible to say,” so he was

²⁶ Ibid.

²⁷ Ibid.

“discharged in consequence of being found medically unfit” on 11 May 1916.²⁸

Symptoms Pte Stecenko was exhibiting as well as his personal history and character pointed his physicians away from a diagnosis of shell shock towards neurasthenia and delusional insanity.

Contemporary medical diagnoses for mental disorders represented both opportunity and restriction for patients seeking care in the First World War; patients received changing medical diagnoses, which changed both their understanding of self and of how physicians interacted with them and administered treatment. The action of identifying someone with a specific disease or illness and then treating them for that had an effect on a patient’s perceived and social identity.²⁹ One particular diagnosis over another might assign an individual a specific course of medication and to particular medical facilities, affect how other perceive them as well as how they perceive themselves, and it might well result in loss of freedoms.

During the First World War, what exactly constituted mental health was unclear and maintaining good mentality was a priority only insofar as it contributed to the good morale of the collective and kept up unit strength. Problems with mental health were referred to as mental disorders or diseases and could be psychologically or physically incurred; physical causes were inherently more respectable as they were typically not the

²⁸ Ibid.

²⁹ Clarke, Juanne N., and Susan James. "The Radicalized Self: The Impact on the Self of the Contested Nature of the Diagnosis of Chronic Fatigue Syndrome." *Social Science & Medicine* 57, no. 8 (2003): 1387-395. doi:10.1016/s0277-9536(02)00515-4.

result of a person's weakness, but of an accident or trauma.³⁰ The stigmas against mental health issues for the soldiers were widely known and encouraged by the military to maintain both morale and military strength; for a soldier to be suffering from any mental health issues would suggest, at various points in the war, that he was weak, unintelligent, feminine, cowardly, irresponsible, and/or homosexual. Essentially, it would mean that he was not a man and therefore not a soldier. As the war progressed, however, some mental afflictions became acceptable to the men, but in ways that still supported traditional ideas of masculinity and permitted the maintenance of unit strength. If a soldier had been on the front for an extended period of time, fellow soldiers would understand if he became shell shocked; he had served his time, protected his fellow men, and deserved a break from the front. The personnel files of such soldiers tended to reflect an individual of good military character, rather than suggesting that he was malingering. All these factors had a restricting effect on medical officers whose goal was to determine how fit the soldier was and what kind of treatment he would receive to be rehabilitated and returned to the front. This war was to be won with numbers and the army was not going to lose strength to the hospitals and asylums if it could be avoided. Combined with the fact that the typical physician's understanding of mental health, psychological practices, and neurological practices was minimal, the outcome for these soldiers was frequent misdiagnoses, poor treatment regimes, and the overall mishandling of the soldiers' health. Although the Canadian and Royal Army Medical Corps attempted to revise medical practices over the

³⁰ Richards, Edward G. *The Psychological Origin of Mental Disorders*. (New York & London: Funk and Wagnalls Company, 1913).

course of the war, there were no specific medical protocols in place, and no standardized health care approaches established for men afflicted with psychological disorders during the First World War. This chapter will focus on the diagnostic processes of the CAMC and the RAMC concerning psychologically afflicted men who were ultimately discharged for being medically unfit. It will demonstrate the variety of definitions of shell shock, the possible impact of being diagnosed by different physicians, and the fundamentally inconsistent nature of mental health care in the First World War.

This chapter will explore the Canadian Army Medical Corps and the medical facilities in which it operated, ultimately to demonstrate that diagnosis and the diagnostic process were not standardized but generalized. A standardized approach to diagnosis implies that there were set medical protocols for all military physicians and medical personnel to follow when a soldier presented with symptoms, complaints, injuries, and issues that permitted specific diagnoses, treatment, and care. In contrast, a generalized approach is the concept that physicians had all-encompassing diagnoses, like shell shock, that could be applied in various conditions and general approaches to treating psychological illnesses. Describing the Canadian and British systems of medicine in place during the First World War as standardized indicates that there was a level of understanding that did not exist and that this level of understanding was agreed upon as standard by all medical and military personnel. To begin this analysis, this chapter will highlight pre-First World War assumptions about psychiatric care and neurological theories to construct a basic road map of the knowledge that the two main camps of physicians dealing with it brought to their diagnostic processes. The chapter will outline commonly held beliefs that arose from treating mental illnesses during the war, to

consider how those ideas changed medical knowledge in post-war medicine. Specifically, by examining medical theories at the time and soldier case files, this chapter will examine the diagnostic process, and what those diagnoses suggest about the state of standardization in medicine during the war.

There are three major arguments in this first chapter. First, men were diagnosed based on the symptoms they presented with; symptoms, especially symptoms of mental or psychological origins, changed frequently or were intermittent, and therefore diagnoses changed. Second, diagnoses changed not because of improved standardization but because physicians were instructed to diagnose men in specific ways in order to get them back on the front or to prevent them from being sent back to the hospital at all. Instead of permitting soldiers leave back to England or Canada, the military was concerned with maintaining strength, and therefore put pressure on the medical corps to keep their men diagnosed with temporary or curable ailments. Mental ailments, being inconsistent and inconclusive, could be considered temporary.

1.1 Pre-First World War Theories and Practices of Mental Health.

The incidence of war neuroses, a broader term to include more psychological issues associated with wartime than shell shock, pre-dates the First World War by at least two centuries. In 17th-century France, army doctors noted that soldiers experienced a kind of homesickness that made their bodies weak and vulnerable to infection. They called it nostalgia, a condition typically associated with emigrant populations who came to Europe to work but could not acclimate, after noticing a similar affliction in French soldiers. “By the early 1700s, some doctors reported that nostalgia was a prevailing condition in the

armies of Europe.”³¹ In the 19th century, with the Crimean War in 1853 and the American Civil War in 1861, medical professionals in Britain and the United States had become well acquainted with nostalgia, but had conceptualized the problem as a cardiac one. Irritable heart, soldier’s heart, or disordered action of the heart were the interchangeable terms that had come to describe a version of war neuroses in the Western world. In an 1871 case study of over three hundred Civil War veterans from every army division of the United States, Dr. J.M. Da Costa stated that this irritable heart was not a new disorder, but one that could be linked back to British descriptions of ill soldiers in Crimea. Soldiers would experience fevers, diarrhea, intermittent gastric problems, breathlessness, dizziness, palpitations, chest pains, and a gradual inability to perform their soldierly duties.³² The cause was overexertion, lack of sleep, poor nutrition, homesickness, and other illnesses. These soldiers, after a round through the relevant hospitals, were either discharged or placed in an invalid corps of troops.³³ Sarah Hartzinger and Jean Scandlyn, in their article “Decentering PTSD: A War Outgrows a Diagnosis,” note that while there are commonalities between irritable heart, shell shock, and ultimately PTSD, irritable heart was perceived as a physiological problem and treated that way with medication to slow the heart, convalescence, and physical training.³⁴

³¹ Copp and Humphries. *Combat Stress in the 20th Century*. 1.

³² Da Costa, J. M. *On Irritable Heart, A Clinical Study of a Form of Functional Cardiac Disorder and Its Consequences*. (S.l.: Elsevier BV, 1871). 20.

³³ *Ibid*, 20-21.

³⁴ Hartzinger, Sarah, and Jean Scandlyn. “Decentering PTSD: A War Outgrows a Diagnosis.” In *Beyond Post-Traumatic Stress*, 96–114. 1st ed. Routledge, 2014. 100-101.

During the First World War, neurologists and cardiologists worked alongside the newer psychologists, a partnership that helped to reframe war neuroses around psychological as well as physiological causes as more and more soldiers were presenting with no heart affectation and were not involved in a physical accident. The link between mental health and war is a long and complicated one shaped by medicine, war, and society; the First World War, with its massive number of casualties, permitted medicine to evolve its understanding of war neuroses as a mental health issue.

The fields of biology, physiology, anatomy, and medicine were expanding over the 19th century, bringing discoveries and theories of the cell. The knowledge of the cell, the gene, bacteria, and germs permitted the possibility of control over the human body and health in a way that medicine did not have before; the role of the physician had shifted from a passive to active one as they could potentially determine cause and cure an illness.³⁵ Before the First World War, British, Canadian, and American physicians were openly recognizing the limits of mental health facilities, in so much as they had yet to develop a cure for insanity and recovery rates were not improving. In 1885, Dr. D. Hack Tuke released *The Insane in the United States and Canada*, which detailed the history of asylums in the United States and Canada and provided an analysis of his tours of both countries' current systems. Dr. Tuke, after looking into the American asylum system, alienists, and the treatment of the insane, concluded that like the asylum system in Britain, "they have not utilized, to the extent they ought to have done, the materials at

³⁵ Ackerknecht, Erwin Heinz, Charles E. Rosenberg, and Lisa Haushofer. *A Short History of Medicine*. (Baltimore & London: Johns Hopkins University Press, 1968). 158-159.

their command; that their annual reports are defective in scientific results; that they have made no great important discoveries in the treatment of insanity.”³⁶ The concept of an asylum had shifted from essentially a jail to a hospital and, in the process, its inmates became patients. The sickness of insanity was broadening to include temporary states or states brought on by a physical cause; insanity was becoming a treatable illness. The expectation had therefore shifted to suppose that alienists, neurologists, and psychologists could make headway into cures or treatments for the now various conditions of insanity. Dr. Tuke took this concept further to discuss the reality of what it meant to cure insanity, and what insanity meant to the population of Britain, Canada, and the United States. While shifting assumptions about mental health would have beneficial outcomes, social constraints still limited practical growth in the field. In his analysis of the American asylum system, Tuke demonstrated the inherent bias that was endemic in the medical system: “the authorities have had enormous difficulties to contend with from the fact of society in America being in a state of continual fusion, including the mixture of races consequent upon immigration.”³⁷ Tuke believed that it could not be the fault of the American or British asylum systems that they were being forced to deal with the insane of foreign countries: “Between 1820 and 1850, 2,250,000 emigrants landed in the United States, making one-tenth of the population foreign. The number of insane in 1850 was 15,610, and of these, 2,049 or very nearly one-seventh, were foreigners.” If more patients

³⁶ Tuke, Daniel Hack, *The Insane in the United States and Canada*. (London, Eng.: H.K. Lewis, 1885). 95.

³⁷ *Ibid*, 96.

in asylums were minority groups, that seemed to mean that these groups were more likely to suffer from poor mental health. Furthermore:

The census of 1880 showed the number of insane to be 91,959; of these, new fewer than 26,346, or between one-fourth and one-third, were not American born. In other words, 13-33 per cent of the general population-that is to say, the imported element-produced 28-75 per cent of so called American lunacy.³⁸

Dr. Tuke also makes clear that the incidence of insanity among black Americans was three times lower than the incidence of insanity among foreign-born Americans.³⁹ At the end of the day, the former were at least born in the United States and therefore considered more American by American and British physicians, giving them more of a right to be treated in American asylums. These growing number of patients to care for explained, at least for Dr. Tuke and his medical community, why insanity had to be cured; the asylum system in the US was being over-extended and burdened by caring for the overwhelming number of foreign mentally ill patients. It could not therefore be expected to advance the science of treatment, let alone advance a cure. Reforms to the asylum system served as a way of explaining why experts had yet to find a cure; this process found scapegoats in immigration populations as opposed to looking at treatment methods and conceptions of diseases. This analytical work alludes to commonly held beliefs of social hygiene in the medical community which, around the turn of the twentieth century, believed humanity to be hierarchically organized according to their genes. This affected how civilian patients

³⁸ Ibid.

³⁹ Ibid, 98.

were treated and would impact the diagnosis and treatment of soldiers during the First World War.

Dr. Tuke found a broader spectrum of care and medical advancements in the Canadian asylum system. Asylums in Quebec were not being led by medical men with a competent knowledge of insanity nor were there frequent inspections made by “efficient” men.⁴⁰ Being without the guidance of qualified, modern, and capable medical authorities left Quebec asylums to reflect older trends in the organization of asylums: little money for clothing and individual maintenance, poor diets that resulted in malnutrition, few attendants, which made proper patient care impossible, the use of physical restraints, and physicians of low caliber because the hospital had not allocated enough money to entice more highly educated doctors to work there.⁴¹ This also meant that, like the physicians and alienists in the American system, they were not advancing scientific inquiry to discover a cure for insanity or improve the treatment of the afflicted. In Ontario, Dr. Tuke called attention to the fact that mechanical restraints were also still actively being used on patients, despite the determination by alienists that they were unnecessary or rather impeded patient care.⁴² Specifically, the asylum in London was guilty of still using these restraints actively. However, Dr. Tuke admired that Ontario asylums were taking seriously the distinction between the incurably insane and the curably insane. Through the construction of external small adjacent buildings, Ontario asylums could effectively

⁴⁰ Ibid, 201.

⁴¹ Ibid, 204-205.

⁴² Ibid, 206.

and completely segregate their curable patients from their incurable, who would remain in the larger facility closer to necessary medical equipment and more staff.⁴³ Another advance that Canada had made was that, at least in its private asylums, people had to meet admission requirements:

No patient can be admitted (except upon an order by the Lieutenant-Governor) without the certificates of two medical practitioners, each attested by two witnesses, and bearing date within three months of admission. Each certificate must state that the examination was made separately from any other practitioner, and after due inquiry into all necessary facts; the medical practitioner specifying the facts upon which he had formed his opinion, and distinguishing those observed by himself from those communicated to him by others.⁴⁴

One of the biggest differences between the systems in Quebec and Ontario was that Ontario had made the care for the insane the responsibility of the province. Dr. Daniel Clarke, the director at the head of the Toronto Insane Asylum, believed that in doing so, treating insanity would be much easier with more funding.⁴⁵ The insane man was a victim of his own personality and the role of the insane asylum should be to assess each man one on one, to better inform the field of psychology and turn the asylum into a hospital to treat these afflicted individuals.⁴⁶ Clarke insisted that all definitions of insanity “must, of necessity, be of a general character, as the signs and symptoms vary as each individual from any other person.”⁴⁷ Intellectual level was also not grounds for a

⁴³ Ibid, 209.

⁴⁴ Ibid.

⁴⁵ Rowland, Jon Stewart, *Troping the Asylum: Authors and Authorities at Toronto Asylum*. (Opensource: 2012). 131.

⁴⁶ Ibid. 131-132.

⁴⁷ Ibid, 38-39.

diagnosis of insanity, according to Clarke: “idiocy or imbecility are simply arrested brain development from nutritive or trophic defect, with the consequent mental limitation.”⁴⁸ Whereas intellect is the product of physiological action or inaction, insanity is a disease. He went into further detail, explaining that insanity was the result of lesions on the brain and molecular changes that happened suddenly or gradually, “yet no initiary stage [can] be pointed out.”⁴⁹ Clarke believed that the weakening of the mind and the onset of possible lesions was caused by age, lack of sleep, fatigue, mental incapacity, “by a feeling of goneness in the body,” an inability to concentrate, poor memory, low morale, and poor appetite.⁵⁰ These theories and concepts came out of experiential asylum interaction that twenty years later would be used to help specify which mental illness an individual was suffering from. Tuke’s and Clarke’s books help illustrate where medical science was moving in North America with respect to mental health in general and reflect what social constraints were active in the functioning of those medical systems moving into the First World War. How physicians, servicemen, and civilians conceptualized mental health all impacted the health care system that attended to the injured and wounded of the First World War.

Private James Jackson is a tragic example of a soldier experiencing a mental health affliction that could not be properly taken care of because of the context of the First World War: general suspicions of malingering, the push on medical officers to

⁴⁸ Ibid.

⁴⁹ Ibid, 129.

⁵⁰ Ibid, 189.

return any relatively able-bodied and -minded men to the front as quickly as possible, and the state of medical knowledge more broadly. Pte Jackson was a Glaswegian who enlisted into Lord Strathcona's Horse on 23 September 1914. He was admitted to Moore Barracks on 17 January 1917 for Melancholia. Three days later, he was transferred to the 1st West General Hospital in Fazakerley, Liverpool, as his condition deteriorated. After four days there, he was transferred to Moore Barracks Canadian Hospital in Shorncliffe, Kent.⁵¹ At Moore Barracks, the Admitting Officer noted his observations about Pte Jackson

The marginally named man has for some days been suffering from mental trouble. He gives a history of seminal emissions for two years, and has lately developed a melancholic condition. He has ideas of persecution and thinks some occult power in responsible for his condition. Kindly have him placed under observation and if necessary boarded.⁵²

His physician repeated these observations on Pte Jackson's Medical History Case Sheet and added: "He is somewhat depressed but answers questions intelligently, does not hear voices etc. his memory is good and he is perfectly oriented. In my opinion he is simple a case of mental deficiency."⁵³ The physician believed that Pte Jackson did not need to be institutionalized but would improve if he were returned to civilian life. As a result of this, a medical board prepared his discharge papers and he was invalided to Canada on 12 March 1917. On 11 April 1917 he committed suicide. The focus in his file on his intellectual abilities shows an ideological belief among his physicians that insanity,

⁵¹ Library and Archives Canada, Personnel Records of the First World War, "Jackson, James", RG 150, Accession 1992-93/166, Box 4748 - 31, Item Number 479224, Regimental Number 2762.

⁵² Ibid.

⁵³ Ibid.

melancholia, or mental health afflictions in general were tied to some extent to lower intelligence. They explained that he could answer questions intelligently, but because he still exhibited psychosis, he was still regarded as mentally deficient.⁵⁴

Social hygiene and eugenic theories, like the idea that intelligence was inherited and could be tied to mental illnesses, affected how soldiers were diagnosed in the First World War. Despite the declared good intentions of Dr. Tuke to improve the care and prognosis of the insane, there were elements of social hygiene and discrimination throughout his book. He separated patients by race and nationality, stated openly that immigrants had higher rates of poor mental health, and lamented the fact that any “lunatic” who committed a crime in Ontario was not immediately sent to jail.⁵⁵ This in-depth analysis of asylums is indicative of a deeply ingrained belief that humanity was hierarchically created. That eugenic brand of Galtonian thinking can be seen in multiple soldiers’ files in this case study.

Sir Francis Galton, cousin to Sir Charles Darwin, took the theory of evolution and adapted it to postulate selective human breeding as a way to perfect the human race. Evolution is a theory that over time and through environmental pressures, different traits within an individual will be selected to better ensure the survival of the species.⁵⁶ Eugenics is the idea that there are superior and inferior traits in people, like intelligence,

⁵⁴ Ibid.

⁵⁵ Tuke, *The Insane in the USA and Canada*, 212.

⁵⁶ Darwin, Charles. *On the Origin of Species: By Means of Natural Selection or Preservation of Favoured Races in the Struggle For Life*. (New York: D. Appleton, 1869). 68.

that can be isolated and bred out.⁵⁷ This theory is racist, sexist, and provided the basis for many flawed scientific practices. Beyond the basic idea that poor genes needed to be bred out to improve the race were ideas about who were carriers of poor genes and how they could be identified. Poor speech, a family history of questionable employment or poor mental health, sexually transmitted illnesses, and masturbation were just some of the identifiers that physicians noted in soldiers' files to gauge mental capability to ultimately determine when and how, or even if, they could be rehabilitated and sent back to the front. Pte Stecenko was considered by his physicians to be weak due to his family history, his inability to speak English, his history with the Russian Army, and his childlike actions and hallucinatory and paranoid symptoms. The underlying common symptom that connected all the melancholic patients in this study was that they were all also diagnosed insane, with varying underlying causes such as alcoholism, mental derangement, mental breakdown, dementia, and suicidal thoughts.

Humphries considered the evolution of neurology and neurological explanations for poor bouts of mental health as having emerged out of a desire or need to expand the two states of accepted mental condition from sane and insane to a spectrum. Many instances can be cited before the First World War where otherwise respected, upper-class, and fit men had inexplicable lapses in psychological fitness. Society could not continue to function by imprisoning people with mild, manageable, or modular mental illnesses any more than it could continue without a cure for insanity. Science had to explain not only

⁵⁷ Galton, Sir Francis. *Inquiries into Human Faculty and its Developments*. (Toronto, ON: JM Dent, 1908). 17.

why insanity was sometimes temporary, but also why people of various classes could contract the same illness of the mind. As the neurological field evolved, it came to be understood that some individuals were physically injured in such a way that could result in psychological symptoms. If they were mentally ill at the mercy of their own physiology, then their condition could be treated, and they had the possibility of being rehabilitated. Rehabilitating and returning to the front soldiers affected with mental health issues during the First World War became necessary very quickly. As a result, medicine rotated from discharging all soldiers who were shell shocked to using alternative diagnoses and creating more transitional hospitals that could provide triage care and prevent congestion in hospitals.

1.2 First World War Theories and Practices.

Prominent theories held by the medical and military communities about mental health leading up to the First World War affected how soldiers were treated during the war. One of the ways in which soldier health care was affected lay in the level of military involvement in the hospitals and the theoretical beliefs of the physicians operating in those hospitals. In his book *A Weary Road: Shell Shock in the Canadian Expeditionary Force, 1914-1919*, Dr. Mark Osborne Humphries makes clear that while civilian-run or temporary military hospitals with civilian-trained staff operated with more freedom, military hospitals operated under strict and standardized care: “While the process at Netley [Hospital] could be standardized because most of the staff were drawn from the ranks of the regular RAMC [or Royal Army Medical Corps], civilian ‘consulting’

neurologists and psychiatrists were used to a great deal more autonomy.”⁵⁸ Essentially, Netley Hospital had specific protocols in place that its physicians all followed when diagnosing and treating patients with specific psychological issues whereas civilian physician-run hospitals approached mental health care on a more individual basis. Outside of his implication that a military-run organization imbues standardization alongside a discussion of streamlining psychological terminology, Humphries does not expand upon this phenomenon. Standardization is classified as the development of an agreed-upon set of rules or guidelines that will direct work and ideally result in desirable outcomes.⁵⁹ The International Standardization Organization offers a broader definition: “Standardization is the activity of establishing, with regard to actual or potential problems, provisions for common and repeated use, aimed at the achievement of the optimum degree of order in a given context.”⁶⁰ In this context, the practice of creating forms, terminology, and sets of treatments for soldiers suffering from shell shock or other psycho-physiological ailments could mean a movement towards attempting to establish standardization, but it falls short of equating to standardized practice or care and is better described as generalization. “For the troubles displayed in the many disorders classed under the official title shell shock are extraordinarily numerous and different, and their removal necessitates a similarly varied repertoire of ‘opening moves’ on the part of the

⁵⁸ Humphries, Mark Osborne. *A Weary Road: Shell Shock in the Canadian Expeditionary Force, 1914-1918*. (Toronto, Buffalo, London: Toronto University Press, 2018). 143.

⁵⁹ "What Are Standards?" Standards Council of Canada. 2019.

⁶⁰ De Vries, Henk J, *Standardization: A Business Approach to the Role of National Standardization Organizations*. (Springer Science & Business Media, 2013). 13.

physician.”⁶¹ The process of simplification of terms to generally diagnose an illness according to the discretion of the physician does not equate to the creation of standardization. The capabilities of medical staff in the CAMC during the First World War was varied and their efficacy continuously impeded by numerous exterior factors. Ben Shephard’s *A War of Nerves: Soldier and Psychiatrists, 1914-1994* traces the evolution of our understanding of psychology in war over the course of the twentieth century. In this book, he discusses the British army’s “model of human psychology”: “Men were either sick, well, wounded or mad; anyone neither sick, wounded, nor mad but nonetheless unwilling to or incapable of fighting was necessarily a coward, to be shot if necessary.”⁶² The name of the game was war, and the strategy was to have better working pieces than the opponent; barring that, more pieces would have to do. This mentality served the army so long as it had cooperation from the medical community. The military could not permit its men to be sent back to England or Canada in sufficient number to deplete the forces at the front. After the offensive on the Somme (1916), so many men were sent back to England and Canada with shell shock and other similar diagnoses that the military placed restrictions on physicians covering what diagnoses they could pronounce. At first, shell shock was a relatively unknown illness and many men were sent back under its wide umbrella. After 1916, new regulations prohibited casualty stations, ambulances, and convalescent station medical personnel from diagnosing a

⁶¹ Smith, Grafton, *Shell Shock and Its Lessons*. (Manchester, Eng.: Manchester University Press & London, Eng and New York: Longmans, Green & Co., 1917). 1.

⁶² Shephard, Ben. *A War of Nerves*, 25.

soldier with shell shock but had to send him to a hospital where physicians would conduct an investigation to determine what exactly the man was sick with. His superiors had to confirm that he had been affected by the explosion of a shell, and only then could they diagnose him thus. This method of triage indicates a desire for efficiency. However, the eventual elimination of “shell shock” from medical parlance cannot be considered standardization but generalized and simplified medical care that served the military machine.

An important reason why diagnoses were subjective and changeable was that they were dependent upon the symptoms a soldier presented with and the physician he was presented to. Because symptoms are always the most apparent indication of a problem, and indeed might be potential problems themselves, they have traditionally been the target of medical care. What patients were complaining of and how they were acting – that was what was wrong, and what needed to be treated. As an example, the extent to which a soldier was shaking could mean the difference between a diagnosis of shell shock, hysteria, or epilepsy; tremors and nervousness were almost essential in the diagnosis of shell shock and neurasthenia, as they were nervous diseases and had to have a nervous connection. In the case of Lance-Corporal Harry James Salmond, his diagnosis shifted drastically over the course of his military career. Lance-Cpl Salmond was a 39-year-old fireman from Rangoon, British Burma, living in Toronto when he enlisted in the 4th Battalion. Over the course of his time overseas, Salmond found himself in and out of hospitals. First, he was shot in his right leg on 25 April 1915. A few months later he subsequently reported to No. 1 and No. 2 Canadian Field Ambulances for nervousness. This initial diagnosis was gradually expanded to “alcoholism, nervous exhaustion or

neurasthenia, and bullet wound to his thigh” at Moore Barracks.⁶³ Having gotten some rest, he was discharged. Almost six months later, on 5 April 1916, he was admitted straight to No. 20 General Hospital in Camiers for a self-inflicted severe wound to the throat. The physician noted that “He says that he felt despondent and wanted to finish himself.”⁶⁴ The circumstances surrounding the event were never made clear in his file. Lance-Corporal Salmond’s physical condition at the time of admission was “nervous and excitable.” Four days later at No. 26 General Hospital in Étaples, his physicians concluded that he had had a nervous breakdown that resulted in self-harm. After a month in Étaples, he was transferred to the Royal Victoria Hospital in Netley. A week later, the Royal Victoria sent him to Moore Barracks in Shorncliffe where he was diagnosed with melancholia. Lance-Corp Salmond had at this point reported to the Moore Barracks physicians that he was experiencing nervousness and a “dull feeling in the head”. Moore Barracks delved more deeply into his family history in an attempt to uncover any reason for his attempted suicide; was there hereditary evidence to support that this was not caused by war but simply aggravated by it? Salmond’s father had shot himself and the condition of his mother remained unknown.⁶⁵ His mental condition had hereditary links and therefore was presumed not to have been caused by the war. “Patient answers questions in an intelligent way but seems very depressed.”⁶⁶ A medical board in July

⁶³ Library and Archives Canada, Personnel Records of the First World War, RG 150 “Salmond, Henry, James.” RG 150, Accession 1992-93/166, Box 8618 - 2, Item Number 211800, Regimental Number 10691.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid.

1916 concluded: “1. That he is still insane. 2. That he was insane at the time of his attempt of suicide. 3. That he would not be fit for action service for a period of at least six months.”⁶⁷ After treatment in Canada, his diagnosis shifted, or rather was made clearer; physicians at the Stationary Hospital in Halifax considered his condition to be neurasthenia and mental deficiency. A significant contributor to this conclusion was that, alongside his previous history of self-harm, he was suspected as having injected something into his frontal sinus to alleviate pressure caused by congestion from a cold. The following medical notes indicate that he gradually felt that he no longer wanted to continue participating in studies and that wanted to be discharged so he could return to his job. On 20 April his physician noted that Salmond had been depressed for the past two days, although nothing was said about what sort of treatment he would or did receive and what that meant for his prognosis. On 9 May 1918, Salmond’s physician noted that he had been sleeping well, reported no headaches, and was generally feeling fine, and sent his case along for review for discharge to the medical board. Over the course of the war, Lance-Corp Salmond was diagnosed with eight different illnesses, each corresponding with different or altered symptoms; his condition evolved from simple debility with headaches on 1 July 1916 to neurasthenia and mental deficiency on 21 August 1918.⁶⁸ Initially physical symptoms, family history, character, and the circumstances under which he was injured all combined to inform the diagnosis.

⁶⁷ Ibid.

⁶⁸ Ibid.

Sociocultural restraints also contributed to the diagnostic process. The diagnosis a soldier received affected his reputation in the army and, by extension, the reputations of any medical officers or staff who were in charge of his wellbeing. If a soldier was indeed shell shocked, then he was privileged enough to be considered a casualty not of his own making, but of unforeseen events. If a soldier was considered a neurasthenic or melancholic, a weakness that was innate to his personality or genetics was at fault and he would be considered a coward or unfit. In his article “War’s Long Shadow: Masculinity, Medicine and the Gendered Politics of Trauma, 1914-1939” and his book *A Weary Road*, Mark Humphries explores the role of the physician in the perpetuation of masculine social constructs and constraints. The Victorian (1837-1901) and the Edwardian (1901-1910) eras’ constructs of and constraints on masculinity show men as stoic, non-emotional, and strong. Earlier in the nineteenth century, men spent more time in the home, but according to John Tosh there was a mass shift away from men in the home that he dubbed the “flight from domesticity.”⁶⁹ For these men of the late Victorian era, “domesticity no longer represented a fresh vision of comfort and reassurance, but a straightjacket.”⁷⁰ This shift away from domesticity was also tied to a reluctance to marry: “young men [were] giving up matrimony as if it were some silly old habit suited to their grandfathers and grandmothers.”⁷¹ A culture surrounding the independence of the

⁶⁹ Tosh, J., *A Man's Place: Masculinity and the Middle-Class Home in Victorian England* (New Haven, CT, Yale University Press, 1999). 172.

⁷⁰ Ibid.

⁷¹ Ibid.

younger man arose in which it was expected that men take their time to become men and establish themselves through their work outside of the home to best connect and support it in a globalizing economy and international community. Participating in the First World War was adhering to, historically, “the most masculine of activities.”⁷² However, with the First World War, the loss of masculinity could occur in numerous unpredictable ways. A loss of courage, an inability to control one’s emotions and break down, uncontrolled aggression, a weak will, and mental deficiency were only a few of the signs that men were having difficulty maintaining their masculinity while the war took its toll on them mentally and physically. Historian Fiona Reid discusses shell shock as a way to explore the Victorian culture of masculinity in crisis in the face of the war: “Medical and military responses to shell shock repeatedly stressed the importance of will power and of the man’s personal commitment to his own recovery.”⁷³ If a man was dedicated to recovery, he would recover. Discipline and self-control were touted as strong characteristics not seen in the “nervous, impulsive, erratic, and unstable” neurasthenic.⁷⁴ The onus was on the man to have the strength of character and will to keep his mental state in check and then, if that failed him, to have the will to recover. This understanding of men extended into the doctor-patient relationship in the RAMC and would, by extension, be experienced by CAMC officers and men being treated by them.

⁷² Reid, Fiona. *Broken Men: Shell Shock, Treatment and Recovery in Britain, 1914-1930* (London: Continuum, 2010). 3.

⁷³ *Ibid.*, 15.

⁷⁴ *Ibid.*

But different classes of men did not experience mental disorders in the same way, and multiple doctors are recorded as noting differences in medical experiences between men and officers. Sir Robert Armstrong Jones of the RAMC noted that officers were less likely to lose their voices in cases of shell shock because officers were more educated and intelligent, and therefore less susceptible to “emotional shock.”⁷⁵ Dr. Frederick Mott, a British physician, agreed with Armstrong that officers were more likely to experience cases of “pure shell shock” whereas men were hysterical paralytics and hysterical as opposed to shocked.⁷⁶ In 1919, Mott published his book *War Neuroses and Shell Shock* in which he postulated that “The majority of so-called ‘shell shock’ are truly ‘emotional shock’.”⁷⁷ Emotional shock was “dependent in a great measure upon the personality of the individual soldier, his mental attitude, and bodily condition at the time of the shock (whether of emotional or commotional origin) which led to his collapse.”⁷⁸ Traumatic shock resulted when a soldier was involved in a physical event that involved the compression of the air (such as in the explosion of a shell). This compression of air was deemed to have a physical effect on the internal chemistry of the soldier, whether that be from jostling or a lack of oxygen after being buried by debris.⁷⁹ In 1917, Dr. Grafton Smith wrote *Shell Shock and its Lessons* in which he discussed psychological analysis

⁷⁵ Ibid, 18.

⁷⁶ Ibid.

⁷⁷ Mott, Frederick Walker. *War Neuroses and Shell Shock*. (London, Eng.: H. Frowde, Hodder & Stoughton, 1919). VIII.

⁷⁸ Ibid, 2.

⁷⁹ Ibid.

and determined (like Mott) that the trouble with mental illness or shell shock was predominantly emotional

Many cases of ‘functional nervous disorder’ or ‘neurosis’ exhibit as their most important characteristics symptoms, the underlying factors of which are demonstrably *mental*. A neurosis may be regarded as the failure of an act of adaptation. The resultant mental disturbances do not seriously affect the ‘reason’ or the ‘intellect’ as was formerly supposed, but are in character predominantly instinctive and emotional.⁸⁰

Mental illness was therefore not responsible for the intellectual state of the individual; an emotional person was predisposed and more likely to be mentally afflicted because of their lack of reasoning and intellectual abilities. A “failure of an act of adaptation” is the concept that an individual is not necessarily as advanced or evolved as others and that might come in multiple forms, not necessarily linked to intelligence, but indicative of a more emotional individual.

Class and masculinity played direct roles in the construction of diseases. Higher ranks were associated with specific types of mental illness that touted the superiority of their higher education and breeding. Lower ranks were diagnosed with hysteria and treated accordingly, both in the hospital and in the military. Given this way of thinking, it is evident that any standardization of care could only be within groups in the class or rank hierarchy. It might have been possible to standardize diagnoses and care for officers, but social and cultural assumptions made it impossible to arrive at standards that took in both officers and other ranks.

⁸⁰ Smith, *Shell Shock and Its Lessons*, 71.

Homosexuality was also a challenge to the masculine ideal that was tackled in this exploration of weakness in shell shock. In L. Lattes' article titled "Homosexuals in the Army," he explores the concept of homosexuality and the front. Specifically, on the matter of morale, he considers it to be a straightforward argument for exclusion:

A soldier's sexuality must not in any way interfere with his military activities nor bring about any scandal to injure the morale of the troops. In as far as a homosexual is markedly effeminate, he is out of place in the army, for he is unfitted for the efforts and privations of war.⁸¹

The author equates homosexuality to femininity and therefore relates it to any discussion or display of weakness. Shell shock was one such display that might mean a soldier was judged as either cowardly or honourable. The main factors that distinguished one from the other were time in service or wounds sustained. If a man had, in the opinions of his fellow soldiers, served his time on the front and knowingly put himself in harm's way, coming down with shell shock or neurasthenia was simply a matter of time and he deserved to get off the front. If, however, a soldier had been recently placed on the front before succumbing to a mental affliction, he was considered weak and cowardly. The opinions of the men affected their medical officers' opinions; cases arose where superior officers wrote to clarify the behaviour of a soldier and betrayed this opinion that fresh men were not fit or that they were not even involved in a shell explosion and therefore had no reason to be presenting with these symptoms.

⁸¹ Brown, Mabel Webster and Williams, Frankwood Earl. *Neuropsychiatry and the War: A Bibliography with Abstracts*. (New York: War Work Committee, The National Committee for Mental Hygiene, 1918). 177.

In this case study, there were no overt statements or concerns about the behaviour of the soldiers with regards specifically to homosexuality. There were two cases in which officers were permitted to resign as they had lost faith in their ability to perform their duties after incidents with shell explosions. Lieutenant Frederick Gates and Lieutenant Raymond Massey were both permitted to resign after they lost confidence in their ability to perform their duties. Lieut Gates served in the CEF from 23 September 1914 to the 9 November 1916 when he was struck off strength and then permitted to resign.⁸² Lieutenant Massey was close to a shell explosion on 12 June 1916 and then admitted to hospital. He lost all confidence in his ability to perform his duties and was sent back to Canada. He would return to the war in Siberia for a short time later.⁸³ Both of these men were in positions of power and their inability to perform their duties challenged the strong masculine ideal and strength of the upper ranks. As such, they were both ushered off the front and given time to recuperate.

Another factor that contributed to the physician's understanding of their patients' mentality as being frail or strong was that "as members of a professional army, doctors readily identified with its shared culture and masculine ideals."⁸⁴ Male doctors were subject to the same social laws that defined masculinity for their patients, and in

⁸² Library and Archives Canada, Personnel Records of the First World War, "Gates, Frederick A." RG 150, Accession 1992-93/166, Box 6020 - 11, Item Number 137271.

⁸³ Library and Archives Canada, Personnel Records of the First World War, "Massey, Raymond Hart." RG 150, Accession 1992-93/166, Box 6020 - 11, Item Number 137271.

⁸⁴ Humphries, *A Weary Road*, 24.

accepting weakness in their patients they were implying that either weakness or femininity were inherent to masculinity. Holding their patients to social standards of masculine ideals protected their identities as much as it defined their patients'. If their patients were feminine and able to suffer from feminine illnesses like hysteria, so too could they; so too were they feminine.⁸⁵ But, like with insanity, the understanding of masculinity had to expand to allow for lapses in otherwise respectable individuals. Dr. Fiona Reid in her book *Broken Men: Shell Shock, Treatment, and Recovery in Britain, 1914-1930* discusses the concept of the hysterical man and how some physicians attempted to expand the construct of masculinity by "acknowledging the exceptional conditions of the war."⁸⁶ M.A. psychology fellow F.C. Bartlett at Cambridge University in his book *Psychology and the Soldier* wrote that "In some cases it can be predicted with practical certainty that a man will suffer mental collapse or disorder if he is subjected to the strain of trench-warfare under normal conditions."⁸⁷ These theories about man were more progressive in that they challenged understood social constructs of what it meant to be a Victorian or Edwardian man.

All of these presumptions about masculinity might have been at work not only in the original diagnoses but in revised diagnoses. Diagnoses could stay the same or change between stations and hospitals as soldiers were moved from field hospitals and ambulances to general or stationary hospitals farther back from the front. Diagnoses

⁸⁵ Micale, Mark S. *Hysterical Men: The Hidden History of Male Nervous Illness*. (Cambridge, MA: Harvard University Press, 2008.) 194.

⁸⁶ Reid, *Broken Men*, 13.

⁸⁷ Bartlett, F.C. *Psychology and the Soldier*. (London: Cambridge University Press, 1927). 11.

changed then as diagnoses change now; physicians do not always agree on the prognosis of a patient and when mental illness or affectation comes into play there is more room for opinion. A common factor that contributed to the changes of diagnoses was that as men were taken off the front, other symptoms worsened or dissipated. Lieutenant Gerald O'Grady was initially diagnosed with shell shock on 4 June 1916 at No. 14 General Hospital in Boulogne, but as he was moved to No. 7 Stationary Hospital in Boulogne, his physicians reclassified his shell shock status to a shell bruise of the spine on 13 July 1916. As his more typical shell shock symptoms dissipated and physical symptoms associated with his spine arose, doctors felt that classifying him as mentally unfit would not be accurate.⁸⁸

There are also instances of physicians continuing to agree with previous accounts. In the case of Private Brooke, his insanity diagnosis was carried through from one station to another to his discharge. His symptoms stayed constant and, combined with his family history and a lack of physical symptoms to draw focus, they could not be ignored. Severity of symptom would seem to play a large role in how the men in this case study were diagnosed and eventually treated for their illnesses.

⁸⁸ Library and Archives Canada, Personnel Records of the First World War, "O'Grady, Gerald Decourcy." RG 150, Accession 1992-93/166, Box 7432 – 30. Item Number 546497. <http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B7432-S030>

1.3 Post-First World War Observations About Mental Health

Immediately following the war, physicians who had been busy at the front or in military and civilian hospitals caring for the ill and infirm released medical studies on their experiences and understandings of psychological illnesses gained during the war. Multiple medical texts emerged in the first few years after the war as physicians amalgamated and published their research on psychologically affected soldiers. Dr. Ernest Southard was one such author. An American neuropsychiatrist and neuropathologist, Dr. Southard was involved in early studies of shell shock during the First World War. In 1919, he released his book *Shell-Shock and Other Neuropsychiatric Problems Presented in Five Hundred and Eighty-Nine Case Histories From the War Literature, 1914-1918*. Over the course of his time overseas, he collated 589 cases in which soldiers were to some degree or another experiencing shock or shell shock.⁸⁹ Sir Frederick Mott was another physician who was able to publish his experiences with shell shock during the First World. Dr. Mott was a neuropathologist, and was therefore in sympathy with physical as opposed to psychological treatments.⁹⁰ Initially, he ascribed to the neurology way of thinking that considered all nervous ailments connected to some form of physical abnormality; whether the abnormality be in the body or the brain, it was physical alterations to the normal human anatomy that caused changes in mentality. By

⁸⁹ Southard, Elmer Ernest, *Shell-Shock and Other Neuropsychiatric Problems Presented in Five Hundred and Eighty-Nine Case Stories from the War Literature, 1914-1918*. (Boston: W.M. Leonard, 1919). v.

⁹⁰ Humphries, *A Weary Road*, 143.

the end of the war, Mott had expanded his definition of trauma to have either a physical cause or a psychological one. Physically caused trauma was considered:

a concussion or “commotio cerebri” by direct aerial compression followed by decompression or by the force of the aerial compression blowing the person into the air or against the side of the trench or dug-out; or by blowing down the parapet or roof on to him, causing concussion; or a sandbag hitting him on the head or spine might easily cause concussion without producing any visible injury.⁹¹

Whereas psychological trauma was classified as:

The psychogenic factor is by far the most frequent and important cause of shock followed by a psychoneurosis, particularly hysteria. This factor is complex in its origin, being dependent in a great measure upon the personality of the individual soldier, his mental attitude, and bodily condition at the time of the shock (whether of emotional or commotional origin) which led to his collapse.⁹²

Shell shock or the psychoneurotic affliction that a soldier experienced during the war, Mott determined, was due to some combination of physical and psychological traumatic injury. Some were completely physical and some completely psychological, but most were some combination thereof. A by-product of this separation of terminology was to separate shell shock from other mental afflictions: “‘Shell shock’ is a useful term if it is limited to cases where there is definite evidence of a shell or bomb bursting near enough to knock the man down, or blow him up into the air and cause a temporary loss of consciousness.”⁹³ After 1916 and the great unexpected loss of men to mental illness generally, and shell shock specifically, this desire to define shell shock emerged as a way to improve clinical practice but also as a way to distinguish real from false sufferers.

⁹¹ Mott, *War Neuroses and Shell Shock*, 2.

⁹² *Ibid.*

⁹³ *Ibid.*, 2-3.

There was a condition separate from other mental conditions that Mott considered to be true shell shock, and if those individuals could be identified they were to have no less than six months' leave from general service, if they were to return at all. Humphries explores the attempt of the RAMC and CAMC to limit the use of the term "shell shock" to only the individuals Mott describes as being worthy.⁹⁴ "Army Form W. 3436 now accompanies the man with a description of the occurrence."⁹⁵ This form was to be completed by the physician or the soldier's CO and signed to approve of the term "shell shock" being used. The precipitating incident had to be documented and sworn to. After the war, this understanding of shell shock persisted, but postwar studies demonstrated that the distinction could not be as cut and dried as military officials insisted it be.

The diagnostic process was also influenced heavily by both neurological and psychological concepts of inheritance, intelligence, and eugenics. The study of neurology expanded rapidly over the course of the nineteenth century to discover the nerve and the neuron, and to postulate how exactly the brain works. The 1911 edition of the *Canadian Medical Journal* described the advances of scientists in the previous century as "increasing the knowledge of physiology, dealing with the functions rather than the structure of the organs in health, was naturally followed by the study of derangements of function encountered in disease – pathological physiology, or general pathology - and an

⁹⁴ Humphries, *A Weary Road*, 143.

⁹⁵ Mott, *War Neuroses and Shell Shock*, 3.

explanation of symptoms was sought for on this basis.”⁹⁶ The author goes on to stress the importance of this stage in any inquiry; science, or at least medicine, had returned to studying the atypical anatomy to discover physiological causes as opposed to working from “a fixed anatomical position.”⁹⁷ Environment and regulative mechanisms, such as hormones or defensive mechanisms through which the body interacts with its environment, became the focus of pathophysiology.⁹⁸

In the case of Lieutenant Vincent Maxted, the effect of this expanded understanding of neurology can be seen in his service file. However, it is also evident that the connection of the physical to the mental was unclear to physicians. On 16 June 1916, Lieut Maxted was shot in the left shoulder and sent to No. 14 General Hospital in Wimereux for treatment. After two weeks, he was transferred to No. 2 General Hospital to continue his treatment. However, while there he was also diagnosed with neurasthenia. In September, “he reported ill at Shorncliffe ... with extreme pain in small of back, so that he was unable to stand for more than a few minutes and movement caused pain.”⁹⁹ In March 1917, he was sent as Adjutant to the General Reinforcement Depot at Shorncliffe and carried on until 22 September, when he had a return of the condition, now with weakness of the legs. Upon examination for this final myalgia lumbago diagnosis, the

⁹⁶ Anderson, H. B. "The Genesis, Classification, Interrelationships and Clinical Diagnosis of Disease." Internet Archive. January 01, 1970.

[https://archive.org/details/journalcanadianm10cana/page/318/mode/2up?q=shell shock](https://archive.org/details/journalcanadianm10cana/page/318/mode/2up?q=shell%20shock). 319.

⁹⁷ Ibid.

⁹⁸ Ibid.

⁹⁹ Library and Archives Canada, Personnel Records of the First World War, “Maxted, Vincent.” RG 150, Accession 1992-93/166, Box 6061 - 6, Item Number 199800, Regimental Number 71978.

medical board determined that his injuries had been caused by service conditions, but also that Lieut Maxted had a family predisposition. On 7 July 1916 Lieut Maxted's medical status was noted by a medical board: "this officer suffers from disability noted above GSW left shoulder and neurasthenia and described in Army Form A. 45 a. Wound superficial, now healed. Has headaches, is restless, and sleeps badly. He has improved by will need some rest." A month before doctors added a diagnosis of neurasthenia, Maxted was simply diagnosed with lumbar myalgia or lower back weakness and/or pain. The physicians took no note of his mental health, stating simply that "He says he cannot walk more than a few miles without back paining him,"¹⁰⁰ implying that it was no longer a symptom that factored into his diagnosis or treatment. The military acknowledged that service had caused his injury, specifying "exposure and infection" as the culprits.¹⁰¹ When it came time to review his condition, doctors disagreed and did not actually conclude that he was suffering from myalgia. Lieut Maxted's file does not explore his diagnosis of neurasthenia beyond that one instance where his pain began to affect his demeanor, and one facility was at least suspect of that transition in health. He got some rest, as prescribed, and presented only with physical symptoms in his following medical case files.¹⁰²

Lieut Maxted demonstrates how difficult it was to walk the line between physical and psychological symptoms. At what point did one's prognosis allow for its own mental

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

¹⁰² Ibid.

diagnosis? In this case and at these hospitals, it was when a man typically and simply suffering from lower back pain began exhibiting headaches, restlessness, and poor sleeping habits. Why those were not indicative of his pain affecting his sleep and morale was not explained. One can presume that a departure from his usual personality was enough for his physician to consider him mentally affected.

Conclusion:

The diagnostic process was generalized and designed to function on a small scale, on a case-by-case basis. It was a generally inefficient process that was influenced by multiple external factors that did not support equalized treatment for all Canadian soldiers in the First World War.

Medical theories surrounding mental health care before and during the war segregated patients into the intelligent and the weak. Galton's eugenic theories that classified people into hierarchical races all capable of different things permeated how physicians thought about the insane. The theory that some people were genetically predisposed to mental illnesses like shell shock was factored into their diagnoses and can be seen in investigations into family history that list family members in asylums or as invalids with no explanation of how that relates to the patient. The implication is that patients with family who have mental illnesses were predisposed to getting shell shock. Ideas about inherent inferiority of races was another factor that played into perceptions of insanity, hysteria, and poor mental health. Dr. Tuke noted that immigrants had a higher incidence of insanity and poor mental health and lamented the extra strain it put on North

American asylums. He even went so far as to blame them for preventing North American asylum physicians from finding a cure for insanity. How physicians conceptualized mental health informed their decisions on how to classify and treat it, which contributed to a non-standardized health care environment.

In its prioritization of military efficiency, the Canadian Army Medical Corps attempted to decrease the number of men sent off the front by restricting the diagnosis of shell shock. The initial practice of diagnosing all soldiers mentally affected by the war with shell shock was quickly revised as too many men were sent off the front for that reason. Patients then had to qualify for the diagnosis of shell shock and, even then, were not guaranteed to be sent off the front. The initial breadth of the term shell shock to encompass all mental afflictions associated with the front and then the subsequent restricted use of said term marked periods of highly controlled medical censorship, not standardization, that served to help the military diagnose fewer cases of shell shock while encouraging physicians to use more established terms.

Chapter 2

2 Treatment.

“Provisions had to be made for medical service alone to a force with a total strength of 3,500,000 men operating in every variety of country and climate.”¹⁰³ The medical services available for the Canadian army in the First World War had to be extensive, prepared, and equipped to deal with any conceivable situation that would result in any known medical injury, and then be prepared and equipped to deal with the most likely. In examining fifty soldiers discharged for being mentally unfit and the treatment they received after their diagnoses, it is evident that there were multiple factors beyond the individual patient’s health that affected the treatment he received. First, all medical discussions took place under the umbrella of military efficiency. While treatment suffered from generalization or broad non-specific approaches as in the diagnostic process, what affected treatment more was an ever-present need to achieve peak military efficiency. The individual and his personal health was not the focus of the Canadian army; the army’s focus was its own fitness. Maintaining that was a priority that in turn affected the medical care that soldiers received during the First World War. Soldiers’ treatment was about restoring their strength and making them more resilient; it was focused on maintaining them as a military resource. Second, treatment was also dependent on the theoretical and ideological beliefs of the physician (psychology vs. neurology) - and

¹⁰³ Macphail, Andrew. *Official History of the Canadian Forces in the Great War 1914-19. The Medical Services*. (Published by Authority of the Minister of National Defence, Under Direction of the General Staff. Ottawa: F.A. Acland, n.d. 1925). 44. Because only 424,000 CEF soldiers went to service overseas, Macphail was likely implying that Canadian Medical Services was expected to serve any wounded of the British Expeditionary Force as a whole, which numbered over 3,5 million all ranks on the Western Front.

therefore the equipment they requested be in their hospitals. Physicians had different conceptions of mental illnesses and how they should be treated; this resulted in different types of care for patients from hospital to hospital. Third, rank affected what was available for soldiers requiring treatment for mental health afflictions. While the Canadian army was not organized by class, it was still a rank-based system in which higher ranking personnel were separated from the more numerous non-commissioned officers and men. Officers' rank and smaller numbers guaranteed them more specialized treatments than their lower ranking counterparts. In addition to rank affecting care, the simple fact that the Canadian army worked as part of the British army for the majority of the war meant that classism affected Canadian soldiers in a multitude of ways. All of these factors combine to create a military-centred system of treatment that was focused on maintaining military strength rather than an individual's overall health and wellness, a doctrine that led to multiple clashes between the military and medical communities throughout the war.

In the service files I have collected for this case study, treatments prescribed to the soldiers went largely undocumented. In their medical case sheets, physicians would typically record what disease a patient was admitted for, when, why, and how their condition was progressing. The focus was always on the status of the patient's condition, the symptoms they were exhibiting, and their prognosis. Were they going to be staying longer, transferred to another hospital or depot, or discharged home? However, in almost every case file in this study, rarely would medical officers note what kinds of treatment the soldiers were receiving. For example, Private Charles Fallaize was admitted to multiple hospitals over the course of the war for shell shock, epilepsy, and hysteria

because of a head injury he received in the trenches in March at Ypres. On 12 June 1916, he was admitted to Bromley to be assessed for epilepsy, a diagnosis that would later change to hysteria as he had no history of it before the war and no family history of epilepsy. The physician described the accident in which a sandbag came loose during an assault on Canadian trenches and Fallaize was buried for an hour; five hours later, he had to march twelve miles, during which he collapsed, feeling sick. He spent several hours unconscious and was sent to multiple hospitals where he had as many as seven seizures.¹⁰⁴ The focus of his assessments was his tendency to lose consciousness, his weakness, headaches, and his poor sleep habits; the documents did not detail any course of action the hospital was taking for his illness or treatments offered to him. The only mention of treatment outside of comments on sleep, food, and fitness, was that on 12 June 1916 he was sent “to Ramsgate for treatment. Shell shock.”¹⁰⁵ The main facility in Ramsgate was Granville Canadian Special Hospital which offered electro-therapeutic devices, radiant heat aparati, eau courante or running water baths, massage, gymnastics, dentistry, and x-rays to their patients.¹⁰⁶

To cite another case, Private Fred G. Bailey, while in the reserve trenches at the Yser Canal, was blown into the canal by an explosion and was hit with shrapnel in his left

¹⁰⁴ Library and Archives Canada, Personnel Records of the First World War, RG 150 “Fallaize, Charles, Allen.” RG 150, Accession 1992-93/166, Box 2986 - 5. Item Number 384441. Regimental Number 192492.

¹⁰⁵ Ibid.

¹⁰⁶ Library and Archives Canada, War Diaries Collections, “Granville Canadian Special Hospital,” RG9-III-D-3. Volume/box number: 5040. File number: 878, Item Number 2006032.

arm. Three weeks later, he was sent to hospital as his left arm, back, and left knee had become extremely painful. At the Canadian Convalescent Hospital in Bromley, physicians took note of the history of his injury, the length of time he had been injured, and in which hospitals he had been treated before arriving there. They also took note of his eating, sleeping, and fitness levels. As for courses of treatments, they only specified that he had spent three weeks at the first hospital and two weeks at a second. What courses of treatment he received there were not noted in his file.¹⁰⁷ These situations were, unfortunately, common in these case files; only rarely were there any mentions of treatments. This necessitated an investigation into the hospitals these men visited and what kinds of treatment were offered there for mental illnesses. In this chapter, case files will be referenced when they can provide insight into treatments men were given. They will be supplemented by hospital war diaries (primarily Bearwood Canadian Convalescent Hospital, No 7 Queen's Canadian General Hospital, Granville Canadian Special Hospital, Moore Barracks Hospital, Bromley, and Craiglockhart) and first-hand accounts of physicians to give an overview of treatment for mental health afflictions, how the military and medicine debate played out on the ground, and the varied treatments Canadian soldiers received during the First World War.

2.1 The Military and the Medicine.

In this first section analyzing the treatment of First World War Canadian soldiers, the relationship between the military and the medical community will be explored to

¹⁰⁷ Library and Archives Canada, "Fallaise, Charles."

reveal that military efficiency was the priority in treating patients. Treating psychologically affected soldiers was a combined military and medical effort. Because both institutions were authorities over the human lives in their care, what resulted was a tense relationship as medical care frequently came out subservient to the war effort. The necessity to maintain a strong and efficient military force often superseded the treatment of individual soldiers, a reality that can be seen in an examination of specific aspects of case files, as well as through an analysis of Canadian hospital records from the First World War.

During the First World War, soldier fitness was a priority of all armies. Having a fit, reliable, and consistent fighting force was essential for victory as the war was proving to be more and more deadly and would obviously be much longer than originally assumed. As the war progressed, maintaining morale and overall fitness became administratively difficult due to an increasing number of psychological cases being taken off the front. Organizing transport and ensuring that space, staff, and equipment were available for all casualties was overwhelming. While these casualties were expected, the construction and staffing of convalescent camps or command depots to care for them outside of hospitals and facilitate their return to reserve corps was delayed.¹⁰⁸ As a greater number of soldiers than expected were hospitalized in the first year of the war, their return to the front became a priority. Only when large numbers of injured soldiers congested hospitals and field ambulances did command depots emerge. Command depots

¹⁰⁸ Macphail, Andrew. *Official History of the Canadian Forces in the Great War 1914-19. The Medical Services*. (Published by Authority of the Minister of National Defence, Under Direction of the General Staff. Ottawa: F.A. Acland, n.d. 1925). 204-205.

were created for two primary reasons: first, to reduce the likelihood that soldiers would reinjure and have to be hospitalized again; and second, to ensure that after their extended stay in hospital, these men were fit enough to return to duty and perform their jobs adequately. Expecting still-recovering men to move from a hospital bed to the front line was impractical. Before the creation of convalescent facilities, hospitals would be crowded with men too sick for the front but not sick enough to require hospital care, and reserve units became “burdened with men for whose care they were not designed.”¹⁰⁹ The solution to this came in the form of command depots and specialized hospitals, both of which served to avoid soldiers having to be sent back to general hospitals and to help facilitate their return to the front. Macphail notes that these command depots were officially referred to as convalescent camps

They were equipped with facilities for electrical and massage treatment under medical direction, but mainly organized and controlled by military officers, with the object of hardening men by suitable exercises and graduated drill for return to active service at the front in a period of about six months.¹¹⁰

Canadian command depots emerged in February 1917 after a campaign in Ottawa to have Canadian facilities available for treating Canadians was successful. Prior to this, Britain operated thirteen command depots that had space allotted for 45,477 men.¹¹¹ At these command depots, men would receive training to harden them back up to face the front. They were taught “physical training, instruction in musketry, bombing, and bayonet

¹⁰⁹ Ibid, 207.

¹¹⁰ Ibid.

¹¹¹ Holt, Richard. *Filling the Ranks: Manpower in the Canadian Expeditionary Force, 1914-1918*. (McGill-Queen’s University Press, 2017). 206.

fighting. From these depots, men would be sent on “to reserve units of their various regiments and corps,” and ultimately to rejoin their lines.¹¹² Command depots also served to alleviate pressure on the hospitals and take on the long-term convalescing patients in times of stress so that hospitals could open up more space for wounded men more recently off the front. Command depots were created out of necessity to better return men to the front and to permit hospitals to treat men coming from the front that much more quickly.

Analyzing the macrocosm of the First World War, such as the construction and purpose of command depots and understanding the overarching necessities that drove the war effort, helps to illustrate how and why military efficiency took precedence over medical care. Historian Richard Holt approaches his analysis of the efficiency of the Canadian Expeditionary Force through a statistical lens that sheds light on the administrative aspects of waging a war. Pulling back from the day-to-day, individual case files, and hospital war diaries and supplementing that information with the realities brought forward by Holt is enlightening. Hundreds of thousands of soldiers were passing through the hospital system, in one way or another, and those interactions, transportations, and treatments had to be facilitated.¹¹³ Men had to be closely monitored to keep track of them as well as to prevent overflow and ensure availability in hospitals, reserve units, and command depots. To maintain a successful system in which soldiers could seek medical help and then return safely to the front required a strict, complex

¹¹² Ibid.

¹¹³ Ibid.

system of procedures whose redundancies and frequent checkpoints regularly caused delays that prevented reinforcements from reaching the front in a timely manner, and also prevented soldiers from being transferred to and between hospitals. The cost of administrative delay was significant because such delays hampered the organization of entire armies. Not only did soldiers need to have the facilities and staff to diagnose, treat, and replace them but the paperwork had to be with them at each stop to permit or redirect soldiers accordingly.¹¹⁴ Holt masterfully demonstrates the truly massive efforts of the administration that existed behind the soldiers of the First World War to express how truly complex the system was. Wastage rates were a severe problem for Borden's war administration; he had specific numerical goals he wanted maintained at the front. However, "with only 191,654 officers and men with the CEF at the end of December 1915" combined with an "average monthly wastage rate for 1915 of 1918 men, the CEF would have to enlist 26 613 recruits every month to reach Borden's [goals] by the end of 1916."¹¹⁵ The mechanics of trying to achieve this one goal can be seen downstream in how soldiers were treated overseas; for each soldier who could be salvaged, rehabilitated, retrained, and returned to the front, one less person had to be recruited, trained, and transported to the war front. Reducing work to save time, money, material, and men saved so much more to the military than just a single individual. Holt demonstrates how the military system was designed to uphold countries and function solely to permit them to continue fighting a war; the importance of the individual was negligible.

¹¹⁴ Ibid.

¹¹⁵ Ibid, 171-172.

Where a patient was sent reveals a military system that was focused on keeping as many fighting men close to the front as possible. Convalescent camps were designed to ensure that men were well enough to be sent back to duty, which indicates that the Canadian military's system of health was designed around perpetuating the war effort. Men were not sent back to Canada to get better; as long as they could potentially be returned to duty, light duty, or in some way support the war effort, they were kept in Europe. Most of the cases in this study align with the narrative that military goals took precedence over individual health. Their hospital records indicate frequent instances of being struck-off-strength and sent to one facility or another before being discharged back to duty, or to light duties as support, before reinjuring or aggravating a pre-existing injury, which might require them to be considered mentally unfit by a medical board. Some of these soldiers suffered from illnesses that were cured, such as venereal diseases, influenza, and bullet wounds. However, many of the soldiers in this case study who exhibited one form of mental illness at one point in the war would remain in Europe to be admitted to hospital or camp for the same or a similar mental health issue. This can be assumed as physicians at later hospitals would reference old wounds from which the soldier could have acquired these mental health issues. Historian Sir Andrew Macphail sums up the realities facing the administration of a medical system designed to serve millions of allied soldiers. In his 1925 book *History of the Canadian Forces, 1914-1915: Medical Services* he notes that by the end of the war, the medical services (British and Canadian) comprised "144, 514, officers and other ranks."¹¹⁶ Those 150,000 men and

¹¹⁶ MacPhail, *History of the Canadian Forces*, 44.

women had to be “trained, equipped, and administered” effectively so that those soldiers could be treated.¹¹⁷ The motivations of the individual physician, soldier, and person were superseded by a need to maintain a functioning military community that permitted Allied forces to wage war.

As the war was progressing, rumours started to spread about the ineffectual Canadian Army Medical Corps. It was being suggested that the CAMC was being mismanaged to the detriment of the health of Canadian soldiers, and that did not sit well with the Canadian public. In response, Prime Minister Robert Borden sent an investigative team headed by Colonel Herbert Bruce to France. Although multiple points in the Bruce’s report speak to the lack of standardized care in the Canadian army and therefore in the CAMC, three sections can be highlighted to demonstrate how treatment was focused on military efficiency over individual health. First, the decision to operate on soldiers was not first and foremost a medical consideration. In his 1919 report *Politics and the CAMC*, Bruce mentioned that one of the issues preventing the Canadian Army Medical Corps from performing more than adequately was that “no attempt had been made to restrict the large number of [surgical] operations producing no increased military efficiency.”¹¹⁸ He further specifies that “the only military justification for operations for minor disabilities is the resulting improvement in the efficiency of the soldier, and after two years of war, definite conclusions ought to have been reached in regard to the

¹¹⁷ Ibid.

¹¹⁸ Bruce, Colonel Herbert A.; Charlesworth, Hector (intro.), *Politics and the C.A.M.C.* (William Briggs: Toronto, 1919). 60.

desirability of many operations which were still frequently performed.”¹¹⁹ These operations were also only supposed to be performed by medical officers with sufficient experience. Bruce’s goal in this section was to identify soldiers whose performance could be improved through minor operations, separate them, and operate on them to return them to duty. If, however, a soldier required a relatively minor operation, but his post-operative prognosis suggested no improvement in his ability to perform his military duties, then it should not be performed. These soldiers would either be considered for discharge to light duties or discharge to Canada as a means of reducing the number of surgeries performed and reallocating the hospital services to other soldiers who could benefit from surgery, in the sense that after recovery they would be able to return to full duty. The application of these policies meant that minor disabilities affecting soldiers but not directly their ability to perform meant that their overall health was not the priority but maintaining the strength of the army was.

Second, “the installation of an expensive plant at Ramsgate was inadvisable, as a large number of the cases treated there should have been sent to Canada for treatment.”¹²⁰ Home to multiple hospitals during the war, Ramsgate was the previous location of Granville Canadian Special Hospital before it was moved to Buxton, and was also the home of the Princess Patricia’s Red Cross Hospital. Bruce outlines his dismay with military procedures that involved sending a soldier back from the front to various treatment facilities and the creation of stationary hospitals designed to deal with severe

¹¹⁹ Ibid, 60-61.

¹²⁰ Ibid, 61.

cases that could no longer be returned to the front; he considered all of this to be a waste of space, time, money, and personnel. While the creation of specialized hospitals worked to the advantage of patients with more complicated prognoses like shell shock, keeping the men overseas was still catering to the needs of the military as opposed to making the health of these men the priority. Keeping them in England was keeping them close to the war, treating them while at the same time maintaining the possibility of one day returning them to the front. Patients were sent to Granville for “joint injuries, nerve lesions and contractures, shell-shock, neurasthenia, and amputations cases,” and Bruce asks why those afflicted with serious cases of these ailments be kept in Britain when better long-term care could be given back in Canada.¹²¹ With cases of nerve and joint injury specifically, operations that required orthopaedic intervention were best done in Canada where “after-treatment and re-education measures” could be properly undertaken.¹²² The other issue with housing shell-shock and neurasthenic patients at Granville in Ramsgate was that the town was the frequent site of Zeppelin visits and bombings.¹²³ Had quality of patient care been the priority for the military, a specialized hospital to treat shell shocked, neurasthenic, and other nervous war-affected patients would not have been established in a city that was frequently bombed. Space, staff, and equipment were available there and that was relevant.

¹²¹ Ibid.

¹²² Ibid, 64.

¹²³ Ibid.

A final significant conclusion in the Bruce Report was a “lack of co-ordination in the Canadian Medical Services between Canada, England, and the front.”¹²⁴ Specifically, Bruce’s issue was that neither the examination of patients nor the administration of Canadian hospitals overseas had enough coordination to function under the same principles of medicine: “As regards to the examination of the men, there was no common standard.”¹²⁵ It was being noticed that soldiers declared capable enough to be discharged to Canadian command depots or the front by one hospital or medical board were being retained at Canadian bases elsewhere as other physicians considered these soldiers unfit for service at the front. This occurred frequently between Canadian medical boards in Canada, England, and France¹²⁶. With different stations defining fitness and wellness differently and their medical boards operating according to these definitions, it did not just matter what you were diagnosed with, what symptoms you were presenting with, and what courses of treatment you were offered. It also mattered where you were released to and what those medical officers believed about your condition. These differences created problems with respect to care as well and military efficiency. A soldier’s condition would be treated, or not treated, depending on where he was sent, so soldiers received different levels of treatment for the same illnesses. If a soldier was considered fit for service by a Canadian hospital in England, but not by a Canadian hospital France, then his ability to return to duty was compromised and he had to be replaced by another body. The Bruce

¹²⁴ Ibid, 77.

¹²⁵ Ibid.

¹²⁶ Ibid.

Report's identification of a lack of standardization in Canadian military medical care and call for that to be corrected is strong evidence that while the military may have been moving towards generalized care, it was prioritizing military goals over the health of Canadian soldiers.

In addition to the military prioritizing efficiency and maintaining unit strength over individual health and wellness, the impact of the military on health care can be seen in preparation for major military offensives. In the hospital records for No.7 Queen's Canadian General Hospital, the author notes that hospitals would prepare for large numbers of casualties on the eve of planned assaults.¹²⁷ This meant that space, staff, and equipment had to be freed up and made available for incoming wounded. For standard admission in times of relative calm during the war, patients coming to Queen's would be identified by their wound type - chest, knee, head, infectious etc. - and then sent to those wards. Mild cases would be given a shower-bath, food, and a change of clothes before being sent up to their ward whereas urgent cases would be assessed by medical officers upon arrival and treated accordingly. The reasoning behind this, the author explained, was "it having been proved that sleep, stimulated by warm soup or cocoa, is the best preliminary to subsequent care."¹²⁸ The author further states that many men who were shaken or considered shell shocked upon arrival would, after an evening of rest, food, and calm, be much improved the next day and even qualify for quicker transfer back to a

¹²⁷ Canada Army No. 7 Canadian General Hospital, A History of No. 7 (Queen's) Canadian General Hospital, March 26th, 1915 – Nov. 15th, 1917. (London: C.W. Faulkner, 1917). 44.

¹²⁸ Ibid.

command depot. What would interrupt this routine was preparation for offensives such as the Somme or Vimy Ridge. “The week prior to these engagements our hospital was emptied to the last possible man, our operating theatres, wards, and dressing centres were piled high with reserves of gauze and dressing. With all our machinery in readiness we wait in anticipation.”¹²⁹ Moving patients to command depots or convalescent homes in preparation for an assault is indicative of military efficiency taking precedence over individual care. Hospitals had to be opened and space had to be made for more serious cases; cases that had already had a chance to convalesce could be transferred to command depots or discharged in favour of a new patient who might have a better chance to rehabilitate fully. Macphail mentions that American hospitals, in times of increased workload, relied on recruiting more medical staff: “the surgical teams were obtained by stripping the base hospitals of their staffs.”¹³⁰ To avoid reducing staff at surrounding hospitals, the British and Canadian medical services opted for moving patients and amassing the necessary resources before major engagements got underway. “Owing to the considerable number of patients still arriving from the various lines, it is necessary to evacuate patients to either convalescent homes or elsewhere at the rate of 60 patients per day.”¹³¹ This was the note that Lance-Cpl Scott made in the No. 7 Queen’s Hospital war diary on 8 December 1915.¹³² That year, Canadians had fought in the Second Battle of

¹²⁹ Ibid, 44-46.

¹³⁰ Macphail, *History of the Canadian Forces*, 103.

¹³¹Library and Archives Canada, War Diaries Collections, “Moore Barracks Convalescent Hospital,” Item Number 2005107.

¹³² Ibid.

Ypres and the Second and Third Battles of Artois and the sheer number of wounded was weighing heavily on general hospitals.¹³³ To cope, they were sending patients away to open up beds so that more recently wounded patients could be assessed and treated. Throughout 1917, Moore Barracks notes in its war diaries that at multiple points throughout a month, it would send patients, around twenty at a time, to the Military Convalescent Hospital in Epsom to convalesce.¹³⁴ There was nothing to imply that these patients returned or were retrieved from said convalescent stay; they did not even record these patients' names, implying that they were sent to convalesce permanently. In this case, those requiring specialized care were the mental health patients and Moore Barracks would send their "mental cases" to Lord Derby War Hospital in Warrington.¹³⁵ These were the only two groups of patients mentioned when discussing large groups being sent out of the hospital in these war diaries. At the No 7 Queen's, it was noted that "in times of stress, when casualties are numerous, the transfer of large numbers of patients is still carried out-though, ordinarily, severe cases are detained at casualty clearing stations near the trenches."¹³⁶ Military offensives and their aftermath took precedence over convalescing patients; it was a system of triage and if a patient was well enough to walk, he was well enough to return to the front or at least be moved out of a hospital where a

¹³³ Macphail, *History of the Canadian Forces*, 36-38.

¹³⁴ Library and Archives Canada, War Diaries Collections, "Moore Barracks Convalescent Hospital," RG9-III-D-3. Volume/box number: 5036. File number: 858. Container: T-10926. File Part 2. Item Number 2005107.

¹³⁵ *Ibid.*

¹³⁶ Canada Army No. 7 Canadian General Hospital, *A History of No. 7 (Queen's) Canadian General Hospital*, 44.

more serious case could be treated in his stead. Complete rest was neither the goal, nor was it possible for patients in military hospitals as long as the war was on.

Space, having enough beds to house and treat patients, was a problem that multiple hospitals faced throughout the war, and dealing with this problem while best treating patients was difficult. The constraints placed on hospitals by the war prevented soldiers' individual health from being the priority of health care work. This can be seen first in the types of treatment offered by hospitals to incoming, non-urgent injured; rest, food, and a bath to help calm and reassure the soldier that danger was no longer imminent. Second, this can be gleaned from what physicians recorded in medical history case sheets. The soldier's condition was the focus: when they became ill, and whether or not the incident could be tied to a pre-war cause or not. What a soldier was treated with and how that treatment affected them beyond being normal enough for discharge was rarely a concern. Soldiers who could have been sent home for optimized treatment with family were not; they would be rehabilitated overseas, at least enough to be sent back to the front and maintain unit strength. Soldiers in hospital were transferred out as major offensives brought increased numbers of casualties to hospitals, all of whom needed beds recently occupied by soldiers still recuperating.

2.2 The Effect of Rank of Treatment.

The Canadian army was a system based on rank and not class, it operated as a part of the British Army for organizational purposes and was therefore subject to levels of classism amongst the Canadian ranks. However the CEF, while it was based on a military rank structure, claimed to be less classist. Historian Jonathan Vance discusses the

experience of classism and the encouragement of anti-classist attitudes in the CEF in his book *Death So Noble*. “Tolerance, unity, devotion to duty, fair play, the sharing of burdens – these had been the watchwords of the CEF.”¹³⁷ In an attempt to revitalize Canadian society to become “worthy of its heroes,” Canadians looked to the Battles of Ypres and Vimy Ridge, where Canadian soldiers united in a spirit of “tolerance and cooperation.”¹³⁸ Canadians wanted to emulate and support these ideals of equality and unity over the economic and class divisions of the past.¹³⁹ Canadian classism was experienced but was actively fought against as national unity became more important during the war. However, Canadian soldiers were still affected by a system constructed around treating officers and non-commissioned officers and men differently. One example where rank affected soldiers was in different treatment centres. Macphail notes that a number of small medical facilities called minor hospitals arose in England throughout the war, each capable of treating from 25 to 25 soldiers at a time. The care for these men was supplemented by the army at 2 to 4 shillings per day per patient. “The majority were in the Shorncliffe area and were annexes to the Shorncliffe military hospital. For officers only: ‘the Limes,’ Crowborough; Helena Hospital, Shorncliffe; Perkins Bull Hospital, Putney Heath; and Norwood Hospital for nursing sisters at Buxton.”¹⁴⁰ There were hospitals available for NCOs as well, but the fact that they were

¹³⁷ Vance, Jonathan F. *Death so Noble: Memory, Meaning, and the First World War*. (UBC Press, 1997). 223.

¹³⁸ *Ibid.*

¹³⁹ *Ibid.*

¹⁴⁰ Macphail, *Official History of the Canadian Forces in the Great War*, 222.

separated suggest at minimum that rank was a factor that divided the soldiers and affected their care. How it affected treatment will be expanded upon in this section.

Until 1917, the CAMC operated administratively under the British Royal Army Medical Corps. This meant that Canadian-trained and employed medical officers were not being used to treat Canadian soldiers exclusively but were sent to locations where the British needed supplementary medical personnel. In Herbert Bruce's 1927 *Politics and the CAMC*, he notes that halfway through the war, "the personnel of the CAMC, with a few exceptions, had not been engaged in the care of the Canadian sick and wounded."¹⁴¹ Approximately 1350 Canadian medical officers were in fact dispatched to the Mediterranean despite no Canadian troops serving in that theatre at that point in time. In France and England, where Canadian facilities had been set up to treat Canadian sick and wounded, the CAMC was only rarely treating Canadian sick and wounded there as well.¹⁴² Andrew Macphail and Herbert Bruce allude to a political debate happening in Ottawa from the beginning of the war regarding this issue of Canada being subservient to British control. Some Canadian politicians believed that Canada should be representing itself in all aspects of the war; Canada should not simply be another dominion at the beck-and-call of the British Empire. Other Canadian politicians believed that Canada and Canadian soldiers abroad would function best under the guidance and with the resources of Britain as it was waging a war.¹⁴³ A large part of this debate that singled out the

¹⁴¹ Bruce, *Politics and the C.A.M.C.*, 78.

¹⁴² *Ibid.*, 78-79.

¹⁴³ Macphail, *Official History of the Canadian Forces in the Great War*, 198-200.

medical services specifically was the Bruce Report. “The organization and system of the Canadian Army Medical Service began to be the subject of criticism within a few months after Canada’s troops became an actual factor in the prosecution of the war.”¹⁴⁴

Criticisms arose to the point where Canada felt the need to send an envoy to Europe and investigate the CAMC and report back and offer suggestions to improve its efficiency. Colonel Herbert Bruce was chosen as he was a prominent Canadian surgeon who was also a “professor of Clinical Surgery at the University of Toronto and Surgeon to the Toronto General hospital.”¹⁴⁵ He had also been a president of the Toronto Academy of Medicine and fellow of the American Surgical Association and possessed numerous other distinctions alongside holding the rank of Lieutenant Colonel in the CAMC.¹⁴⁶ For three months, Bruce was overseas investigating the CAMC; he reported back to Ottawa by September 1916 with many controversial observations: the allocation of Canadian medical officers to serve other wounded needs despite the desire of Canadian men to remain together and be treated by medical officers they were familiar with; and the problem of “taking over fifty-seven small V.A.D. (Voluntary Aid Detachment) hospitals in the Shorncliffe Area, at a time when the entire Toronto General Hospital Staff was lying idle at Shorncliffe.”¹⁴⁷ Shorncliffe hospital had the staff to care for more patients and could handle incoming surgical cases from the battlefield whereas the VAD hospitals

¹⁴⁴ Bruce, *Politics and the C.A.M.C.*, 7.

¹⁴⁵ *Ibid.*, 8.

¹⁴⁶ *Ibid.*, 8-9.

¹⁴⁷ *Ibid.*, 14.

were outfitted primarily by nurses who, “though devoted and enthusiastic, had no adequate training to deal with such casualties.”¹⁴⁸ The nursing staff relied on local civilian doctors, while Canadian surgeons whom Bruce considered eminent were “standing idly by,” a clear misuse of resources.¹⁴⁹ What Bruce brought back was a report on the poor performance of the Canadian government in the organization and care for Canadian lives. Its suppression was attempted, but the Bruce Report became public knowledge and debates played out in newspaper columns demanding explanations of Prime Minister Borden. A 7 February 1917 edition of Montreal’s *The Gazette* outlined the back-and-forth between the Canadian and British Parliaments, Dr. Bruce, and Sir Sam Hughes, Canada’s former Minister of Militia and Defence. It ended with a declaration from the government that friendship between Canada and Britain would be maintained, but a grudging agreement with the Bruce Report findings.¹⁵⁰ It would take until 1918 for Bruce’s policies to be fully enacted.¹⁵¹ In total, Bruce outlined twenty-three issues with how the army organized the medical services to the detriment of the soldiers and recommended fourteen steps to ameliorate the situation.

Ultimately, in 1917, Canada made the decision to pull the CAMC out from complete British control, a decision that manifested itself clearly in the operations of the

¹⁴⁸ Ibid.

¹⁴⁹ Ibid.

¹⁵⁰ A Special to The Gazette. “Bruce and Baptie Reports Discussed in Parliament: Sir Same Hughes Repeats that the Canadian Medical Service Had Serious Defects.” Newspapers.com. (The Gazette: Montreal, Quebec., February 7, 1917.) 9.

¹⁵¹ Bruce, *Politics and the C.A.M.C*, 14.

medical services. Canadian hospitals were established that would be geared towards Canadians treating Canadians. Macphail notes in his 1927 book *History of the Canadian Forces* that Canadian leadership should have looked to American organization of medical services prior to separating their system from the British; he noted that because of their operational isolation, Americans suffered from understaffing of medical personnel: “operating surgeons were on duty for 72 hours, some base hospitals organized for 500 men patients were forced to take 2,100 and practically all cared for 1,500 while some had 3,000 or more.”¹⁵² The Chief Surgeon said that the one reason the American medical surgical system survived was that in times of increased workload, “the surgical teams were obtained by stripping the base hospitals of their staffs.”¹⁵³ Both of these conditions, overworked hospital staff and pulling staff from other facilities essentially rendering them without medical officers, had negative effects on patients and therefore negatively affected the war effort. According to Macphail, the armistice kept the American medical service from collapsing under the strain; he suggested that the Canadians could expect a similar outcome.¹⁵⁴ Operating overseas, in England, and on the European continent, Canadian services would have done best to navigate these new contexts with the expertise and resources of the British Empire. The Canadians therefore chose independence and self-sustenance over cohesiveness and subservience.

¹⁵² Macphail, *Official History of the Canadian Forces in the Great War*, 103.

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*

Historian Ben Shepherd makes an important point in his book *A War of Nerves* that officers and non-commissioned officers were offered care in different facilities and that, despite the fact that rest away from the front was essentially the same from one place to another, some soldiers perceived this segregation as different levels of care. Whereas officers were typically sent to specialized hospitals, non-commissioned officers and men were more likely to be sent to convalescent homes, asylums, or to hospitals with a higher number of patients to care for that were therefore unable to provide more specialized treatment.¹⁵⁵ Alongside the fact that officers had the option of going to smaller convalescent facilities because British families in northern England opened their home as convalescent destinations for officers, there was also the fact that British physicians were officers in the British army and themselves propagators of rank disparity. Dr. William Rivers was a British psychoanalyst who took some cues from Freud to help expand psychology's treatment of war neuroses. Rivers considered Freud's proposition that sexual desires were at the root of mental health issues to be wrong. However, he accepted that dreams helped to connect a person to their inner, subconscious desires and could help to treat shell shocked men.¹⁵⁶ Rivers believed that treating men with electrotherapy as a means of convincing them that they were not ill was torture. In that way he was a sympathetic character who functioned on the idea that patients got better because they believed that their doctors could make them better. Convincing a patient to believe in him helped him overcome their fear that they were incurable, and his psychotherapy

¹⁵⁵ Shephard, *A War of Nerves*, 74-75, 110.

¹⁵⁶ *Ibid*, 85.

progressed from there. Despite his psychological approach, Shepherd notes that Rivers still found it difficult to deal with patients outside his class; being at Craiglockhart, a hospital for those of his class with whom he could communicate intelligently, he felt more capable.¹⁵⁷ The role of the physicians to treat all indiscriminately was not a role traditionally fulfilled by physicians. They too brought their prejudices to their practices, some more so than others, and that had an effect on their patients and how they were treated.

Class disparity affecting the treatment of First World War soldier can be seen in hospital war diaries. Granville Canadian Special Hospital was an 800-bed hospital located in Ramsgate, Kent, that specialized in treating soldiers afflicted with nerve and bone injuries. While officers and men were both being cared for at Granville, specific entertainments were organized for officers and to which men were not admitted. One such event was described on 29 January 1918, when Mrs. Dent and other ladies of the town organized a “drive” in the smoking room, specifically for officers.¹⁵⁸ Coffee and cake were served at this party for officers only. This was not an uncommon occurrence nor was it unique to Granville. Hospitals that treated mixed ranks would have specific events organized for the officers and larger events for all patients.¹⁵⁹ While excursions from convalescent camps and dinners should not be considered as direct treatment, they did constitute specialty care that encouraged segregation amongst the ranks.,

¹⁵⁷ Ibid, 87.

¹⁵⁸ Library and Archives Canada, War Diaries Collections, “Granville Canadian Special Hospital,” RG9-III-D-3. Volume/box number: 5040. File number: 878, Item Number 2006032.

¹⁵⁹ Ibid.

2.3 Just What the Doctor Ordered.

In every medical faculty, in every large community, there are persons who profess to have acquired special skill in the various departments of surgery and in the treatment of certain diseases; but one might have all skill in opening a cavity, in setting a bone, in repairing an organ of the special senses, or watching a fever, and yet be quite incompetent in the wide field of human activity, known as war, that lies beyond his ken.¹⁶⁰

This quote from historian Andrew Macphail exemplifies the contested relationship between the medical and military communities during the First World War; a doctor could set a bone but did not know what it took to win a war. Treatment for mental illnesses or afflictions during the First World War was affected by multiple external factors such as rank and military efficiency. Another major external factor that impacted the treatments a soldier received, touched on in the previous section, was the hospital he was sent to and the physicians who were stationed there. Different physicians in the CAMC and RAMC, and in civilian hospitals used by Allied forces during the war ascribed to different methods of treatment, ideologies of care, and theoretical approaches to medicine. These differences in approaches resulted in specific hospitals being able to provide specific types of care, which in turn generated different levels of dissent and approval from the military. This section will focus on the differences between hospitals and hospital groupings to demonstrate that, alongside rank and military goals, where a soldier was sent as a patient altered what kinds of treatment he could access.

¹⁶⁰ Macphail, *Official History of the Canadian Forces in the Great War*, 187.

It would be a mistake to imagine that all military hospitals during the First World War were similarly equipped, either in terms of the personnel or the diagnostic and treatment tools. Even something as fundamental as an x-ray machine was not universally available. Discovered in 1895 by Wilhelm Rontgen, the x-ray was a relatively new technology that was not readily available everywhere; there were also relatively few individuals trained in its operation.¹⁶¹ Furthermore, x-ray rooms were large, because the radiographer and other patients required extensive protection behind concrete walls that involved a great deal more construction than was possible for some facilities. Moore Barracks Hospital was without an x-ray machine until 1916, despite housing up to 800 patients at a time. As a solution, Moore had to send patients to Shorncliffe Military Hospital for x-rays. However, in late 1915, Shorncliffe Military Hospital was taken over by No. 3 Casualty Clearing Station [CCS] a unit that had no radiographer, which meant that neither hospital had access to x-rays as they had no physician or radiographer to take and interpret the images.¹⁶²

The story of Moore Barracks Hospital's x-ray services applies to all other equipment and personnel matters, including those involving soldiers diagnosed with psychiatric conditions. Not every hospital had the same specialists with the same approaches or tools to use in treating psychiatric patients, so how a soldier was treated depended very much on where he was sent. But where he was sent depended not on the

¹⁶¹ Thomas, Adrian M.K. and Arpan K. Banerjee, *The History of Radiology. Oxford Medical Histories.* (Oxford, England: Oxford University Press, 2013). 9.

¹⁶² Library and Archives Canada, War Diaries Collections, "Moore Barracks Convalescent Hospital," Item Number 2005107.

facilities available at any given hospital, but space. The soldier went to a specific hospital because it had space, so he ended up getting the treatment that the specific hospital was able to provide, whether or not it was the treatment that the soldier actually needed. By the same token, the soldier would be treated by the specialists at the hospital with space, rather than by a particular specialist who might be better suited to his condition. This was particularly significant given the wide range of opinions among doctors who specialized in psychiatric cases.

2.4 Psychology and Neurology.

Macphail notes that the contest between medical officers and military personnel lasted throughout the course of the war, pitting physicians who tried to expand and adapt care against the military, which enforced a system of care that supported the rehabilitation of soldiers to rejoin their units so that their numbers could be maintained. Historian Ben Shepherd explores the evolution of early treatment of shell shock in his book *A War of Nerves*. In his chapter on shell shock in France, he describes the work of Dr. Charles Myers and his efforts as a medical representative working against military doctrine. Leading up to the war, Myers was a lecturer in experimental psychology at Cambridge University.¹⁶³ His experimental psychology explores the motivations and awareness of the Self and its symbiosis with the unconscious. It also works alongside physiological and neurological theories to help push science's understanding of the

¹⁶³ Myers, Charles Samuel. *An Introduction to Experimental Psychology*. (Cambridge: University Press, 1914).

nervous system. He criticizes ideas about these hard sciences, implying that there are also unanswered questions in their specialty as there are in psychology. Psychology is also not free from Myers' criticisms. In his book *An Introduction to Experimental Psychology*, he explores the importance of the uniqueness of personality and while each brain may be constructed similarly, they operate to serve each individual's needs. This individuality, the person, had to be at the center of psychological inquiry as opposed to focusing on the average so as to understand the differences between minds and the reasons behind those differences.¹⁶⁴ In 1916, Myers was appointed a consultant psychologist to the British army where he worked to "alleviate the crude treatment, both military and medical, of psychoneurotic cases" and would be a key figure in the identification and treatment of shell shock.¹⁶⁵ In 1917, he was the first physician to write in *The Lancet*, a British medical journal, using the term shell shock.¹⁶⁶ He explained that there were both physical and psychological causes, predisposing conditions, and that ultimately shell shock was a disorder that affected the conscious and the unconscious personality which could present as functional disorders like poor "intelligence, memory, movement, sensation or reflexes."¹⁶⁷

To get the Army to acknowledge shell-shock as something distinct from the traditional categories of wounded, sick, well or mad and to provide separate

¹⁶⁴ Ibid, ix-x.

¹⁶⁵ T. H. Pear. "Charles-Samuel Myers: 1873-1946." *The American Journal of Psychology* 60, no. 2. April 1, 1947. 289-290.

¹⁶⁶ Myers, Charles S. "Contributions to the Study of Shell Shock: Being an Account of Certain Cases Treated By Hypnosis." Internet Archive. September 09, 1916.

<https://archive.org/details/contributionstos00myer/page/466/mode/2up?q=shell>.

¹⁶⁷ Ibid.

facilities for its treatment in France, so that ‘innocent men who had mentally broken down under the strain of warfare’ were not flung together with the genuinely insane, epileptics and criminals, or put into general wards with wounded soldiers.¹⁶⁸

After a year of advocacy, at the beginning of 1917, specialist facilities for the treatment of shell shock were created in Boulogne and back in England.¹⁶⁹ Myers was of the opinion that most men dealing with shell shock were just “badly shook-up or temporarily confused.”¹⁷⁰ Myers was a patient advocate who believed in a shift away from asylums as the established treatment for soldiers with mental health issues because “by treating soldiers as if they were mad, the Army was often pushing them into genuine insanity.”¹⁷¹ Separating soldiers based on their illness or ailment helped for organizational purposes, and removed stigma from fellow patients and staff not specialized in mental health care. Giving patients a safe space to heal was the basis for hospitals away from the front; Myers was simply taking that logic a few steps further. Myers would go on to push for further improved treatment of shell-shocked soldiers by petitioning the army to treat men earlier on in their medical journeys to improve their prognosis. Proximity to war was the immediate problem and if a man could be distanced from it early for a period of recuperation, then he was more likely to return to the front rather than be discharged to light duties or to hospital in England. Myers advocated for a triage system of mentally affected individuals to keep them from congesting general facilities that could not

¹⁶⁸ Shepherd, *A War of Nerves*, 27.

¹⁶⁹ *Ibid.*

¹⁷⁰ *Ibid.*

¹⁷¹ *Ibid.*

adequately treat them anyways.¹⁷² More hospitals, convalescent, and rest stations in France were the solution in his mind. Despite this, Shepherd notes that most cases of shell shock and mental affliction were still just returned to England where they stayed for lengthy periods of time.

In addition to contending with military opposition and orders, there were also multiple instances in which members of the medical community disagreed amongst themselves. Typical of most academic communities, medicine was not always in agreement on how best to treat an individual but in the context of war, this made progress in medicine that much more difficult and the consequences that much greater. Shepherd makes this intra-medical conflict clear in his discussion of Myers by addressing the opposition to Myers' ideal of rest, relaxation, and distance from the front to treat those not necessarily afflicted with shell shock but whose nerves were just fraying. Some believed that encouraging female visitors, providing too many entertainments, and distracting relaxations discouraged the soldier's return to the war; essentially, the action of making life outside the army look too good for a soldier off the front was dangerous and only encouraged him to stay in hospital. "Rest in bed and ample encouragement is not enough to educate a child. Progressive daily achievement is the only way whereby manhood and self-respect can be regained."¹⁷³ Opposing arguments came from the medical military personnel who were more intimately acquainted with army life and believed that the need for discipline over comfort did not stop just because men were

¹⁷² Ibid.

¹⁷³ Ibid, 74.

hospitalized and that seeing a hospital as an escape instead of just another military institution was detrimental to soldier morale and motivation. In sum, medicine could no longer navigate treatment alone. It had to frame treatment in the context of war and weigh the pros and cons of treating one soldier over another instead of ensuring that each person received the time, care, and space necessary.

Another aspect of intra-medical disagreement was the neurologist's and the psychologist's theoretical and subsequent practical approaches to treating shell shock. The conflicts arising in how to treat patients with shell shock between the psychological and neurological communities were contentious and depended heavily upon diagnosis, symptoms, and the continued manifestation of those symptoms. Psychology itself was a newer field containing multiple ideologies regarding the treatment of mental health. Once such popular approach pioneered by Sigmund Freud was psychoanalysis, which took many forms during the First World War in the treatment of the mentally affected. Among the accepted practices for treating military mental health patients were sedation, restraints, isolation, psychotherapy, physical therapy, and ultimately sending them home or to an asylum where they could be perpetually isolated and sedated to keep from harming others and themselves (assuming the soldier could not be salvaged from his mental illness. Poor mental health was for a long time considered a permanent debilitating disease that put others at risk or generated discomfort; therefore, segregation was a popular choice. With the increasing awareness that those people who were not expected to suffer from poor mental health -- upper classes and powerful individuals -- actually were as vulnerable as anyone else, ideas of the permanence of poor mental health started to shift towards the belief that it was curable. Psychotherapy and alternative

treatments to isolation, restraint, and sedation promised and saw hopeful results. These shifts occurred in the mid to late-nineteenth century and were encouraged in the early twentieth. During the First World War, when manpower was a limited resource that had to be recycled as efficiently as possible, mental health could no longer always be a life sentence for a soldier, a reality that encouraged further policy and treatment adaptation. Could mentally afflicted soldiers be rehabilitated adequately to keep fighting? Both neurology and psychology found in this question a niche in which to expand their research. Psychology focused on causation to discern a cause of poor mental health, which in turn resulted in the exploration and focus on fear. Shepherd quotes David Eder, a British psychologist during the First World War, concerning this crippling and mind-altering fear that incapacitated soldiers. Eder was not alone, and a lot of psychological treatments came to involve an analysis of fear in some way. Eder operated on the theory that

The unconscious, acting on behalf of the ego sets the eye watering, forcing [the soldier] to relinquish his post. Then the soldier's instinct reasserts itself, the eye ceases to water and he returns to the loophole. But here the egocentric instinct, self-preservation, reasserts itself and the unconscious adopts a stronger attack. He is stricken blind in the shooting eye... He is now unable to carry out his conception of the soldier's duty and, without loss of self-respect is able to retire, his safety guaranteed.¹⁷⁴

This quote explores the build-up of fear in the soldier to the point of inaction or illness as a form of self-preservation. The result is mental affliction and some level of inability to perform the duties of soldiers, with fear as the root cause.

¹⁷⁴ Ibid, 86.

These ideas are echoed in F.C. Bartlett's 1927 *Psychology and Soldier*. After the war at Cambridge University, Dr. Charles Myers, formerly the Official Psychologist to the British Expeditionary Force in France, and Lieutenant Colonel L. H. Thornton, then director of Military Studies at Cambridge, held courses "on psychology in relation to military problems."¹⁷⁵ Bartlett, who led these lectures from 1921 to 1927, presented this book as introduction to the role of psychology in a soldier's life. According to Bartlett, fear was the central and constant factor in mental health. Fear becomes normalized as it becomes part of the soldier's everyday existence; it is a constant, where before it was a passing feeling. This shift towards normalization happens gradually and is expected. Bartlett explains that normalization of a work environment is natural; in a regular job back home, a man would be striving for raises or promotions but at war, a man becomes accustomed to vying for promotions of rank that includes the added responsibility of men's lives. This is one stage of normalization. Another is that men in one's unit die frequently and violently. The normalization of death takes a toll on the psyche of the soldier.¹⁷⁶ These normalizations combine to create a psyche more suited to war. Ultimately, Bartlett makes the point that the normalization of war is not the problem but when fear becomes increasingly attached to all normalized processes, it becomes overwhelming and the soldier has a mental breakdown. The association of fear with other war front actions, such as manning the trench or even holding a gun, has to be broken. Therein lies the treatment; what is associated has to be dissociated, to permit a

¹⁷⁵ Bartlett, F.C. *Psychology and the Soldier*. (London: Cambridge University Press, 1927). V.

¹⁷⁶ *Ibid*, 204-205.

soldier to return to the trenches without the overwhelming fear of death. This underlying theory of needing to separate the soldier from the front and the fear can be seen in a myriad of treatments, from merely sending a soldier to a convalescent hospital to electrotherapy, trying to untangle the brain from trauma, at the heart of treating the mentally afflicted men.¹⁷⁷

Tackling the fear behind shell shock took many different approaches as different psychologists acknowledged it as an important hurdle to overcoming shell shock. Some physicians believed that to cure it, the patient had to be convinced that he was going to be cured before the treatments had even started. For Lewis Yealland, this came in the form of a good reputation to encourage a patient to believe that his doctor had the ability to heal him. To reinforce that, he would use electrotherapy as a disciplinary measure. Historian Mark Humphries notes that like hydrotherapy and other physical treatments, electrotherapy was used “to provoke a sensory reaction that would help convince the patient that symptoms of anesthesia or paralysis could be alleviated” as a form of disciplinary treatment.¹⁷⁸ The use of physical shock to assist the patient in believing that he could be cured was a common practice of Yealland’s at Queen Square hospital. This was part of his psychological approach to convince patients that they could be cured before even starting treatment. Yealland found conflict in his field in that, while a soldier was with him receiving treatment, he did appear to be improving. However, as soldiers filtered through his hospital and returned to the front or to another hospital or home, they

¹⁷⁷ Ibid, 210-211.

¹⁷⁸ Humphries, *A Weary Road*, 145.

were likely to relapse. Yealland was also criticized for his excessive use of electrotherapy on patients. If a patient had a history of resisting his suggestion that electrotherapy would help or appeared to be losing faith, Yealland would increase the amperage to get the patient to yield mentally as opposed to actually curing any illness. Dr. William Rivers was on the other side of this. While he agreed with Dr. Yealland's approach in needing to convince the patient that he could be cured by his physician, he was strictly against using physical stimuli to reinforce that belief and to force a result.¹⁷⁹

Neurological treatments for shell shock and other psycho-neurological illnesses were more traditional and therefore accepted by the medical and military communities. The nervous system had come to be understood as an electrical circuit and nerves the harbingers of electric energy. Its failings were functional, not mental, and that was also an attractive attribute that had more physicians and professionals turning to neurology over psychology. It was believed that the introduction of electric current to muscles could gradually help to increase blood flow and ultimately return strength and movement to shaky, inappropriately active, or paralyzed limbs. Electroconvulsive therapy was not used in the First World War. In the 1930s and by the Second World War, electroconvulsive therapy would become a popular treatment for the mentally affected. In this treatment, a patient would be put under general anaesthesia and then an electric current would be applied to their brain to trigger brief seizures.¹⁸⁰

¹⁷⁹ Shepherd, *A War of Nerves*, 76-77.

¹⁸⁰ Jonathan Sadowsky, "Electroconvulsive Therapy: A History of Controversy, But Also of Help." *Scientific American Online*. January 13, 2017.

In the First World War, electrotherapeutic methods centered around Galvanism and Faradism. Discovered in 1791, Galvanism is the creation of an electric current through chemical catalysts. This electrical current was then applied to tissues to induce a contraction/convulsion of muscle, not to the brain to induce seizures; simple and controllable electric currents were used to contract, then relax a muscle to simulate natural muscle movement.¹⁸¹ Faradization is the use of alternating current electricity or AC electricity on the body. Galvanism uses direct current or DC electricity. Faradizing alternating current is generated electromagnetically as opposed to chemically. According to E.M. Magill's 1917 *Notes on Galvanism and Faradism*, the use of electricity in medicine had been an established practice for years.

The constant current, because of its beneficial effects upon metabolism, was used for the following conditions, when it may be applied to the whole body as a hydro-electric bath, or especially to the nervous system: insomnia, neurasthenia, general debility, hysteria, rickets, anaemia, other constitutional diseases.¹⁸²

In the early days, before current electricity or electricity in motion was applied to pathological conditions, shocks from a static machine were given for muscular wasting; paralytic cases were more usually treated by Galvanism and Faradism by the First World War.¹⁸³ Instead of using pulses or using the person as a way to complete a circuit of “moving” electricity, simple and instantaneous shocks were administered to

¹⁸¹ Whewell, William, *History of Inductive Sciences: From the Earliest to the Present Times*. (Cambridge, Eng.: Cambridge University Press, 2010). 77.

¹⁸² Magill, Ethel M., *Notes on Galvanism and Faradism*. (London: H.K. Lewis&Co., LTD, 1917). 137

¹⁸³ Magill, *Notes on Galvanism and Faradism*, 15.

neuromuscular systems.¹⁸⁴ Nevertheless, exactly what electricity was, the author makes clear, was still unclear to the general public at this point and therefore its applications were largely experimental.

Magill's notes make clear that they were writing not for a scientific readership, but for masseuses and others who wished to practically apply Galvanism and Faradism in their therapeutic practices. Masseuses would come to be employed in hospitals like Granville to help in the rehabilitation of neuralgic patients. In a 1916 book review in the *American Journal of Surgery*, the journal's publishers commended E.M. Magill for this instructional book. Not only did they applaud the clarity with which the author conveyed major theories involved in the application of Galvanism and Faradism, but they recommended it to "medical schools, and to house surgeons and other who may be in need of concise but practical guide to electrotherapeutic treatment."¹⁸⁵ It permitted the use of electrotherapeutic techniques without having to be specially trained in electrical engineering.

For mental diseases, the manual recommends the use of sinusoidal baths where the patient is immersed in a bath, an electrode using alternating current is placed at their feet and arm. The probe positions are switched halfway, and the current is increased to comfortable tolerance of patient.¹⁸⁶ Depending on what a patient was diagnosed with

¹⁸⁴ Ibid.

¹⁸⁵ American Journal of Surgery. "Notes on Galvanism and Faradism." *The Indian Medical Gazette* vol. 51,8 (1916). 309.

¹⁸⁶ Ibid, 201.

determined whether Galvanism, Faradism, or ionic electric treatments were the solution. For neuralgia, the manual recommends the use of galvanism and/or quinine or salicyl ions.¹⁸⁷ For neurasthenia, the manual recommends that if blood pressure is high, use high frequency, and if blood pressure is low, use static electricity. If the patient is suffering from insomnia, central Galvanism was the recommended treatment. For neuritis, the manual recommends the use of acute-anodal stabile galvanism and or subacute salicyl ions. Given the number of diagnoses each patient would pass between, those with access to electric treatments could have received any number of them, rendering it impossible to be specific about how these treatments were organized. When electrotherapy was applied, minimal results were noticed, and improvements were more likely to be temporary. Standardized application of electrotherapeutics was attempted and can be seen in manuals like Magill's. However, given the fact that diagnoses were different between medical institutions and not all institutions provided the same equipment and level of care, treatment could at most only be expected to be standardized within an institution and potentially with other close institutions.

In examining the case files, few examples arise in this study in which physicians stated specifically what specific treatments a soldier received. Most case files mention physique, fitness, and heart and lung status, and would indicate where a soldier was being sent to infer the type of treatment he was receiving. Major Herbert Graham Starr is one case in which his specific treatments were recorded in his medical case sheet. Major Starr was an engineer from Maple, Ontario, who enlisted into the CEF on 9 September 1915.

¹⁸⁷ Ibid.

On 17 September 1916, he was admitted to No. 7 Stationary Hospital in Boulogne for a shell shock wound. The very next day he was sent to No. 4 London General Hospital where he stayed until 28 November 1916, when he was discharged back to duty. A few months later he presented to Granville Special Canadian Hospital in Ramsgate on 2 February 1917 for sciatica problems in his lower back. He stayed there until 19 April 1917. In July and August 1917, he returned to Granville and then to the Canadian Convalescent Hospital for Officers for “sciatica (railroad spine)” and neurasthenia respectively.¹⁸⁸ At the CCH, doctors specified that a shell explosion knocked him into a wall and compressed his spine, resulting in the lumbar pain as well as extreme shakiness. He went back and forth between these two hospitals, receiving Faradism and massage treatments as well as light duties to test how much he could do before being overcome with pain. He was then transferred to the Furness Hospital in Harrogate for sciatica from where he was discharged 4 January 1918. He returned to Canada on the SS *Chiselhurst* from Liverpool on 26 February 1918.¹⁸⁹ In the case of Major Starr, for his railroad spine/sciatica/shell shock, he received electrotherapy, x-rays, heat treatments, and physical massage to treat his pain. Because it was not lessening and he was also presenting with poor memory, dizziness, palpitations, and extreme nervousness, he was struck off strength on 6 June 1918 in Ottawa. However, he would be listed as a demobilization discharge and not a mentally unfit discharge. This case demonstrates that

¹⁸⁸ Library and Archives Canada, War Diaries Collections, “Starr, Herbert Graham.” RG 150, Accession 1992-93/166, Box 9245 – 15. Item Number 248379.

¹⁸⁹ Ibid.

officers had the option of being sent back to the home front and still remain in the army despite being mentally unfit.

Conclusion:

The treatment of soldiers was provided by and through a military system that promoted efficiency, strength, morale, and success. Once a soldier was diagnosed with an illness, he was sent to a facility that treated him. The goal of treatment was to restore the soldier's fitness and ability to fight, so that he could be returned to the front. This is seen in how soldiers were sent back to hospitals, how they were treated, the expansion of the convalescent facilities and command depots, and the fact that soldiers were kept in Europe to try and rehabilitate them at all costs before sending them back to Canada. How the mental health of the soldier was accommodated in this system of military health care can be seen in the push-back from Canadian medical officers as well as in the likelihood of a soldier reinjuring himself; Canadian soldiers wanted to be treated by Canadian physicians, physicians pushed for humane treatment methods, and soldiers who had been in hospital once for shell shock, neurasthenia, myalgia, hysteria, and debility were extremely likely to appear in multiple hospitals, stations, and camps throughout their service. Military priority directed the medical community's methods of care, as made evident by hospitals implementing procedures to empty their beds as much as possible before major offensives to make room for more soldiers.

Treatments mentioned in the men's service files were vague and focused on their physical fitness: how the patient looked, ate, slept, and their overall behaviour. What treatments they were receiving, outside of general convalescence, were not reported. The

only exceptions in this study of men receiving specialized treatments like massage, electrotherapy, and heat apparatus treatment were officers. These treatments were offered at convalescent stations that housed both officers and men and yet there is no mention that men received specialized care. If physicians were including these types of treatments in the files of officers and not men, was this indicative of specialized treatment only being used to treat officers? Rank and class affected the treatment of soldiers; treatment for soldiers was not standardized, and was not even equally available. Officers had facilities open to them that men did not, and their files reflected closer attention to mental health and nervous care. Officers also had the privilege of being sent back to Canada for rest without needing to be considered unfit. This disparity in health experience demonstrates a lack of standardized treatment.

Military efficiency was a driving force behind the types of treatments officers and men received. In the beginning of the war, the term shell shock emerged and was liberally applied by any medical officer in the field or hospital. Hospitals were the primary care station for men and the CAMC administered care to whichever soldiers the British army needed it to. As the war progressed and casualties mounted, the need for convalescent spaces and command depots arose and the term shell shock was restricted to prevent as many soldiers being sent back and also to diminish the number of soldiers presenting with mental affectations. The emergence of these stations and restrictions was to better serve the military's need to maintain men on the front lines through rehabilitation stations that would gradually reintroduce them to the front while simultaneously opening up hospital space to permit better triage procedures. Canada was at war and that meant that the medical military personnel were responsible for

maintaining the health of the force to win the war. This caveat of needing to support the military machine resulted in a lack of adequate mental health care for soldiers as well as an uneven distribution of available resources.

Chapter 3

3 An In-Depth Analysis of First World War Canadian Service Records.

The previous two chapters have explored major themes that influenced the diagnostic and treatment practices during the First World War for Canadian soldiers and made it difficult for those practices to be standardized. The first chapter takes the common adage that with the First World War came advancement and improvement, which included a process by which medicine and treatment were standardized. It analyzed how, at the diagnostic level, this was not true. Rather, the Canadian military focused on generalized medical care, which did not mean that care was standardized. It looked at the inconsistency in diagnostic practices between hospitals, the inconsistent nature of the neurological and psychological medical communities leading into the First World War, and finally the almost constant shifting of diagnostic practices to privilege military efficiency over individual soldier health. The second chapter looks at the treatment of fifty Canadian who were admitted for psychological affectations. More closely, it identifies military need as the driving force behind where a soldier was sent for recuperation, when, and why. Rank also affected Canadian soldiers in that the lower ranks were not given as lengthy or specialized care as officers. Finally, this chapter looks into how different doctors with different ideological beliefs with regards to mental health offered different treatments for the patients they received at their respective hospitals; care was different based on the facility to which you were sent. An individual soldier was not the focus of the health-care system employed by the CAMC during the First World

War; it was in fact a system of health centered around maintaining strength at the front, morale, and fitness. If men could be rehabilitated to the point where they could be returned to the war, they were. If this meant using them for light duties instead of trench fighting, that was still a body saved to maintain strength against enemy forces.

3.1 Case Study #1: Private Frederick Bailey and Private Thomas Essery.

A contrast that was touched on in the first chapter, but not fully explored, was the differentiation between shell shock and neurasthenia by the medical community during the First World War. Initially the diagnosis of shell shock was thought to be adequate and was applied liberally to all soldiers who exhibited a kind of nervous behaviour. Eventually, however, the men who fell into the category of shell shock became too varied to treat so some degree of classification had to be established. Neurasthenia, an already common condition by the time of the First World War, was readily applied to soldiers who were exhibiting shell shock symptoms but who did not incur physical injuries in battle. It also came to be applied to soldiers who were shelled but who did not display the neuro-typical symptoms of shell shock such as shakiness, tremors, nightmares or bad sleep habits, and nervousness. Gastritis and headaches as well as non-conformist or poor behaviour were all common symptoms of neurasthenia. Two case files that exemplify the fluctuating and transient definitions of shell shock and neurasthenia are Private Fred G. Bailey and Private Thomas Essery. Over the course of the war, both men would be diagnosed with shell shock and then have that diagnosis shift to neurasthenia.

In his 1887 book *Functional Nervous Diseases Their Causes and Their Treatment*, Dr. George Stevens discusses neurasthenia in conjunction with nervous problems due to spinal irritation: “They are characterized by general loss of nervous energy and by local symptoms more or less complex; certain symptoms, however, prevailing more in one than in the other form of nervous disturbance.”¹⁹⁰ Specifically, with

neurasthenia in men there is less of the neuralgic element, with more dull pain in the extremities, or general sense of exhaustion, inability to continue at office-work where writing or attention to accounts is required, and frequently a general sense of illness which prevents the patient from following his usual avocation or even confines him to his bed. These cases have been known as neurasthenia.¹⁹¹

These were vague symptoms that reduced an individual no longer able to perform tasks or duties that they previously could. Therefore, during the First World War, when patients showed up to hospital with symptoms that generally prevented them from doing work, they could be easily classified as a neurasthenic. In their 1921 book *The Form and Functions of the Central Nervous System, An Introduction to the Study of Nervous Diseases*, Dr. Frederick Tilney and Dr. Henry Riley built on the idea that neurasthenia is related to nervous energy, but modernized it; neurasthenia was simply “a condition characterized by loss of nerve strength.”¹⁹² The concept of strength in nerves or nervous energy being necessary for a person to function indicates that neurologists were still

¹⁹⁰ Stevens, George Thomas. *Functional Nervous Diseases Their Causes and Their Treatment; With a Supplement on the Anomalies of Refraction and Accommodation of the Eye and of the Ocular Muscles*. Internet Archive. New York, Appleton, January 1, 1887. Page 81.

¹⁹¹ Stevens, *Functional Nervous Diseases Their Causes and Their Treatment*, 81-82.

¹⁹² Tilney, Frederick and Henry Alsop Riley, *The Form and Functions of the Central Nervous System, An Introduction to the Study of Nervous Diseases*. Internet Archive. (New York, Hoeber, 1921). Page 957.

trying to understand exactly how the nervous system worked. They could only really tackle when it was malfunctioning by trying to treat the symptoms; galvanism and faradism, electricity applied to muscles groups to simulate contractions as a way to regulate muscle spasms, were the most common interventions.

Private Bailey was a 36-year-old cook from London, England, who enlisted into the Canadian Expeditionary Force on 11 September 1914 at Valcartier, Quebec. According to his personnel file, “while in the reserve trenches at the Yser Canal, about 1 April 1915, [Pte Bailey] was blown into the canal from the explosion of a shell.”¹⁹³ At the same time, a light shrapnel wound was inflicted about the middle of the left arm. How he was retrieved from the canal and what treatments were administered in the field were not detailed in his file. However, it was noted that his “clothes dried on him,” which resulted in his getting chilled.¹⁹⁴ Three weeks after this incident, he had to be carried out of the trenches as he was experiencing a great deal of pain in three major extremities. After receiving hospital treatment for rheumatism at the Canadian Convalescent Hospital in Bromley, Kent from 5 June 1915 to 22 June 1915 he would be discharged back to his unit. His file notes that he was on duty until 2 June 1916 when a bombardment overwhelmed his unit and he was buried. On 9 June 1916, Pte Bailey presented to the

¹⁹³ Library and Archives Canada, Personnel Records of the First World War, RG 150 “Bailey, Fred. G”, Accession 1992-93/166, Box 344 – 1, Item Number 19630, Regimental Number 21796.

¹⁹⁴ Ibid.

No. 3 Division Rest Station with symptoms of shell shock and was so diagnosed. Five days later, he reported from base to rejoin his unit.¹⁹⁵

The next month, on 13 July 1916, he presented to No. 9 Canadian Field Ambulance with pyrexia and gastritis.¹⁹⁶ Pyrexia is simply a raised temperature, essentially a fever. In Dr. Stevens' *Functional Diseases, Their Causes and Their Treatment*, he mentions how in cases of neuralgia or nerve pain, "pyrexia sometimes accompanies the paroxysms" or the potentially violent emotional outbursts from the patient.¹⁹⁷ Violent, emotional outbursts become a part of the illness as the pain increased or was unpredictable. Stevens and his contemporaries believed that there were no telltale symptoms of the individual being affected by this neuralgia: "while some sufferers from this complaint are ruddy and apparently in robust health, others are exceedingly anaemic and feeble to an alarming rate."¹⁹⁸ This vague explanation of nerve pain and those affected by it made the diagnosis of neuralgia easily to apply to many soldiers who were presenting with symptoms of what might be considered shell shock or neurasthenia. Any individual expressing pain in association with a wound could be diagnosed thus, regardless of their general demeanor. However, in Bailey's transition from shell shock to neurasthenia, despite the clear indications of pain, there was no transitional diagnosis of

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

¹⁹⁷ Stevens, *Functional Nervous Diseases Their Causes and Their Treatment*, 61.

¹⁹⁸ Ibid, 62.

neuralgia. Instead, the physicians described his condition as feverish and suffering from gastritis.

Gastritis, or inflammation of the lining of the stomach resulting in abdominal pain, was not considered to be a symptom of shell shock generally but had historically been associated with neurasthenia and neurasthenics. Much like what exactly would come to define shell shock in the First World War was continuously disputed, what defined neurasthenia was also inconsistent and hotly debated. Dr. Gilbert Ballet, a prominent Parisian physician who worked out of the Hotel Dieu Hospital, published a book in 1909 called *Neurasthenia*. He argued that, although many physicians had tried to clarify the etiology of neurasthenia, most were operating solely on part-truths and therefore had little valuable information regarding prophylaxis or therapeutic treatments for neurasthenia.¹⁹⁹ Ballet explains that physicians had frequently connected the “the different symptoms of neurasthenia, to some lesion or functional disorder of the stomach or of the other abdominal viscera.”²⁰⁰ Many scientists at the time were exploring the theory that “neuropathic states had either gastritis or dyspepsia for their origin.” However, the author and his colleagues, while coming to the conclusion that there was indeed a link, could not say that all neurasthenic cases had gastric origins. In fact, dyspepsia was more likely a symptom than any kind of cause.²⁰¹ If, however, the patient was exhibiting gastric issues as well as neurological ones, the physician would be right to

¹⁹⁹ Ballet, Gilbert. *Neurasthenia*. Internet Archive. (New York: Paul B. Hoeber, 1909, c.1908). 126.

²⁰⁰ Ibid.

²⁰¹ Ibid, 127, 131.

treat the neurasthenia by treating the gastric problems.²⁰² Gastritis was only considered a supposed link to neurasthenic states.

On the other side of this debate were physicians like British doctor Thomas Dixon Savill, who published his findings that linked gastric disorders to neurasthenia in his 1908 book *Clinical Lectures on Neurasthenia*. Savill determined that 102 out of 157 neurasthenic cases at the Hospital for Nervous Diseases “were associated in some way with symptoms of gastric disorder.”²⁰³ Forty-six of the 102 cases had some gastric disorder from one to seven years before becoming neurasthenic.²⁰⁴ Only twenty-eight of his total cases had acquired a gastric disorder during or after neurasthenia; he does not specify how long after. To explain why some cases had a longer onset than others, Savill suggests that mental trauma, overwork, and strain were the contributing factors that resulted in neurasthenia in his patients in conjunction with the gastric disorders. Further proof of the connection between gastric disorders and neurasthenia came when Savill indicated that “as the digestion was gradually relieved, the neurasthenia began to disappear, even without any remedy directed to the nervous system.”²⁰⁵ In his 1911 edition of *Neurasthenia*, Savill still maintained that the neurasthenic/gastric connection was still just supposed, and that it was to deliberately misunderstand the neurasthenic to equate the incidental symptoms like gastritis with constant ones indicative of a

²⁰² Ibid, 132.

²⁰³ Savill, Thomas Dixon. *Clinical Lectures on Neurasthenia*. Internet Archive. (London: Henry J. Glaiser; New York: William Wood, 1908). 72.

²⁰⁴ Ibid, 72-73.

²⁰⁵ Ibid, 73.

disorder.²⁰⁶ Pte Bailey, previously presenting with shell shock symptoms, was now exhibiting symptoms more commonly associated with neurasthenia, according to his physicians who ascribed to the notion that gastritis and gastric problems were highly associated with neurasthenia. This would be a contributing factor to his being diagnosed as a neurasthenic later on.

On 22 July 1916, Pte Bailey reported from base to rejoin his unit, evidently requiring little or no convalescence from his hospital stay before being sent back to his unit. On 15 August 1916, a medical board reviewed his condition as it stood after being sent to Monks Horton, to be treated for acute articular rheumatism; he developed rheumatism in his right ankle and complained of palpitations. The physicians found that there was no organic lesion of his heart and that there was no evidence of rheumatism in his right ankle. On 25 October 1917 he finally set sail from Liverpool, England, for Canada. In the proceedings of the medical board at the discharge depot in Quebec City, the reason for his discharge is given as neurasthenia. It notes that he had a history of rheumatism and that he was also evacuated from France for shell shock. His present condition was that he was now “rather pale and complains of indefinite pains in the back while lying down. He is 45 years of age and fairly well developed.”²⁰⁷ They also noted that his heart and lungs were normal. His degree of incapacity was considered to be 10%, a disability that would last at least 3 months. The medical board did not consider any

²⁰⁶ Smith, P. Campbell and Gilbert Ballet. *Neurasthenia*. Internet Archive. (London: H. Kimpton, 1911). 381.

²⁰⁷ Library and Archives Canada, “Bailey, Fred. G.”

special treatment or appliance to benefit him, but just recommended time at home to rehabilitate. This was signed 1 November 1917.²⁰⁸

On 30 November 1917, his Medical History of an Invalid sheet expanded upon the reasons for which he was discharged: rheumatism, palpitation, and dyspnea nervousness. His rheumatism originated May 1915 and his palpitations and dyspnea nervousness in June 1916; both were acquired in France. The cause of his rheumatism was determined to be exposure on service, while his other ailments were put down to the strain of service.²⁰⁹ His condition as of November 1917 was

Slightly anaemic – face rather pasty appearance; complains of some pain in lumbar region: cannot bend over and touch toes: has palpitations, is nervous and tremulous – sleeps poorly; appetite indifferent: frequent headaches: some swelling in feet at night/ Urinalysis 1012 – no albumen – no sugar: slight dyspnea: lungs and heart normal: moderate general debility.²¹⁰

It would not be until 27 February 1919, when Pte Bailey reported to the Military hospital in Toronto with symptoms of neurasthenia, that discussions would begin about the possibility of his being discharged as medically unfit. Ultimately, this board recommended that Pte Bailey be “placed in Class E., and be allowed to pass under his own control – further treatment not being indicated.”²¹¹ The information listed by this medical board conflicts in multiple ways with the other medical information available in Pte Bailey’s file. First, the medical board reviewing his case in Quebec had noted that his

²⁰⁸ Ibid.

²⁰⁹ Ibid.

²¹⁰ Ibid.

²¹¹ Ibid.

experience with rheumatism had started in 1905, before the war. Another physician could not even detect a rheumatic flare up when he presented with pain in his ankle, supposedly due to rheumatism. Why the board concluded that his rheumatism was acquired from service during the war was not explained. Another aspect of this discharge form that conflicts with previous information in Pte Bailey's file is that his heart was considered normal and yet palpitations, alongside dyspnea nervousness, were a contributing factor to his being discharged.²¹² Dr. J. Abrams, a Toronto consulting physician and electro-therapist, in his 1895 book *Electricity: Its Mode of Action Upon the Human Frame, and the Diseases in Which It Has Proven Beneficial*, discusses heart palpitations with regards to nervous origins:

Though sometimes connected with organic disease of that organ, [palpitation of the heart] is far more frequently a mere symptom of some disordered state of the body or mind, such as dyspepsia anaemia, nervous debility from sexual excesses, protracted nursing, late hours, insufficient rest, or the excessive use of coffee, tea, or alcoholic stimulants.²¹³

Dr. Abrams recommends Faradic current “applied to the upper and middle portion of the spine as well as to the epigastrium” for treatment.²¹⁴ For these illnesses, Pte Bailey received medication and hospitalization in France and England. The sources do not specify what type of treatment he received, but they do indicate that he would likely not benefit from any further treatment beyond time away from the front. Moderate general

²¹² Ibid.

²¹³ Abrams, J. *Electricity, Nature's Tonic: Its Mode of Action Upon the Human Frame, and the Diseases in Which it Has Proven Beneficial, with Valuable Hints Respecting Diet, Etc...* Internet Archive. (Toronto: Dudley & Burns, 1895). 88.

²¹⁴ Ibid.

debility was his final diagnosis.²¹⁵ He had shifted from shell shock to neurasthenia to debility, the diagnostic shift from one illness to the next was based upon symptoms he was expressing. Had he been at a different hospital, his physicians could have easily diagnosed him with neuralgia or even myalgia and lumbago instead.

Private Thomas Essery was a 30-year-old moulder from Oshawa, Ontario, when he enlisted into the Canadian Expeditionary Force. He was married to Dorothy Ella and together they had four children: Helen, Dorothy Isabell, Reha, and Cecil. On 14 February 1916, he enlisted in Brantford, Ontario, in the 125th Overseas Battalion of the CEF. On 3 November 1917, Pte Essery was admitted to 21st Southern General Hospital in Birmingham with shell shock. From there he was transferred, on 21 December 1917, to Granville Canadian Special Hospital in Buxton.²¹⁶ He would stay at Granville until 20 June 1918. Initially, he was admitted to hospital on a straightforward diagnosis:

Patient is giving history of being wounded May/17 and being buried Sept/17. Before being buried he had difficulty in carrying on, after being buried he found himself with short breath, poor sleep, bad dreams, stuttering and trembling, and showing all the symptoms of ordinary shell shock.²¹⁷

Over the course of his stay at Granville, Essery's physicians noted that this condition continued to improve. His sleep was more consistent and lasted for greater lengths of time, his appetite was good, and he was sleeping well and "without dreams."²¹⁸ On the

²¹⁵ Library and Archives Canada, "Bailey, Fred. G."

²¹⁶ Library and Archives Canada, Personnel Records of the First World War, RG 150 "Essery, Thomas", RG 150, Accession 1992-93/166, Box 2930 - 50, Item Number 380596, Regimental Number 772866.

²¹⁷ Ibid.

²¹⁸ Ibid.

advice of his medical officers, however, it was determined that should he return to general service, his improved condition would deteriorate; he would revert to displaying symptoms of shell shock, resulting in his return to hospital or even to Canada. While soldiers were sent to convalescent and command depots in between hospitals and returning to their units, there was also the realization that even with physical rehabilitation, some soldiers could not expect to be returned to the front no matter the level or types of treatments they were receiving. Unless the soldier's prognosis was judged to be hopeless, he was sent to hospital, and rehabilitation attempts could span years. Granville was a special hospital outfitted to accommodate multiple types of treatments for dealing with shell shock or any other exhaustion or mental health-related problem that necessitated at least some convalescence. It was equipped with radiant heat apparatuses, electro-therapeutic apparatuses, massage, and orthopaedic gymnastics alongside other more recreational convalescent treatments like concerts, visits to nearby towns, and arts and crafts activities.²¹⁹ Many soldiers in this study found themselves staying here for long periods, sometimes having to return for treatment and convalescence.

Like Pte Bailey, Pte Essery's first status reports on his health, from November 1917, focused on his present condition which no longer reflected shell shock symptoms; with both men, there was a clear physical improvement which physicians took to mean

²¹⁹ Library and Archives Canada, War Diaries Collections, "Granville Canadian Special Hospital," RG9-III-D-3. Volume/box number: 5040. File number: 878, Item Number 2006032.

that they could no longer be said to have traditional or “ordinary” shell shock.²²⁰ A chest report in Pte Essery’s file explains that he was coughing a lot, mostly in the mornings and evenings, and that in conjunction with this he was experiencing a tightness in his chest and dyspnoea, or difficulty breathing, after walking short distances. Ultimately, doctors ruled that there were no physical problems with his chest and that his lungs sounded normal. This report, alongside other observational conclusions, suggested that his illness was becoming more mental than physical, which resulted in a shift in his diagnosis. The shift from shell shock to neurasthenia was not necessarily indicative of a lack of physical health issues but demonstrated that physicians could use the terminology fluidly depending on what criteria the patient did or did not meet. Some patients were nervous with tremors in their extremities and still some physicians would only diagnose them neurasthenic. Diagnoses were applied to the patient as the physician saw fit based on their own theoretical and ideological practices; because many and varied practices existed during the war, there could not be any standardization with regards to diagnosis.

According to Pte Essery’s Medical History of an Invalid form, completed at Park School Barracks on 16 October 1916, doctors considered his original disease to be shell shock due to his having been blown up while in service. Like Pte Bailey, Pte Essery was no longer considered shell shocked but neurasthenic. By way of explaining this shift in diagnosis, the doctors elaborated further in his present condition section: “when excited or disturbed by noise, becomes nervous, confused, dizzy and develops a headache in back part[. A]t such times must lie down and if quiet will pass [...] in an hour or so. Worse

²²⁰ Library and Archives Canada, “Essery, Thomas.”

several months ago. Improving.”²²¹ According to the physicians, Pte Essery’s objective present condition was:

Well developed, well nourished, adult. Nervous, sluggish in his movements, slight incoordination in movements and jerky movements of hands, and fingers. Fine incoordinated tremor of hands. Reflexes slightly exaggerated. Heart and lungs normal. Incapacity due to partial loss of function of nervous system due to shock from bursting shell.²²²

The two assessments indicate that physicians believed he was progressing to an acceptable level of physical fitness; he was fit, fed, and relatively normal. The only biological system affected was the nervous system; he had no disability according to his physician’s objective analysis. He had no dyspnoea. His disabling condition was expected to last 6 months and, unlike with Pte Bailey (in whose case doctors recommended he return home and be given time as no treatment was likely to help), Pte Essery was advised to seek hospital treatment of “10 months for neurasthenia.” This document was completed 8 November 1918.²²³ A recommendation for further hospital treatment initially seems severe, but in the context of the hospital as a place for rehabilitation during the First World War it suggests a more positive prognosis for Essery and his future as a rehabilitated soldier.

Private Bailey and Private Essery’s files reflect instances in which soldiers were diagnosed with shell shock, and then later diagnosed with neurasthenia. The reasons behind this, medically, were that they no longer presented “ordinary” symptoms of shell

²²¹ Ibid.

²²² Ibid.

²²³ Ibid.

shock.²²⁴ As the war progressed, the cases of shell shock increased during 1916 to the point where the military pursued redefinition, restriction of diagnosis, and alternatives to shell shock and enforced them upon the medical community. Pte Bailey and Pte Essery's case files are representative of this shift away from shell shock. At first it had to be proven that they were involved in incidents that were likely to produce shock; they were. Then the transient nature of shell shock symptoms became a target; if someone was not exhibiting nervousness, tremors, shakes, poor sleeping habits, poor nutrition, and nervous affectation then they should not be treated for such things, and their diagnosis should reflect this change in behaviour and experience. The fact that many soldiers would revert and return to hospital after being discharged, even the war, indicates that although symptoms were transient, mental affliction was not. Reducing a disease or illness to symptoms expressed reflects a medical and military system focused on rehabilitation as opposed to standardized medical care.

3.2 Case Study #2: Lieutenant Raymond Massey and Lieutenant Frederick Gates.

The second chapter explored how rank affected the treatment of NCOs and other ranks as opposed to officers. While the CEF was not a classist organization, because it was involved with the British Army, rank separation and segregation had a similar effect on Canadian soldiers' treatment as classism did on the British Army. Officers had access

²²⁴ Ibid.

to facilities that housed them in much smaller numbers and, in the case of convalescent homes especially, would not reflect a typical hospital environment but a more comfortable one. Large houses were converted at the request of wealthier families living in the countryside, and officers came to convalesce there. Even in institutions that treated officers and men in England, such as the King's College Hospital or the No. 4 London General Hospital, there were a certain number of beds reserved for officers. There were approximately 300 beds reserved for officers in No. 4 London General, one quarter of the total number of beds reserved for men.²²⁵ Even in specialized units such as tuberculosis and mental health units, officers were separated from men.

An example of an officer from this case study receiving specialized or abnormal treatment concerns Lieutenant Raymond Hart Massey. A student from Toronto, Lieutenant Raymond Massey was only eighteen years old when he enlisted in the 9th Battery, Canadian Field Artillery. On 18 June 1916, Lieut Massey was admitted to No. 4 London General Hospital, Denmark Hill, for neurasthenia. Unlike the medical case sheets for most NCOs in this study, Lieut Massey's intake medical case sheet file was empty save a signature from an unknown captain indicating that Lieut Massey had been seen and his condition approved of by a medical authority.²²⁶ What has been observed as typical of soldiers having suffered from a form of shell shock or neurosis and been sent to

²²⁵ King's College Hospital, Denmark Hill. "Our Wartime History." NHS King's College Hospital. <https://www.kch.nhs.uk/wwi/wartime-history>.

²²⁶ Library and Archives Canada, Personnel Records of the First World War, RG 150 "Massey, Raymond Hart." RG 150, Accession 1992-93/166, Box 6020 - 11, Item Number 137271.

a medical facility is an explanation of the incident, the present and objective conditions of the soldier, and sometimes a mention of family history, or any kind of status update on the patient over the course of his stay in hospital. That Lieut Massey had no explanation or record of his care suggests it was not necessary. According to a note dated 20 June 1916,

This officer suffers from disability noted above (shell shock). He was admitted to No. 5 Red Cross Hospital, at Wimereux, on 12 June 1916 and was there for a week. Was admitted to No. 4 General Hospital, London on 19 June 1916. He has lost all confidence in himself; thinks he will never be any good and dreads going back, and he is very nervous and shaky. Sir B. Dawson, A.M.S., considers this officer requires a complete rest. A change and sea voyage would greatly benefit this Officer.²²⁷

Sir B. Dawson AMS [Army Medical Services] was in fact Lord Dawson of Penn and “physician-in-ordinary” to King George V. Dr. Dawson became a major-general in the RAMC, assumed a baronage, and became active in the House of Lords in the 1930s.²²⁸ Dr. Dawson was also the doctor who tended to King George V on his deathbed. The fact that this highly educated and well connected physician would treat Lieut Massey is indicative of Massey’s rank as well as the importance of rank in treatment.²²⁹ Massey’s family was a prominent one from Toronto. His brother, Vincent, attended Oxford with William Lyon Mackenzie King and would eventually become Canada’s eighteenth governor-general.²³⁰ Dr. Dawson’s recommendations for Massey are indicative of their

²²⁷ Ibid.

²²⁸ Sisson, Edward Hawkins. *America the Great*. (Sisson, 2014). 2032.

²²⁹ Spingola, Deanna. *The Ruling Elite*. (Trafford Publishing, 2014.) 411.

²³⁰ Ibid.

shared social rank; no private would be sent on a sea voyage just to improve their constitution. That an officer had lost confidence in his abilities to perform his duties, however, was problematic and would require either convalescence or discharge.

Wimereux and No. 4 London were common destinations for officers afflicted with shell shock in this case study. Lieutenant Frederick A. Gates would be sent to Wimereux and then subsequently to No 4 London as would Lieutenant Wilfred Holloway. Lieut Holloway had been posted to the Ypres Salient. He was shelled and experienced subsequent nervous and nerve tissue problems in his back and legs that required some rehabilitation. He spent two weeks in Wimereux before being transferred to No. 4 London General Hospital in Denmark Hill. Physicians analyzing his case determined that he would not be fit for general service at this point and would require at least 2 and a half months' rest. They also determined that this "disability [was] contracted in the service" and that he had no control over the circumstances under which he contracted it.²³¹ Specifically, his shell shock was caused by a shell explosion. Lieut Gates was also a visitor of No. 14 General Hospital at Wimereux and then was transferred to No. 4 London General Hospital in Denmark Hill before being discharged to Canada. Lieut Gates was at Wimereux for a week, and at No. 4 from 4 July 1916 until 9 August 1916. It is unclear if his transfer to Shorncliffe Military Hospital was just for a Medical Board or if he was sent there and then permitted to return to Canada.²³²

²³¹ Library and Archives Canada, Personnel Records of the First World War, RG 150 "Gates, Frederick A." RG 150, Accession 1992-93/166, Box 6020 - 11, Item Number 137271.

²³² Ibid.

On 23 June 1916, Massey was permitted to leave for Canada. At that time, Massey was not necessarily considered mentally or medically unfit for service but was permitted to leave based on his belief that he could not adequately perform his duties. A medical examination was conducted on this officer, according to the procedure for soldiers wishing to be relieved of duty. It stated that his physique was good, his nutrition was good, and his heart, arteries, vision, and hearing were normal. Regarding the state of his physiology, doctors considered that all systems were functioning normally, without any affliction acquired at any point in his life, except his nervous system.²³³ Later, the physician expanded on this by saying: “Shell shock July 1916 full recovered, no disability due to service.” This assessment was performed in Toronto on 12 May 1919. Massey had served 15 months.²³⁴

Outside of these medical case sheets, little is understood about Lieut Massey’s condition. He was nervous and multiple references in his files indicate that he had tremors. The only other pages in his service file are pension and payment information that do not provide any more insight into his condition. His illness began in May 1916 and it was noted in his file that despite his wounds, he chose to stay on the front and is therefore deserving of convalescence. A month later, he was hospitalized, and then proceedings began for him to be treated and sent back to Canada.²³⁵ A key difference between this case of shell shock and others is that there is no explanation of the accident,

²³³ Library and Archives Canada, “Massey, Raymond Hart.”

²³⁴ Ibid.

²³⁵ Ibid.

and no discussion of neurasthenic symptoms despite a diagnosis as such. Despite not leaving service until 1919, he was granted leave to Canada on 23 June 1916, less than a month after presenting with shell shock to the Anglo-American Hospital in Boulogne. Massey was sent to Yale University to help train officers on the home front. Two years later, he was sent back to the war front, but this time to Siberia (on 26 October 1918) with the ammunition column. He was struck off strength on return to Canada on 21 April 1919.²³⁶ Massey would return to the military for the Second World War as a major in the adjutant general's branch in 1942.²³⁷ The following year he would be invalided back to Canada. He went on to become a prominent Canadian actor, earning two stars on the Hollywood Walk of Fame.²³⁸ His leave from the front was quick and reflective of a military priority that showed preference towards rank as opposed to medical needs.

3.3 Case Study #3: Private Allen Robertson Darby and Private Charles Stevens.

This final section explores the story of a soldier who should not necessarily be part of this study as he was not discharged as mentally or medically unfit. However, his case file raises an important element of the experience of the shell shock: the pretend patient. One of the biggest driving forces behind the attempt to rein in the liberal use of

²³⁶ IBID.

²³⁷ McGregor, Nancy and Patricia Wardrop, "Massey". In *The Canadian Encyclopedia*. Historica Canada. Article published February 07, 2006; Last Edited December 16, 2013.

²³⁸ IBID.

the diagnosis of shell shock, aside from needing hospital space and to maintain military strength at the front, was that a number of the soldiers presenting with shell shock to field ambulances and convalescent stations were thought to be faking their illness as a way to get away from the front. Because shell shock symptoms were so varied and inconsistent, the incidence of soldiers thought to be lying about having shell shock was apparently steadily growing. Officially, these men were called malingerers, people who feigned or exaggerated an illness as a means of avoiding their duty as soldiers. Historian Ben Shepherd discusses the presence of malingerers as becoming problematic by 1917 for the Canadian and British armies. At that point, a prominent trend was noticed in soldiers who were close to being discharged from hospitals: they were experiencing sudden onset hysterical episodes.²³⁹ The result would be a longer hospital stay and more time off duty and away from the front. This had multiple impacts through the medical and military systems. First, malingerers took up hospital space that could be used for newly more severely affected soldiers. A lack of space to treat patients would necessitate the creation of more convalescent centres. Second, Shepherd discusses the influence of malingerers on medicine itself. As soldiers presented with spontaneous hysterical episodes, neurologists and psychologists had to figure out how best to treat them. If neurological treatments were not going to work on a patient, psychologists would take over, employing treatments based on convincing patients that they were not actually sick or could be cured with relative ease. Physicians would start to use electricity as a way to

²³⁹ Shephard, *A War of Nerve*, 102.

show the patient that their symptoms were not physical but mental and to “reawaken [the soldier’s] sense of patriotism and masculine self-respect.”²⁴⁰

In another effort to cope with men who might be feigning shell shock to escape from the front or shirk duties, hospitals had tiered and tailored admission processes based on the severity of affliction, illness, injury, or disease. As explored in the treatment chapter, No. 7 Queen’s Hospital would identify patients based on illness type and then severity. The type of illness would determine the wing they were sent to - chest patients together, tuberculosis patients together, mental health patients together - and then the severity of their case would determine if the patient needed immediate treatment or if he just needed some rest.²⁴¹ The war diaries for Queen’s indicate that most of those who were admitted for nervous or shock-related illnesses just needed clean clothes, a shower, some food, and rest. Hospitals made it part of the admission procedure to account for men who were not sick, or at least required no specialized treatment.

There were frequent cases where soldiers were brought in for shell shock and then their diagnosis altered as their symptoms did. However, discerning the shifting diagnosis from the malingerer is difficult. One case where the malingering is more clearly expressed is Private Allen Robertson Darby. Pte Darby was a 21-year-old machinist and carpet-stretcher from Toronto, Ontario. On 17 August 1915, he was examined in Toronto and approved to be enlisted to the 35th Battalion. On 15 April 1916 Pte Darby was

²⁴⁰ IBID, 103.

²⁴¹ Canada Army No. 7 Canadian General Hospital, *A History of No. 7 (Queen’s) Canadian General Hospital, March 26th, 1915 – Nov. 15th, 1917*. (London: C.W. Faulkner, 1917). 44.

admitted to No. 3 Canadian Field Ambulance in Belgium for shell shock, staying ten days before being discharged back to his unit. On 3 June 1916 Pte Darby was admitted to No. 2 Canadian Field Ambulance for shell shock; he stayed for eleven days before being discharged back to his unit.²⁴² There is no medical history case sheet to document his stay at either of these field ambulances or to indicate what symptoms brought him in, his condition, or why he was discharged instead of transferred. In February, Pte Darby again returned to hospital, but this time was just simply listed as sick. Again, there were no forms to specify the type of sickness or the incident that brought him in. On 9 March 1917 Pte Darby received an appendectomy and 30 March 1917 he was well enough to be transferred to the Canadian Convalescent Hospital in Monks Horton. On 20 May 1917, as a result of having surgery, Pte Darby was up for a medical board review to determine whether he would be discharged home, remain in hospital, or be sent out to a command depot and ultimately return to the front or light duties. According to the record, he “states that his bowels never moved without having an enema till about four weeks ago. Is troubled with constipation at present time. Is using purgatives. Looks to be in good condition. This man does not tell an honest story.”²⁴³ In this case study, soldiers accused of misconstruing the facts were diagnosed with other mental afflictions that helped to explain why they might be misremembering or lying about something. Poor mental acuity, hallucinations, melancholic behaviour, hysteria, early onset dementia, psychic

²⁴² Library and Archives Canada, Personnel Records of the First World War, RG 150 “Darby, Allen Robertson.” RG 150, Accession 1992-93/166, Box 2292 – 68. Item Number 346820. Regimental Number 405237.

²⁴³ Ibid.

disturbances, and even “queer actions” are a few of the terms used to help explain the mental state of different soldiers. In the case of Pte Darby, no explanation is given even by the medical board personnel. On 21 May 1917, he was discharged from Monks Horton to as a category AIII and was destined for the reserve unit. On 26 March 1919 Pte Darby received a medical examination, standard for soldiers leaving the service who had no disability; his physique, nutrition, pulse, arteries, vision, hearing, and all-around general health were considered good. In the section that asks physicians to describe what systems were affected by the war, “digestive” and “nervous” were listed.²⁴⁴ From 15 April 1916 to 14 June 1916, he was diagnosed with shell shock but considered “recovered.” From 27 February 1917 to 21 May 1917, he was diagnosed with appendicitis and was also considered “recovered” from that illness.²⁴⁵ 4 April 1919 is the date of his discharge at the No. 2 District Depot in Toronto. He was 24 years old at this point and had been transferred from the 35th to the 4th Canadian Infantry Battalion. He was discharged on demobilization and not for any medical or mental health reasons.²⁴⁶

Shepherd mentions that physicians had a difficult time diagnosing the malingerer from the affected patient and some physicians even admitted that the line between the two groups was arbitrary and ultimately had to be approached on a case-by-case basis.²⁴⁷ As a comparison to Pte Darby, Private Charles Stevens was 24-year-old London,

²⁴⁴ Ibid.

²⁴⁵ Ibid.

²⁴⁶ Ibid.

²⁴⁷ Shepherd, *War of Nerves*, 102.

England-born chimney sweep who enlisted on 13 December 1915 into the 72nd Canadian Infantry Battalion. On 27 April 1917 he was admitted to No. 4 Stationary Hospital in Arques for “NYD Shell Shock.”²⁴⁸ Ten days later he was transferred to No 2 General Hospital in Havre for Neurasthenia, and on 23 May was transferred again to the 2nd Western General Hospital in Manchester for Neurasthenia. On 2 June 1917 physicians noted that the patient had a hysterical fit that lasted five minutes after when “falling, struck his occipital against a stone.”²⁴⁹ On 15 June he was transferred to the Canadian Convalescent Hospital in Woodcote Park, Epsom, for Neurasthenia. On 29 June he was discharged, but on 21 July he was admitted to the Canadian Convalescent Hospital in Eastbourne for mental observation due to hysteria. Stevens was in hospital for 71 days before being boarded for return to Canada. In each case, his condition was documented and changed accordingly. When he started presenting hysterical symptoms, family history was delved into as a potential explanation. Physicians found out that his father had in fact died in an asylum and that his sister was a known invalid.²⁵⁰ While the fall could have caused his seizures, it was not posited as a possibility but his family history with asylums was touted as the cause for his hysteria and fits. In the case of Pte Darby, no investigation was done into his present or past conditions. Physicians and hospital personnel did not even fill out a medical history case sheet for his shell shock visit. With Pte. Stevens his case was still explored medically, and he was eventually discharged for

²⁴⁸ Library and Archives Canada, Personnel Records of the First World War, RG 150 “Stevens, Charles RG 150, Accession 1992-93/166, Box 9283 - 5, Item Number 250672 Regimental Number 472815.

²⁴⁹ Ibid.

²⁵⁰ Ibid.

being medically unfit. The biggest difference between these two men's case files was that Pte Stevens, despite a known history of alcoholism and family history of invalidism, was still considered to have good character and was therefore worthy of medical treatment.

Conclusion:

The soldiers analyzed in this chapter were selected from a study of fifty men discharged from the CEF for being mentally unfit at some point over the course of the First World War. These men's experiences provide microcosms to examine what it meant on the ground for men to be diagnosed with shell shock and what it meant to be diagnosed with neurasthenia. Pte Bailey and Pte Essery's files demonstrate that shell shock was not always a permanent disability or mental illness, even though it could affect you permanently. How physicians recorded that and tracked that progression out of shell shock to neurasthenia was arbitrary and served a military war machine that required men out of hospitals and back on the front lines to maintain unit strength. Both men were shifted from a diagnosis of shell shock to neurasthenia as their symptoms shifted away from purely neurological. This was not an uncommon occurrence, and at least 20% of the soldiers in this study would bounce between these two diagnoses at least once.

Rank was important factor that affected how a soldier was treated in the First World War. Lieut Massey's family was well connected and his rank allowed him privileges. His treatments were better recorded and followed up on, he was able to see a doctor who worked for the royal family, and when he lost faith in his ability to perform his duties he was sent home to work with other officers at Yale to help train them for a few years. Most men, when sent home, did not have the option to return let alone the

option to remain in the army. If a soldier was sent back to Canada by reason of mental unfitness, it was because they could no longer be of service to the military. Officers and men in convalescent camps were offered different treatments and had access to different facilities that were outfitted with different equipment and physicians. One's treatment was strongly influenced by one's rank in the First World War.

Malingering has been an issue with armies as long as they have existed. Shirking duties and trying to get out of war is what obedience training works against. In the First World War, malingering was thought to be rife in hospital cases, specifically in mental health cases. In this case study, only one soldier could be identified as potentially malingering. His hospital case sheets were not filled out, his medical history was not explored, and treatment was limited. The only explanation for this arose in a medical board analysis of his case in which someone indicated that "this man does not tell an honest story."²⁵¹ Again, no explanation was offered, but in case files that usually explore a patient's complaints and comment on the quality of his character as a soldier, the lack of these two things indicate that he was considered to be a malingerer. Because this study focused on analyzing files that were discharged for being mentally unfit, isolating files that described malingerers was difficult.

A multitude of forces outside the soldier's individual health affected how they were diagnosed and treated. Military needs determined where they would go for

²⁵¹ Library and Archives Canada, Personnel Records of the First World War, RG 150 "Darby, Allen Robertson." RG 150, Accession 1992-93/166, Box 2292 – 68. Item Number 346820. Regimental Number 405237.

treatment, and how long they would be there. Physicians determined how their patients would be treated according to their training and practices. Officers and men were exposed to different levels of care. With all these factors at play in the CAMC during the First World War, the health care they provided could not be standardized.

4 Conclusion.

The First World War saw the advent, advancement, and application of new medicines, sciences, and technologies. While the term shell shock came into being during the First World War to describe men who had seemingly been mentally affected by shell explosions happening around them, psychological conditions brought on by the stresses associated with war, or war neuroses, were not a new category of disease. Physicians had been working with the insane, the hysterical, those of irritable heart, and the neurasthenic long before 1914. What the First World War changed about war neuroses was that it generated such a large number of psychological casualties as to threaten unit strength and to call into question contemporary notions of masculinity, sanity, and class. The field of psychology was able to expand its foothold in the world of medicine and academics due to the massive numbers of psychological casualties demanding treatment that traditional, physiologically-oriented physicians could not alone address. As the war progressed and these fields of medicine opposed each other on how exactly to classify and treat shell shock, conflict emerged between them, with psychologists wanting to secure their place as a valued specialty and neurologists defending their expertise on nervous disorders and the brain. In addition to this conflict, these physicians had to operate cohesively under the umbrella of the Canadian military to establish acceptable procedures and treatments that could be applied to all wounded soldiers. Yet war propelled all fields of inquiry forward at such a staggering pace that to expect a standardized mode of operation was improbable.

Psychology and neurology, two prominent fields of medicine, were both plagued by disagreements and disputes over what mental health was, how to treat shell shock, and how to distinguish a nervous, physiological disorder from a psychological one.

Neurology was an older field of medicine based on physical evidence of medical pathology; in treating shell shock, neurologists would take functional neurological approaches and try to assess if there were physical lesions present on nervous tissue.

They were more likely to employ electrotherapeutic treatments on shell shock and other neurologically afflicted patients. However, like most other physicians, neurologists were at a loss in explaining how to specifically treat shell shock and neurasthenia. Nerve pain and exhaustion could be treated with analgesics and sleep aids. To cure the shakiness and the tremors, outside of convalescence, neurologists looked to older treatments like electrotherapeutics to reset the body's nervous energy in non-responsive or poorly responsive muscles. Having been employed as a means of keeping paralyzed muscles active, Faradism and Galvanism were employed as ways to combat uncontrollable actions. Neurologists experienced some success with these techniques, but most soldiers would return to hospital with a resurgence of tremors; it was, at the very most, a short-term solution. Psychologists offered a different perspective; while physical symptoms directed their investigations, they were focused on the mentality of their patients.

Different types of psychologists put greater weight on other matters of importance: what soldiers' level of intelligence was, how their standard behaviours could be indicative of weak or poor mental abilities, what they were dreaming about, and how they perceived their illnesses. Assessing the mental status of the patient would help inform the physician about the origins of their patient's illness. Was it brought on from the war? Why? Does

their family history explain some hereditary mental weakness that predisposed them to a mental breakdown? All these questions and more directed multiple physicians' inquiries into the origins of and, ideally, the cure for shell shock. Fear became a central psychological point upon which the psychologist focused, often using coercive, hypnotic, and sometimes electrical means to convince patients that they were going to get better – or, in the case of the electrical stimuli, also to convince patients to stop malingering and return to the front. Electrotherapy, an old treatment but one that the public still poorly understood, was a startling technique and its instruments as well as the fact that it employed electricity was as much about intimidation as it was a muscular therapeutic tool. Physicians could agree that if a soldier was expressing nervous symptoms like shaking, tremors, or even an inability to move, he would receive electrotherapeutic treatments in the form of Faradism or Galvanism, alongside ionization baths, massages, and other relaxing convalescent treatments if their conditions permitted, in an attempt to correct the nervous energy in these men. Underlining all these different treatments and convalescent diversions that physicians had at their disposal for a patient was military need. Would the patient benefit from treatment to the extent that they could be rehabilitated? The goals of the medical community were undercut by the need to conserve manpower; what that meant for treatment was efficiency over efficacy.

The prioritizing of military efficiency over medical efficacy can be seen in war diaries as well as the case files. Prior to major military operations, men in hospitals who could be moved were ushered into command depots and convalescent hospitals to begin their army training again and get them back to the front. Space had to be made for new wounded and injured men; if a soldier appeared to be on the mend, he was taking up

triage space. Military efficiency over individual care and medical preference also emerged in the diagnostic process of treatment. As dramatic numbers of soldiers were being sent to England, and home, with shell shock, the army restricted use of the term only to those soldiers who had been involved in a shell explosion; even then, only physicians in hospitals could diagnose a soldier with shell shock. Convalescent hospitals, field ambulances, and rest stations could only assess and send a soldier back to a hospital if his condition was serious enough to require specialized treatment for shell shock. It became hospital protocol to give stable soldiers presenting with shell shock symptoms rest and relaxation their first night, as opposed to any specialized treatment, because it was assumed that most soldiers just needed a rest or were malingering.

Rank and classism also affected how a soldier with psychological afflictions was treated. Officers had specialized hospitals and convalescent homes designed for smaller, more manageable numbers of patients. Officers were also offered more specialized treatments like Faradism and Galvanism more frequently; in this case study, electrotherapeutic methods as treatments were only mentioned in officers' files. Men may have received electrotherapeutic treatments at the hospitals and convalescent homes, but their physicians did not record it in their files. How class operated to affect the treatment of soldiers was not in that it guaranteed officers better treatment, but that they were given more opportunities to improve their health. Specialized convalescent homes and officer-only events at hospitals resulted in better individualized care for officers suffering from psychological issues. Men and non-commissioned officers were subject to the same types of treatment, but because of rank they were more likely to be sent straight back the front if presenting with psychological issues. This was done to maintain the health of the

officers so as to maintain hierarchical organization of the military but also to maintain morale amongst the men; having officers who did not believe in their abilities did not engender obedience, strength, or success. Some physicians treated soldiers differently depending on their class and rank. Intelligence and education affected how a man was treated by his officers; if an officer felt that communication was impeded, there is evidence of physicians feeling disinclined to connect with men. While Canada believed itself a classless army, upper-class Canadians had strong upper-class British connections and the CAMC operated under the RAMC; both realities resulted in one class being treated better than another for the same or similar illnesses. If class and rank brought about different treatments and treatment levels, the CAMC could not have been offering its soldiers standardized medical practice.

My approach to the study of shell shock in this thesis has been to take the macrocosmic perspectives of other historians and apply them to individual case studies as a means of testing the validity of their research on the ground. In 2018 historian Mark Osborne Humphries released his book *A Weary Road*, an exploration of shell shock as it was experienced by the members of the Canadian Expeditionary Forces. In it, he argues that

Until the creation of the special hospitals after the Battle of the Somme, most cases of nervous illness evacuated from the front were sent to non-specialist base hospitals along the coast. The creation of a network of army-level hospitals, which began in December 1916 and continued throughout the winter of 1917, initiated a process of standardization which ultimately proved to be successful.²⁵²

²⁵² Humphries, *A Weary Road*, 254.

He goes on to say in his conclusion that the creation of specialized hospitals to treat shell shocked and other psychologically injured soldiers was an organic process that resulted in “the standardization of distinct diagnostic and treatment models at those hospitals.”²⁵³

These quotes struck me as an interesting starting point; could it be said that the processes and procedures instituted and implemented by the CAMC during the First World War were standardized? Were diagnoses and treatment equally applied to all soldiers at all hospitals? In the early stages of my research, I noticed that while the military was trying to streamline and make more efficient its medical practices for treating soldiers and sending them back from the front, those methods were more accurately described as broadly generalized practices rather than standardized ones. Restricting the use of the term shell shock, while permitting different medical specializations to operate on their own definitions of shell shock, was not standardization. Military hospitals employed electrotherapy, dream therapy, hypnosis, psychotherapy, and massage. Permitting officers to receive longer care in hospitals and at home, more specialized treatments, and access to different convalescent activities than other ranks is not standardization; it was tiered, generalized care that was, again, given at the discretion of the physicians treating these officers. Adding this historical lens to an analysis of First World War medicine will permit more practical understandings of the experiences of the men and connect the microcosm of the individual experience to the macrocosm of the institutions waging war in Europe.

²⁵³ Ibid, 318.

This case study explored the experiences of First World War Canadian soldiers at the front to determine if information in their medical case files corresponds to larger historical ideas about medical progress during the war. The concept that as the war progressed, medical diagnostics and treatment of soldiers with psychological issues became standardized glosses over the evolution of medicine and ignores the experiences of men on the ground. These case studies, alongside war diaries and medical books published during and after the First World War, offer evidence of what it meant to be involved in an evolving medical practice, not a standardized one.

In conducting research for this thesis, I noticed some inherent restrictions in my methodology that could inspire different case study projects. This study aimed to find a randomized sampling of soldier who were rendered mentally unfit at different points in the war (to create a broader understanding of their experience), but its opposite could be pursued. Case studies could be done on each year, during periods around major engagements, to provide a sampling of men exposed to similar conditions. It would be possible to explore the variations within this subset of individuals to determine if there was a shared reaction to a shared experience, and to examine how the medical community diagnosed and treated these individuals differently. Performing more case studies to amass statistically relevant data would help to test theories, and either reaffirm them or call them into question.

Exploring fifty case files of soldiers discharged for being medically unfit allowed this thesis to discuss the concept of standardization within military medical institutions. It revealed that because of intellectual, medical, military, and classist biases held by the medical and military communities, health care was unevenly distributed. In a medical

military system that supported treating ranked officers and men differently, permitted neurologists and psychologists to treat shell shocked and other psychologically affected soldiers differently, and prioritized military goals over the health of its soldiers was a system based on reactive generalized strategies as opposed to a standardized system of health care.

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Appendix A.

The fifty soldiers' names and regimental numbers used in this case study can be found in the table below. The regimental numbers and item numbers can be used to search the Library and Archives Canada Website where all their digitized First World War Canadian service records can be found.

Soldier	Regimental Number	Link
Roderick Lebreton	666630	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B5506-S022
Herbert Swaine	59942	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9448-S036
Hugh Boyd	348395	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B0974-S012
Philip Luckoshanko	105255	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B5786-S021
Jacquet Joe	51239	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B4841-S020
Lawrence McKay	165834	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B6933-S035
William Ingram Thompson	15440	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9665-S039
Ernest Fraser	502820	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B3279-S026
James Jackson	2762	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B4748-S031
Fred G. Bailey	21796	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B0344-S001
Wilfred A. Holloway	-	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B4451-S017
Raymond Hart Massey	-	https://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=6020-11
Frederick A. Gates	-	https://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B3438-S045

Gerald O'Grady	-	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B7432-S030
Walter James Barr	-	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B0460-S010
Lewis Earl Thomson	648890	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9650-S045
Herbert Edwin Osborne	648690	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B7495-S011
James Coulthard	451204	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B2047-S014
Silas Miller	404895	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B6196-S055
Herbert Graham Starr	-	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9245-S015
Charles Alexander Fallaize	192492	https://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B2986-S005
Frederick Binns	464585	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B0739-S003
Stanley H Cooper	79822	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B1977-S046
Ernest Lawson	440870	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B5468-S060
John Waters	703509	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B10120-S012
Ernest George Warman	428802	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B10097-S014
Gerasim Stecenko	448219	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9251-S014
James Ritchie	29620	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B8301-S009
Edward S Brooke	441865	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B1097-S011

George Augustus Fisher	602866	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B3106-S016
Stephen Osbourne Harvey	184152	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B4138A-S059
William Wickert	874573	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B10339-S013
Abram Funk	288151	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B3339-S001
James Salmond	-	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B8618-S002
Daniel Young	68263	https://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B10646-S036
Richard Edge	142470	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B2824-S041
Thomas Essery	772866	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B2930-S050
E. L. Baker	733360	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B0367-S045
Charles Leslie Mosher	2700740	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B6434-S017
Cyril Cedric Hughes	472417	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B4588-S009
John Dyce	24474	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B2787-S053
Vincent Maxted	71978	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B6061-S006
George Swanson	775965	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9455-S001
William Cady	696750	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B1371-S028
Thomas Moore	443868	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B6337A-S059
Frederick Charles Ernest Arnold	17093	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B0243-S004

David Denholm	472299	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B2437-S034
Charles Struthers	2204168	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9391-S045
Charles Stevens	472815	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B9283-S005
Allen Robertson Darby	405237	http://central.bac-lac.gc.ca/.item/?op=pdf&app=CEF&id=B2292-S068

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