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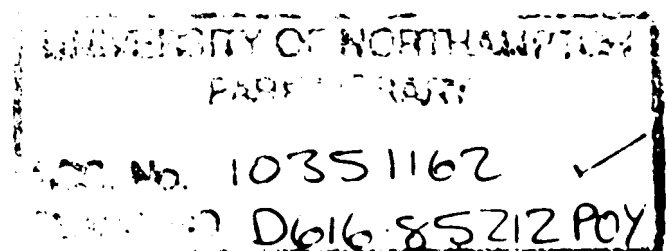


'The Report on her Transfer was Shell Shock'. A Study of the Psychological Disorders of Nurses and Female Voluntary Aid Detachments who served alongside the British and Allied Expeditionary Forces during the First World War, 1914 – 1918.

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2008

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'The Report on her Transfer was Shell Shock'. A Study of the Psychological Disorders of Nurses and Female Voluntary Aid Detachments who served alongside the British Expeditionary and Allied Forces during the First World War, 1914 - 1918.

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Ph.D

The University of Northampton

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ABSTRACT

Shell Shock, described as the 'emblematic psychiatric disorder'¹ of the First World War has long been synonymous with its soldiers. Its association with close proximity to exploding shells and thus the front lines, leading to the various symptoms of 'shock', has both facilitated and ensured its existence throughout the twentieth and twenty first centuries as a masculine affliction. Of the many shell shock studies that have been produced over the last few decades all have focused purely on the experience of the male combatant, predominantly because of this long held preoccupation with 'front-line' warfare and its consequences apparently being the preserve of men. Despite the prolonged interest and analysis of shell shock by medical and social historians along with a significant amount of work by feminist and, more recently, revisionist historians, detailing the involvement of women in the First World War, there is still no comprehensive study of the psychological problems encountered and suffered by the women who served alongside the British Expeditionary Forces (BEF). However, this study of the roles and duties of a specific group of women, namely nurses, voluntary aid detachments, and ambulance drivers, reveals they frequently endured a variety of traumatic experiences, involving injuries and fatalities, through the vicarious witnessing and dealing with horrific sights and sounds, all compounded by extremes of conditions and privations. Many, if not all, of these factors were given as antecedents for war neurosis in soldiers. Yet, while the nurse has been idolised for her role in the Great War, her experience of psychological 'breakdown' has not been examined.

¹ Allan Young. *The Harmony of Illusions. Inventing Post-Traumatic Stress Disorder*. (Princeton University Press, 1995)

This thesis, through the analysis of professional medical literature, of medical case notes, personal testimonies, diaries and autobiographies, is a contribution to the areas of women's history, medical history and, more specifically, to the history of psychological war trauma. Following a review of the literature in chapter one, chapter two is a re-examination of the proximity of nurses to the fighting zones and therefore of their exposure to danger. Chapter three analyses the nurses' experience and subsequent symptoms of war trauma, including, importantly, how contemporary medical authorities understood the disorder, and then cared for and managed their female sufferers. These two chapters fundamentally argue that the notion of war-induced traumatic neurosis being the preserve of men is essentially pretence, and that this 'focus' on male sufferers means the history of the condition is incomplete.

Chapter four essentially examines the issues of repatriation faced by these nurses, specifically examining the evolution of war disability pensions process of which they were excluded until 1920. It also looks at how the nurse, as female war veteran, coped with the consequences of her war experience.

In conclusion, this thesis asserts that these nurses did indeed suffer psychologically for their involvement in this war and not because their symptoms and disorders 'resembled' those experienced by men, but were in fact, indistinguishable to the extent that some nurses were classed as 'shell-shocked'.

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A very special thank you to my daughter, Sam, who always managed to say the right thing just when I needed it most.

DEDICATION

For Ian

LIST OF ABBREVIATIONS

ADS	Advanced Dressing Station
AMS	Army Medical Services
BEF	British Expeditionary Force
BRCS	British Red Cross Society
CCS	Casualty Clearing Station
CMS	Commissioner of Medical Services
DAH	Disordered Action of the Heart
DCMS	Deputy Commissioner of Medical Services
EEF	Egyptian Expeditionary Forces
FAP	First Aid Post
FANY	First Aid Nursing Yeomanry
GSW	Gun Shot Wound
HMHS	Her Majesty's Hospital Ship
LWPC	Local War Pension Committee
MEF	Mediterranean Expeditionary Force
MO	Medical Officer
MoP	Ministry of Pensions
NYD-N	Not Yet Diagnosed - Nervous
PTSD	Post-traumatic Stress Disorder
QAIMNS	Queen Alexander's Imperial Military Nursing Service
QAIMNS(r)	Queen Alexander's Imperial Military Nursing Service (Reserve)
RAMC	Royal Army Medical Corps
RAP	Regimental Aid Post
RMO	Regimental Medical Officer
TANS	Territorial Army Nursing Services
TFNS	Territorial Forces Nursing Service
VAD	Voluntary Aid Detachment
VDH	Valvular Disorder of the Heart

CHAPTER ONE

Introduction

There are others who suffered, to whose voices we must also attend.¹

In 1989 Sandra M. Gilbert stated, the effects of the Great War were 'in every case gender specific problems, problems only men could have'.² One 'problem', which has become synonymous with the men of the First World War, is that of 'shell shock'. It was a popular term rather than a medical one, created because of its alleged association with close proximity to exploding shells and thus the front lines. This view has both facilitated and ensured its existence throughout the twentieth and twenty-first centuries as a masculine affliction. However, contemporary medical authorities shunned its usage as early as 1915 in favour of more familiar medical terms such as neurasthenia and debility, claiming it was just one of a number of psychological reactions, classified under the heading of war neuroses, to the extremes of contemporary warfare. Yet despite a good deal of interest and analysis of the condition known as shell shock and its allied conditions by medical and social historians, along with the significant amount of work by feminist and, more recently, revisionist historians detailing the involvement of women in the First World War, there is still no comprehensive study of the psychological problems encountered and suffered by the women who served alongside the British and Allied Expeditionary Forces. These women, who served predominantly as qualified nurses, in Voluntary Aid Detachments (VADs) and as ambulance drivers, regularly witnessed and coped with horrific sights and sounds and were frequently called

¹ Jay Winter. 'Shell Shock and the Cultural History of the Great War'. *Journal of Contemporary History*. Vol. 35, No. 1 (2000) p. 10-11

² Sandra M. Gilbert. 'Soldier's Heart: Literary Men, Literary Women, and the Great War', in *Signs: Journal of Women in Culture and Society*. Vol. 8, No. 3 (1983) p. 423.

upon to endure the extreme and dangerous conditions of contemporary warfare, including shelling and bombing raids, all of which were held to be responsible for the range of symptoms seen in men who were diagnosed as 'shell-shocked'. Whilst the nurse has been idealised for her role in the Great War, her experience of psychological 'breakdown' has not been examined.

The intention of this thesis, therefore, is to examine the psychological conditions suffered by the women who served alongside the British Expeditionary Forces in France and Flanders during the First World War in order to challenge the idea that 'shell shock' and other psychological conditions resulting from warfare were solely masculine disorders. It will do this by, first, re-examining female nurses' proximity to danger. Previous studies have supported the view of First World War contemporaries, namely that women were protected. It is acknowledged that women did not serve in the trenches but this thesis will show that they were stationed in dangerous locations, for example in Casualty Clearing Stations (CCS). Casualty Clearing Stations were mobile medical stations and positioned as close to the fighting as was appropriate. However, because of the mutable nature of trench warfare and the increasing advances in technology and weaponry meaning firepower could reach further, it was sometimes the case that they were *too* close and working there could be extremely dangerous. Similarly nurses were stationed in base hospitals located in coastal towns such as Etaples for instance, and these frequently saw enemy action in the form of bombing raids.

Secondly, it will look at their roles and duties as nurses and how the many unpleasant tasks they performed may have contributed towards psychological trauma and illness. For example, nurses frequently dealt with injured and maimed men, nursing them sometimes until death. One factor that

was shown to induce breakdown in soldiers was seeing their comrades injured, maimed and dying in distressing circumstances. This thesis will argue that what nurses found themselves having to face was little different. It will also examine the symptoms displayed by the nurses and the diagnoses given to them by doctors and medical authorities and the ways in which these doctors treated their illnesses and complaints. It will ask whether they showed any bias or prejudice towards nurses given they were in a male dominated environment. It will also look at the system of financial compensation for nurses and the process by which they were finally awarded war pensions. Finally, this thesis will look at how these women, once taken ill, were managed from their removal from duty through to discharge, and how the experience of war trauma affected their repatriation into society.

When discussing the traumatic consequences of the First World War shell shock is the condition that frequently comes to mind. Shell shock as a subject has attracted much attention from scholars over the last four decades and has been described as the 'emblematic psychiatric disorder' of the First World War.³ It is a benchmark to which scholars turn when embarking on any study of war trauma. To suggest, therefore, that women suffered from this condition is a challenge in itself. Yet this thesis aims to make, not only a contribution to the history of women's involvement in war, specifically the First World War, but also to the many shell shock studies and the abundance of material relating to war-induced psychological trauma throughout the twentieth and twenty-first centuries by placing women into this discussion. To do this, this

³ More recently, scholars of the subject of war trauma have applied the psychiatric definition of Post-Traumatic Stress Disorder, (PTSD) the term that originated after the Vietnam War experience. As a term, PTSD, facilitates the use of a framework of symptoms and experiences with which to study Shell shock and other war-related psychological disorders; symptoms of mental disturbance including 'flash-backs', nightmares, mutism, memory loss etc. See also Allan Young. *The Harmony of Illusions. Inventing Post-Traumatic Stress Disorder*. (Princeton University Press, 1995) p. 1.

thesis will first review the literature that has discussed how women have been addressed in relation to the history of modern war.

The Woman's Place in the History of Modern War

Mainstream historiography, and particularly traditional military history, of the First World War has tended to avoid any serious analysis of women, and has primarily dealt with the causes of the war, military strategy and the development and evolution of weaponry in the first 'industrialised' war. The tendency has been to 'employ categories that masked the realities and complexities of women's participation in ...conflict'.⁴ Traditional historical analysis saw women subsumed to the home front, as problems requiring evacuation and protection, or, where they filled men's pre-war roles, as 'interesting but temporary anomalies'.⁵ Where women have been included it is largely to see them, and the various role they took on, as anomalous, temporarily included and, on the whole, unaffected by their experiences. With the exception of Arthur Marwick, who has written on the positive effects of war on women's lives,⁶ most traditional historians present a marginalized view of women, mentioning them briefly in chapters confined to the home front.⁷ Indeed, even some feminist historians have echoed a similar view and argued that any significant advances to women's positions in society was really only the result of changes on the home-front.⁸

⁴ Margaret R. Higonnet, *et al.* (Eds) *Behind the Lines. Gender and the Two World Wars*. (New Haven: Yale University Press, 1987) p. 2.

⁵ *Ibid.*

⁶ Arthur Marwick. *Women at War, 1914-1918*. (London: Fontana, 1977)

⁷ See for instance, Trevor Wilson. *The Myriad Faces of War*. (Cambridge: Polity Press, 1988) J.M. Bourne. *Britain and the Great War, 1914-1918*. (London: Edward Arnold, 1993) Eric Leed. *No Man's Land: Combat and Identity in World War One*. (Cambridge University Press, 1979)

⁸ Anne Wiltsher. *Most Dangerous Women. Feminist Peace Campaigners of the Great War*. (London: Pandora, 1985) Wiltsher studied women's role in the pacifist movement but viewed them within the confines of the home-front where they were embroiled in contemporary gender politics. See also Gail Braybon *Women Workers in the First World War. The British Experience*.

Perhaps one of the more extreme views of women during wartime is that held by social historian, Trevor Wilson, who highlighted the contempt in which combatants were alleged to hold civilians, particularly female civilians. Certainly some war veterans emphasised the gulf in experience between combatants and civilians, but Wilson seemed to echo this through the anti-war sentiments of war poet Siegfried Sassoon who protested at the ignorance of civilians. Of the effects of war on women, Wilson writes

It must be said that, excepting those mothers and wives and brides to be whose loss of men folk was never made good, the female experience of war was highly privileged compared with that of most able bodied males. It was the latter who, by choice or (increasingly) compulsion, conformed to military direction, suffered under gunfire, saw comrades mangled, inflicted death in close combat or at remote distance, possibly sustained atrocious injuries, and sometimes died abruptly or lingeringly. For non-combatants, and this meant virtually all females, the desire to care might be present, but the gulf between experience and its absence was well nigh unbridgeable. Siegfried Sassoon recognised, and was enraged by, it.⁹

He continues by arguing they [women] could never really understand what war was like for men and that they could only live the experience vicariously through them, since it was only men who made the 'supreme sacrifice', because it was only men who 'suffered under gunfire, saw comrades mangled, inflicted death in close combat or at remote distance, possibly sustained atrocious injuries, and sometimes died abruptly or lingeringly'.¹⁰ However, Nosheen Khan, in *Women's Poetry of the First World War*, when comparing the poetry of men and women, found that male writers often 'distorted images of the role played by women in war, images not a little touched by their misogyny and homosexuality, (which) being the only ones widely known, become embedded in the modern

(London: Croom Helm, 1981) and Angela Woollacott *On Her Their Lives Depend*. (Berkeley: University of California Press, 1994)

⁹ Trevor Wilson. *The Myriad Faces of War*. p. 710.

¹⁰ *Ibid.* p. 708.

consciousness and are accepted as the norms of female behaviour at the time'.¹¹

Stephen Cullen has similarly argued that combatants' misogynistic tendencies were generally directed only at those women (and, indeed, men) who either profited from the war, were engaged in the white feather campaigns, or who worked and profited as prostitutes. In short, any 'hostility towards women was on the activities and attitudes of some women, not women as a sex'.¹² It can be said, therefore, that Wilson's views towards women in wartime are curious at least and he similarly appears to forget that up till 1916 men volunteered for service. Furthermore, Wilson's views compound the idea that the trench experience was the war experience. It is the persistence of this view in particular that has seen women excluded from any analysis of the consequences of warfare, in particular the psychological consequences. Whilst this thesis acknowledges the extreme conditions of serving in certain forward trench areas, it will argue that the traumatic consequences of warfare could result from experiences that extended beyond the trench boundaries, and so encompassed women.

Adherence to the views of Wilson, or poets like Sassoon, promotes the idea that war was dull and unexciting for women and hell for soldiers and further exacerbates a gender conflict whereby the experiences of men and women become polarised. This thesis echoes the sentiments of Lucy Noakes.

Women's memories of wartime are less likely to appear in official discourse; memories of bombardment, grief or simply coping with wartime exigencies of family, work and shortages of food and fuel are far less likely to be memorialised than the

¹¹ Nosheen Khan. *Women's Poetry of the First World War*. (London: Harvester Wheatsheaf, 1988) p. 2.

¹² Stephen Cullen. 'Gender and the Great War. British Combatants, Masculinity and Perceptions of Women, 1918 - 1939.' (Unpublished PhD., Oxford. 1998). p. 184.

experiences of male combatants. When women write or speak about these experiences, their voices often sound less confident, and quieter, than men's. The valorised role of the male combatant in public, national narratives of wartime, has served to marginalize both memories and representations of the female experience of total war.¹³

A misleading picture has therefore emerged over the twentieth century, one that has failed to acknowledge the diversity of life at the front amongst men and women in 1914-18. For instance, the experiences of men alone varied greatly. Forty two per cent of men were physically unfit to fight and not all men at the front were fighting soldiers.¹⁴ Similarly, the nurse and female Voluntary Aid Detachment (VAD) as portrayed in Horace W. Nicholls' portrait 'Reverie: A Red Cross Worker' has been viewed as one of self-sacrificing, caring, nurturing angel, immune to the horrors and traumas of the front.¹⁵ Another popular female image is that of a band of women, who,

In the service of their country, nurses and VADs wore overalls and aprons, jodhpurs and trousers, heavy boots, and 'little red capes' or 'little grey capes with red edging' designed it was said, 'to hide the top part of their anatomy from the men they had to nurse'.¹⁶

These views are, arguably, highly romanticised views of the women who served in the First World War and are not generally supported by research. Conversely, the experiences of an elite few may serve to distort completely this view, such as the example of Flora Sandes who served as a female soldier in

¹³ Lucy Noakes. 'Gender, War and Memory: Discourse and Experience in History.' In *Journal of Contemporary History*. Vol. 36 No. 4 (2001) p. 664.

¹⁴ Lynda Dennant. 'A Civilising Mission? Women at the Front during the First World War: The Politics of Class, Gender and Empire. (Unpublished Ph.D., Warwick. 1998) p. 6.

¹⁵ (IWM Q31011) The image shows, through a romantic title, a prettily posed figure of a young VAD clearly presenting the role of these women as reassuringly feminine. The starched cotton uniform is reminiscent of a nun's habit and portrays the traditional attire of a dedicated woman. The faintly virginal religious aura is further strengthened by the presence of Madonna lilies in the background. It is a popular image, one that sees the woman nurse and Voluntary Aid Detachment (VAD) as the female equivalent of the male war hero, the male volunteer soldier.

¹⁶ Laurie Kaplan. 'How Funny I Must Look With My Breeches Pulled Down To My Knees': Nurses' Memoirs and Autobiographies from the Great War'. In *Rodopi Perspectives on Modern Literature*. Vol. 24, 0923 - 0416 (2001) p. 1.

the Belgian Army. Her experience is somewhat extreme and anomalous, as is the experience of the Baroness de T'Serclaes, born Elsie Knocker, who served as a nurse in Belgium throughout the war, whose story is less than representative of nurses as a whole. Perhaps representative of the view towards women who wanted to offer their skills to the war effort abroad, was the comment made to suffragist doctor Elsie Inglis, who was advised by the Royal Army Medical Corps to 'go home and sit still'.¹⁷ Despite this, a number of women, arguably with class, status and importantly, money, were able to establish themselves strategically on or near the front, and were soon followed by significant numbers of female volunteers, who offered their services

Driving ambulances and staffing stationary hospitals, casualty clearing stations, hospital barges, aide posts, psychiatric wards, and rehabilitation units across the Eastern, Western, and Home Fronts.¹⁸

The military was thus forced to concede and recognised that the services of military nurses were both valuable and vital to the war effort.

The accounts of the Great War's women writers have, themselves, to some extent, further compounded the popular and romanticised image of the female volunteer. Acknowledgement must be given to the possibility that these women were just as likely to distort or exaggerate their experiences in much the same way that the men did, and, that only a few actually recorded their experiences leading us to formulate unrepresentative images of the nurse in this war. Yet in many cases accounts of this nature still serve as valuable testimony for understanding the personal experience of trauma. For instance, Vera Brittain's personal account, *Testament of Youth*, published in 1933 as part

¹⁷ Margot Lawrence. *Shadow of Swords: A Biography of Elsie Inglis*. (London: Michael Joseph, 1971.) p. 98. Cited in Sharon Ouditt. *Fighting Forces, Writing Women. Identity and Ideology in the First World War*. London: Routledge, 1994). p. 8.

¹⁸ Laurie Kaplan. 'How Funny I Must Look...' p. 1.

of a wave of anti-war literature, was typical of a middle class woman's personal experience of war. It chronicled her experiences of being a 'young woman from a provincial middle-class background, without medical training, going off to war to nurse as a way of comprehending the experiences of the men closest to her...'¹⁹ Brittain gave up her studies at Oxford University to become a VAD in South London in 1915. She was stationed in Malta and near the front in France before concluding her war service in London. Her account, albeit the record of a middle-class woman, nevertheless recalls what was expected of her and of a number of these young and relatively untrained women. For example, whilst in France she arrived for duty one morning to discover her 'medical hut' had been turned in to a surgical ward overnight with 40 desperately wounded men. She found herself

Gazing, half hypnotised, at the dishevelled beds, the stretchers on the floor, the scattered boots and piles of muddy khaki, the brown blankets turned back from smashed limbs bound to splints by filthy blood-stained bandages. Beneath each stinking wad of sodden wool and gauze an obscene horror waited for me.²⁰

Brittain's work characterises perhaps more than any other, the experience of some of the women who went to the front, and, is of particular interest for this thesis, in that it demonstrates how she and other young women were required to endure extremes in the course of their nursing duties and roles, and, more importantly, how many went on to suffer the psychological consequences of their war service. Indeed, Brittain herself went on to suffer psychologically as a result of her war service.

Despite much post-war analysis, particularly of the two world wars, the 'mythical differentiation between men and women in relation to war has

¹⁹ Vera Brittain. *Testament of Youth. An Autobiographical Study of the Years 1900 - 1925*. (London: Gollanz, 1933) p. 195

²⁰ *Ibid.*

persisted.’²¹ Yet this began to change as the ‘dissonance between myth and reality attracted a new generation of historians, particularly revisionist historians, frustrated by the power of popular belief’.²² The imbalance previously posed by traditional historical analysis, i.e., that the war is a purely masculine enterprise, is being challenged by revisionist and feminist historians. Both interesting and varied, these studies have shown that women occupied a number of secondary roles, both at home and near the front lines, as auxiliaries or in paramilitary units, but almost always the format has been to compare and justify the woman’s existence in a man’s world. In short, the experience of the soldier remains paramount and therefore anything the woman experienced is often negated. This is especially the case where the traumatic experiences of this war have been concerned and is a significant concern of this thesis, which will argue that, while historians have been busy comparing and contrasting the woman’s role with that of the soldier, they have failed to acknowledge the women’s traumatic experience. The nurse’s experience of trauma during this war has resulted in symptoms of shock and of neurosis, and revealed by this study, all of which can be argued to be the same as those seen in soldiers. This means that comparisons are unnecessary. In short, this thesis claims a woman’s battle to come to terms with her war experience was (and is) just as real as any man’s. It is to some of the works conducted in relation to women’s specific experience of the war of 1914-1918 that this thesis will now turn.

²¹ Margaret Higonnet. *Behind the Lines*. p. 2.

²² Daniel Todman. ‘Representations of the First World War in British Popular Culture, 1918 - 1998’. (Unpublished PhD., Cambridge. 2003) (Abstract). See also Daniel Todman. *The First World War: Myth and Reality*. (London: Hambledon, 2005); Gary. D. Sheffield. *Forgotten Victory: The First World War, Myths and Realities*. (London: Review, 2002); and Brian Bond *The Unquiet Western Front: The First World War in Literature and History*. Cambridge University Press, 2002)

Women and the First World War

The first major contribution, and groundbreaking study, came from Sandra Gilbert in 1983.²³ In 'Soldier's Heart: Literary Men, Literary Women, and the Great War' she claimed that the Great War witnessed a 'crisis of masculinity', which manifested itself in the psychological illness seen in soldiers. According to Gilbert, the war created a disturbance that resulted in an imbalance between the sexes. Gilbert's main argument was that all the world became

Topsy-turvy, since the War began... [and as] young men became increasingly alienated from their pre-war selves, ... immured in the muck and blood of No Man's Land, women seemed to become, as if by some uncanny swing of history's pendulum, even more powerful. As nurses, as mistresses, as munitions workers, bus drivers, or soldiers in the "land army", even as wives and mothers, these formerly subservient creatures began to loom malevolently larger.²⁴

She claimed that the 'crisis' came about as men struggled to come to terms with their imprisonment in the trenches while women benefited from the war's experience because it increased and promoted their freedoms, and therefore instilled in them a new found sense of confidence. Gilbert's work remains controversial, mainly for its conclusion.

The war to which so many men had gone in the hope of becoming heroes ended up emasculating them, depriving them of autonomy, confining them as closely as any Victorian women had been confined.²⁵

This view was mirrored in Gilbert and Gubar²⁶ in 1989, with *No Man's Land. The Place of the Woman Writer in the Twentieth Century. Vol. 2. Sex Changes*, which argued again for a powerful reversal of gender relations. They

²³ Sandra Gilbert. 'Soldier's Heart...' p. 424.

²⁴ *Ibid.* p. 424.

²⁵ *Ibid.* p. 443.

²⁶ Gilbert and Gubar. *No Man's Land. The Place of the Woman Writer in the Twentieth Century. Vol. 2: Sex Changes*. (London: Yale University Press, 1989) 258 - 323.

specifically argued that the figure of the nurse came to occupy a dominant position over 'emasculated' men. They suggested that nurses, rather than being passive, were more mobile than men, operating outside of the trenches and therefore in a more dynamic position, which contributed to their economic and sexual freedom. This thesis argues this may have had more to do with issues of class than gender since the majority of nurses were from middle and upper class backgrounds and the soldiers they nursed were often from the working classes. Furthermore, and regardless of any increased mobility of freedom, this thesis will show that these women were just as susceptible to the horrors of war and thus to war trauma.

Gilbert also claimed that, particularly as a result of the male First World War experience, 'a barrier of indescribable experience'²⁷ had been pushed between the sexes. In 'The Matrix of War: Mothers and Heroes' Nancy Huston similarly wrote, 'war is the only human activity that signals masculinity to the same extent that childbirth signals femininity'.²⁸ She continued by suggesting that 'women are always perceived as dangerously weakening and polluting to masculinity in war'.²⁹ Francois de Witt-Guizot has also stated, '[i]t seems paradoxical to unite these two words: women and war'.³⁰ However, this thesis suggests that any 'barrier of indescribable experience' was more discernible between the *home* and the war front, and not, as Gilbert claims, between the sexes. Furthermore, the idea of any 'indescribable experience' is weakened when the psychological experiences of women at the front are examined

²⁷ Sandra Gilbert. 'Soldier's Heart...' p. 424.

²⁸ Nancy Huston. 'The Matrix of War: Mothers and Heroes' in Susan Suleiman (Ed) *The Female Body in Western Culture*. (Cambs, Mass: Harvard University Press, 1986) 119 - 136.

²⁹ *Ibid.*

³⁰ François de Witt-Guizot. 'La femme et la guerre: Comment une femme peut-elle servir la France en temps de guerre?' Deux Conférences données à l'Action sociale de la femme. Paris, 25 Avril et 6 Mai, 1912. (Auton 1913) Cited in Margaret Darrow in 'French Volunteer Nursing and the Myth of War Experience in World War I.' *American Historical Review*. (February 1996) p. 80.

alongside those of the men. Many women, who similarly left the shores of Britain early in the war in order to 'do their bit', shared the men's feelings of adventure and excitement. Similarly, those same feelings, which were rapidly to descend into those of 'darkness', were also shared. However, Gilbert and Gubar's work does allow for two pertinent questions to be re-asked, namely, '[w]hat part, ...did women play in the Great War?'³¹ and did they 'experience the wound of the war in the same way that their sons and lovers did?' This thesis will argue that the role of the nurse was as important, in many respects, as that of the soldier, and the execution of this role placed them close enough to the danger to the extent that they would go on to suffer from psychological trauma and illnesses that necessitated their removal from duty, or even their discharge from service altogether.

It is important to look at the role and the status of nurses during the Great War in order to question if, and how, perceptions of these factors, both of themselves and by others, operating as they did within a masculine environment, influenced their predisposition towards psychological illness. For example, did being in the role of 'carer' add to, or offer some form of immunity, towards psychological illness? Anne Summers' landmark study of military nurses in 1988, *Angels and Citizens; British Women as Military Nurses, 1854 - 1914*,³² provided the first detailed study of military nursing as a newly emerging profession, but it did not address the personal experiences of these nurses. It contained a detailed account of the development of military nursing and the creation of the Voluntary Aid Detachment prior to the war of 1914. It also revealed how military nursing became a respectable profession involving and recruiting women from the middle classes, largely because the military felt that

³¹ Gilbert and Gubar. *No Man's Land*. p. 199.

³² Ann Summers. *Angels and Citizens. British Women as Military Nurses 1854 - 1914*. (London: Routledge, 1988)

it was only middle class women who would be able to cope with the horrors of warfare. This thesis will argue that neither class nor gender offered any immunity or protection for women from experiencing war trauma but these factors may have influenced the manifestation of their symptoms and, in turn, their coping strategies.

In 1990, Claire Tylee³³ did much to include women's writing in the canon of literature of the Great War. She criticised earlier writers for focusing too heavily on men's experience of the war. This was followed by historian Lyn Macdonald's work, *The Roses of No Man's Land*.³⁴ Macdonald's work encapsulated the role of the inexperienced female volunteer who stepped from her Edwardian confines into the horrors of the front and became the heroic female equivalent of the volunteer soldier. Relying heavily on the evidence of diaries and of oral testimony, she reconstructed the lives of nurses during the First World War, but, as her title suggests, she endorsed the idea that nurses were self sacrificing angels of mercy despite some evidence to the contrary in her selection of material.

In 1994 in *Fighting Forces, Writing Women. Identity and Ideology in the First World War*,³⁵ Sharon Ouditt deconstructed the image of the passive and marginalized woman at the front. She argued that constraints on femininity ultimately resulted in the failure of women to progress socially and politically despite the advances made in the war. In short, women were 'forced' to be 'feminine' even in war and even more so once they returned home so any

³³ Claire Tylee. *The Great War and Women's Consciousness: Images of Militarism and and Womanhood in Women's Writing 1914 - 1964*. (Basingstoke: Macmillan, 1990)

³⁴ Lynn MacDonald. *The Roses of No Man's Land*. (Harmondsworth: Penguin, 1993)

³⁵ Sharon Ouditt. *Fighting Forces, Writing Women*.

possibility of liberation was lost.³⁶ With regard to the issue of gender this thesis will similarly question whether the role of gender had a part to play in the context of war trauma and if gender similarly influenced the manifestation of symptoms.

In 1996, Margaret Darrow in 'French Volunteer Nursing'³⁷ argued that nursing in wartime was particularly difficult because it had to take place in a masculine environment. In order for the nurse to survive she had to be able to project the male myth of war and projecting this myth meant being very feminine. While many women projected a very feminine stance, others similarly adopted masculine traits in order to survive in a man's world and which may have been a possible coping strategy in itself. (This was reflected in the behaviour of some nurses who smoked and who cut their hair). Adopting these traits may have had implications for the expression, or non-expression, of psychological symptoms and disorders. For example, this thesis will argue that women 'adopted' some masculine disorders, in particular that known as Disordered Action of the Heart, in order to communicate their distress in a military environment. Margaret Darrow also states, in relation to the studying women and war:

The difficulty almost all commentators displa[y] in relating women to [...] war is evident in their ambivalent views of all the possible postures women could take [...] from the most traditional, of waiting, praying and grieving, to the most radical, of donning uniforms and serving in the military.³⁸

For Darrow there is no 'middle ground' and she highlights the fact that these commentators either 'trivialized' women's war work, such as calling munitions

³⁶ In relation to the barrier of femininity, Leah Leneman 'Medical Women at War' *Medical History*. Vol. 3 (1994) 160 - 177, claimed that women failed to advance in their roles as doctors within the confines of the British Army. Any progress made by British women doctors was done so because they served with the Allied Forces.

³⁷ Margaret Darrow in 'French Volunteer Nursing' p. 80.

³⁸ *Ibid.*

workers, 'munitionettes', to claiming that some were 'war profiteers' because those who did charity work for soldiers, refugees and war orphans were 'merely filling their social calendars', and women who 'adopted' soldiers through correspondence were mainly interested in 'flirting'. War widows' mourning was 'insincere', 'fashionable', or 'excessive'.³⁹ So, claims Darrow, 'volunteer nursing offers us the best example of the pervasive unease with any connection between women and war. The nurse offer[s] the best possible parallel to the soldier.'⁴⁰ This thesis echoes Darrow's sentiments when she states that despite this, 'the intrusion of the nurse into the war story barely survived the war itself'.

While the stone and bronze of war memorials and the pages of fiction and popular memoirs commemorate the trench fighter, nurses have disappeared from the national memory.⁴¹

Janet Watson's study, 'Khaki Girls, VADs, and Tommy's Sisters: Gender and Class in First World War Britain' made reference to the comparisons between men's and women's war work, during which, she stated, the war

Acted as a battleground for a struggle over gender: setting limits to what women might do, defining how they should behave, and also defining their position in society relative to that of men. Different types of war work were seen as socially acceptable or problematic for different groups in comparison with perceptions of other groups. Thus, while gender and class shaped perceptions of war work, at the same time war work shaped ideas about gender and class.⁴²

In 1998 Lynda Dennant produced her thesis on nurses and nursing in the First World War, 'A Civilising Mission? Women at the Front during the First

³⁹ *Ibid.*

⁴⁰ *Ibid.* p. 83.

⁴¹ *Ibid.*

⁴² Janet S. K. Watson. 'Khaki Girls, VADs, and Tommy's Sisters: Gender and Class in First World War Britain.' *The International History Review*. Vol. xix, No. 1 (February 1997) p. 33.

World War: The Politics of Class, Gender and Empire'⁴³ in which she challenged the notion that women were impeded by their gender, that they were weak, slow and unskilled and only fit for the role of nursing. The existence of a professional nursing body proved inadequate for the casualties of modern warfare and it was left to middle and upper class women who were considered more suited for the job. Only when there was a crisis of manpower were working class women recruited. As a result she concluded that there was no authentic female experience of war and women's experience of this war was therefore as varied as the women themselves, and which this thesis endorses. However, she also went on to claim that, because women imagined the front to be the heart of the war, an area they were excluded from, they had to construct their own front in order to feel a part of it. Dennant's view echoes, surprisingly, the sentiment of Ernest Hemingway who served in the Ambulance Corps, and said that 'women's lack of war experience forced them to borrow from men who had war experience'.⁴⁴ This thesis takes issue with this claim and argues that women, like men, experienced the front with no degree of uniformity. Rather, for both, it was more a complex set of experiences, and more importantly, women did not need to construct their own front in order to feel included.

In 2000 Angela K. Smith published *The Second Battlefield: Women, Modernism and The First World War* in which she 'explores written representations of First World War experience ...by women'.⁴⁵ Smith writes that the 'men and women who made up the medical personnel of the First World

⁴³ Lynda Dennant. 'A Civilising Mission?'

⁴⁴ Cited in Sharon O'Brien. 'Combat Envy and Survivor Guilt: Willer Cather's Manly Battle Yarn' in Helen Cooper, Adrienne Auslander Munich and Susan Merrill Squier (Eds) *Arms and the Woman: Gender and Literary Representation*. (Chapel Hill: University of North Carolina Press. 1989) p. 186. Also cited in Margaret Higgonet. 'Authenticity and Art in Trauma Narratives of World War 1' *Modernism/Modernity*. Vol. 9, No. 1 (2002) 91 - 107.

⁴⁵ Angela K. Smith. *The Second Battlefield: Women, Modernism and the First World War*. (Manchester University Press, 2000)

War did not, for the most part, operate in the line of fire, but they were very often close enough to experience the activity of the front line in a unique way [and that] service on 'the second battlefield' brings its own rights and privileges, [which] in many cases, enabled them to produce written records from an unusual perspective. They were not soldiers, did not experience actual combat, but were still exposed to many of its most disturbing results'.⁴⁶

The work of Angela Smith is interesting for this thesis as she confirms that much of the interwar writing was by men and about the trench experience, with the implicit assumption that the lack of writing by women was because they were not so deeply affected by the war. In her deconstruction and analysis of specific texts, including Rose Macauley's *Non-Combatants and Others* and *Not So Quiet* by popular novelist Evadne Price under the pseudonym of Helen Zenna Smith,⁴⁷ Angela Smith argues that in order to communicate their distress they employed, consciously or otherwise, new forms of expression in their writing. For instance, she argues that *Not So Quiet*, a direct response to *All Quiet on the Western Front*⁴⁸ offered a complex retort because it

Deconstructed both feminine and masculine codes to identify a universal suffering; a female retelling of the story of a complete generation, not just a generation of men.⁴⁹

Trudi Tate's thesis, 'Modernist Fiction and the First World War: Subjectivity, Gender, Trauma', similarly argues that 'structures of gender were complicated by women's participation in the war (because) small but visible

⁴⁶ *Ibid.* p. 70.

⁴⁷ Rose Macauley. *Non-Combatants and Other.* (London: Hodder and Stoughton, 1916), and Helen Zenna Smith *Not So Quiet...Stepdaughters of War.* (London: A. E. Marriott, 1930; New York: The Feminist Press, 1989)

⁴⁸ Erich Maria Remarque. *All Quiet on the Western Front.* (London: Picador, 1929)

⁴⁹ Angela Smith. *The Second Battlefield.* p. 116.

groups of women were active at the front as ambulance drivers, (and) nurses.⁵⁰

She confirms that although

women were not combatants, they were not civilians either. Like the non-combatant military men at the front, their contribution was vital to the functioning of the war. In other words, the distinction between civilian and combatant simultaneously reinforced and undermined structures of gender.⁵¹

Congruent with the themes in both Angela Smith's work and that of Trudi Tate, are the views from a more recent study into nursing. Sarah Brady's, 'Nursing in Cardiff during the First World War. A Study of the Interaction between Women, War and Medicine in a Provincial City',⁵² is a fascinating study for its detail into four specific areas of nursing in Cardiff, namely, 'the architectural space provided by three different types of hospital, their finances and administration; medical knowledge and practice; nurse training and employment; and the social background of nursing personnel'.⁵³ In it Brady claims a central argument of her thesis is that 'nursing was an experience which brought women close to that of the combatants [...] and therefore crossed the gender barrier in relation to war'.⁵⁴ This thesis aligns with the views of Brady in that

Women who were working or training as nurses during the First World War were part of an exclusive group of civilian women, as they came into direct contact with military casualties. They were not only more closely involved in the public sphere of war than the majority of their contemporaries; they were already part of another patriarchal circle, that of medicine.⁵⁵

⁵⁰ Trudi Tate. 'Modernist Fiction and the First World War: Subjectivity, Gender, Trauma.' (Unpublished Ph.D. Cambridge, 2003) p. 5.

⁵¹ *Ibid.*

⁵² Sarah Brady. 'Nursing in Cardiff during the First World War. A Study of the Interaction between Women, War and Medicine in a Provincial City'. (Unpublished PhD., Wales. 2005)

⁵³ *Ibid.* 'Introduction', p. 1.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.* Interestingly Leah Leneman claims that women failed to advance in their roles as doctors within the confines of the British Army. Any progress made by British women doctors was done so because they served with the Allied Forces. Leah Leneman. 'Medical Women at War.'

It was, therefore, because of their distinctive position within the military and within the field of medicine, that this thesis believes nurses did not have to re-create images of the front and of battle in order to feel a part of it. They were uniquely placed to witness it at first hand and, for some, to suffer the consequences of witnessing the appalling sights and sounds.

Interestingly, it is literary historians who have been amongst the first to hint at the possibility of women experiencing the trauma of war. Whilst most have explored this in terms of the trauma experienced by *civilians* or, in the case of women, as wives and mothers who had to deal with war traumatised relatives, there have been some occasional, but brief, glimpses into the trauma through the writings of nurses.⁵⁶ In 2002 Margaret Higgonet published 'Authenticity and Art in Trauma Narratives of World War 1'.⁵⁷ She wrote that 'behind [the] moving accounts of combatants' psychological injuries lies concealed another history of wartime trauma, one that has only begun to be written ...and the shock experienced by combatants during the war for a long time displaced our attention from non-combatants traumas.'⁵⁸ This thesis, first and foremost endorses Higgonet's comments, but particularly in the comment she makes when referring to the work of Darrow.

Margaret Darrow has argued that French women disappeared from the cultural memory of World War 1 not because of any 'memory loss' but because the story was never created: a failure of memory creation.⁵⁹

⁵⁶ For work relating to trauma in civilians and relatives see the studies of Suzanne Raitt and Trudi Tate. (Eds) *Women's Fiction and the Great War*. (Oxford: Clarendon Press, 1997) in particular Chapter 11 'HD's War Neurotics' by Trudi Tate. Also Trudi Tate. *Modernist Fiction and the First World War: Subjectivity, Gender, Trauma*. (Unpublished PhD., University of Cambridge, 1994). See also Trudi Tate. *Modernism, History and the First World War*. (Manchester: Manchester University Press, 1998). V.B.E. Newman. *Women's Poetry of the First World War: Songs of Wartime Lives*. (unpublished Ph.D., Essex. 2004) and Jane E Potter. *Boys in Khaki, Girls in Print. Women's Literary responses to the Great War, 1914 - 1918*. (Unpublished PhD., Oxford. 1998).

⁵⁷ Margaret Higgonet. 'Authenticity and Art.'

⁵⁸ *Ibid.* p. 92.

⁵⁹ Margaret Darrow. 'French Volunteer Nursing' p. 5.

This thesis will now turn to a discussion of the literature concerning the psychological consequences of warfare, particularly the First World War, and how women have been essentially excluded.

Shell shock and the Psychological Aftermath of War

The last three decades has seen an ever-increasing interest in the study of the psychological aftermath of warfare. Both historical and clinical evidence now exists to support the view that 'war exacts a heavy toll in terms of human suffering, not only for combatants but also for military personnel and affected civilians'.⁶⁰ One idea that emerges from this perspective is the view that the psychological aftermath of warfare is a very natural human response to fear and has a very long history dating back as far as Homer's *The Iliad* for instance.⁶¹ The condition known as shell shock stands only as a small part of that history. Conversely, some historians, including Jay Winter, prefer to see it as a condition culturally specific to the First World War and have described it as 'an essential element in representations of war developed while the conflict was going on, ...it informed a language which contemporaries used to frame our sense of the war's scale, its character, its haunting legacy.'⁶² It became a term of 'mediation, but one with a quicksilver and shifting character, [standing] between soldiers who saw combat and physicians behind the lines who rarely did, between pensioners and medical boards, between veterans and families, often unable to comprehend the nature of the injuries that man bore with them in later years.'⁶³ He states that shell shock was

A term that took on a notation which moved from the medical to the metaphysical. In one set of contexts, the term had a very

⁶⁰ Frank Weathers *et al.* 'Military Trauma' Chapter Five of John R Freedy and Stevan E. Hobfoll (Eds) *Traumatic Stress: From Theory to Practice*. (New York: Plenum Press, 1995) p. 103.

⁶¹ Homer. *The Iliad*. (Oxford: Oxford University Press, 1984 Edition)

⁶² Jay Winter. 'Shell Shock and the Cultural History of the Great War'. p. 7.

⁶³ *Ibid.*

specific location, documented in medical files, in asylum records and by pension boards.⁶⁴

This thesis concurs that shell shock is, first and foremost, socially and culturally specific to the First World War and recognises its metaphysical nuances but also ventures beyond the idea that implies it is an age old human response to the trauma of war. In acknowledging it to be a human response to the fear and trauma of war, necessarily means women, also humans can similarly be afflicted, and this perspective locates the women, or nurses, who served in war firmly in the picture. However, to look at the plight of the female sufferer during World War One, when it was held to be a purely masculine affliction, absolutely relocates the female into both fields of enquiry. In short, to examine and recognise the 'shell-shocked woman' is to question why she has never been included in this history before. This is a view confirmed by the fact that our First World War contemporaries adopted a framework for understanding shell shock, which did not exclude women.

The interest in shell shock originated in the 1970s with Paul Fussell's *The Great War and Modern Memory* (1975).⁶⁵ Fussell's study focused on the soldier's experience of war within the context of the surrounding culture and society. For instance, Fussell declared that his aim was to

Understand something of the simultaneous and reciprocal process by which life feeds into literature while literature returns the favour by conferring forms upon life.⁶⁶

However, Fussell's work, despite being held as perhaps the most 'well known and widely read scholarly work on the First World War'⁶⁷ is not without its

⁶⁴ *Ibid.*

⁶⁵ Paul Fussell. *The Great War and Modern Memory*. (Oxford: Oxford University Press., 1975)

⁶⁶ *Ibid.* p. ix.

critics. Lynne Hanley, in *The War Zone*, commented on its narrow focus through its 'omission of all literature by women and civilians',⁶⁸ further clarified by the sardonic statement, 'a platoon of soldiers who fought on the Western front is licensed here to shape our culture's imagination of war'.⁶⁹

More recently Robin Prior and Trevor Wilson have questioned Fussell's work in *Paul Fussell at War*.⁷⁰ Fussell's work deals with the First World War but, claim Prior and Wilson, it can be criticised for drawing heavily upon the experiences of writers such as Siegfried Sassoon and Edmund Blunden. Fussell, a Professor of English, claimed to write as a historian believing his 'literary training and raw material equip[ed] him to lay bare the realities of war'.⁷¹ He claimed conventional historians, 'only dress up the distorted, fanciful version of official apologists'.⁷² Prior and Wilson replied that, if this was the case, i.e., that 'diplomatic documents and battle narratives could not explicate all facets of modern war, will literary sources reveal the entire story?'⁷³ Secondly, Fussell was concerned with the 'facet' that this war 'sent innocent young men to their doom for no worthwhile purpose' yet, he does not 'exclude significant aspects of the war which were not manifestly futile' or that Fussell's profile of trench life 'leaves the reader imagining that the typical fighting man spent most of the war - or as much of it as he managed to survive - in close proximity to enemy shells and mortars and machine gun bullets'.⁷⁴ This thesis addresses the issue that Prior and Wilson raise, i.e., that not all the fighting in the First World War was

⁶⁷ Elizabeth Townsend. "This is the World I Create:" A Review Essay on Current First World War Scholarship'. In *UCLA Historical Journal*. Vol. 14 (1994) p. 254.

⁶⁸ Lynne Hanley. *Writing War: Fiction, Gender and Memory*. (Boston: The University of Massachusetts Press, 1991) Chapter entitled 'The War Zone'. p. 26.

⁶⁹ *Ibid.* p. 27.

⁷⁰ Robin Prior and Trevor Wilson. 'Paul Fussell at War'. In *War in History* Vol. 1. (1994) pp. 63-80.

⁷¹ *Ibid.* p. 63.

⁷² *Ibid.*

⁷³ *Ibid.*

⁷⁴ *Ibid.* p. 67.

dangerous *all* of the time. Conversely, while women did not serve in the trenches, many received bomb injuries and gun shot wounds because of their location in dangerous areas, and in this respect there is a sense in which both the soldier, who could be both combatant and non-combatant, as well as the nurse, as non-combatant, can be placed in the same context.

In 1977, P.J Lynch's, 'The Exploitation of Courage'⁷⁵ was acclaimed for being a study of psychiatric care in the British Army between 1914 and 1918, using contemporary medical opinion as depicted in specialist journals. The strong point of Lynch's thesis was in its use of the medical opinion that was revealed in these specialist journals. However, the lack of personal testimony meant that the study was more an examination of the theory of psychiatric care, but useful all the same, for providing an insight and therefore an understanding of how the treatment of psychological casualties of the war was carried out in a male dominated environment.

Although considered to be pivotal in the historiography of shell shock, Eric Leed's 1979 study, *No Man's Land*,⁷⁶ did not devote any concentrated analysis of the condition per se, but rather he aligned with Fussell in that he related the experience of war to the culture of its participants. Leed was attempting to create a 'cultural history of the First World War through the men who participated in it'.⁷⁷ According to Leed, the pressure to escape from modern industrial society was a major driving force behind participation in the war for many. Yet the warfare they went into was more industrialised than the peace they left behind, and claims Leed, was a major factor in contributing

⁷⁵ P. J. Lynch. 'The Exploitation of Courage: Psychiatric Care in the British Army'. (Unpublished MPhil., University of London. 1977)

⁷⁶ Eric Leed. *No Man's Land*.

⁷⁷ *Ibid.* p. ix.

towards the breakdown of many men. The women that served in the First World War would not have been immune to the same industrialised warfare that, for Leed, troubled its men.

The first contribution to the study of shell shock from a gender perspective came from Elaine Showalter in *The Female Malady: Women, Madness and English Culture, 1830 - 1980*.⁷⁸ Accordingly, her intention in this study was to 'write a feminist history of psychiatry and a cultural history of madness as a female malady'.⁷⁹ In it, she discussed and saw shell shock as a unique outbreak of large-scale male hysteria and introduced the concept of a 'conflict of masculinity'. Two years later she was to surmise

The psychiatric discourse of shell shock and literary discourse of war memoirs open up a significant discussion of masculinity that has been avoided by previous generations. Feminist interpretations of hysteria in women have helped us decode physical symptoms, psychotherapeutic exchanges, and literary texts as representations of feminine conflict, conflict over the meaning of femininity within a particular historical context. Yet the meaning and representations of masculinity have been accepted as unproblematic. By applying feminist methods and insights to the symptoms, therapies, and texts of male hysteria, we may begin to understand that issues of gender and sexual difference are as crucial to understanding the history of masculine experience as they have been to shaping the history of women.⁸⁰

Elaine Showalter's analysis of shell shock in *The Female Malady* raised questions about cultural norms and identity. Showalter contended that shell shock could be understood in terms of gender roles. She followed on from the work of Eric Leed who viewed it as an unconscious and implicit protest against

⁷⁸ Elaine Showalter. *The Female Malady: Woman, Madness and English Culture, 1830-1980*. (London: Virago, 1993)

⁷⁹ *Ibid.* pp. 5-6

⁸⁰ Elaine Showalter. 'Rivers and Sassoon: The Inscription of Male Gender Anxieties', in Margaret Higonnet. *Et al. Behind the Lines*. (1987) p. 69.

industrialised warfare.⁸¹ For example, Showalter claimed wartime Britain emphasised masculine traits and nowhere could these traits be better exhibited and revealed than in the front lines and the trenches. According to Showalter, increasing numbers of men became hysterical because the enforced passivity coupled with the terror of the trenches served to 'feminise' and emasculate soldiers because they became powerless, much like the Victorian woman. For instance, rather than be in a position to fight and demonstrate masculine ideals, confinement in a trench meant men were subjected to enforced passivity and loss of control, much like the Victorian woman whose lack of control over her environment and circumstances led to 'hysteria'. Trench warfare, therefore 'feminised' men, and shell shock was a form of male hysteria.⁸²

If the essence of manliness was not to complain, then shell shock was the body language of masculine complaint, a disguised male protest not only against the war but against the concept of "manliness" itself.⁸³

Criticism has been directed at historians like Showalter and Leed, who prefer to see shell shock as a condition that can be analysed and understood in terms of gender, and, who promote and maintain the stance that it was a masculine affliction. Secondly, she also suggested that the emergence of [male] psychological casualties in such large numbers constituted a crisis of sexual identity. For instance, she claims that doctors 'dismissed shell-shock patients' as 'cowards' and 'malingerers', and hinted at 'effeminacy and homosexuality'.⁸⁴ This argument is grossly overstated, but also weakened in light of the revelation, within this thesis, of a significant number of female psychological casualties.

⁸¹ Eric Leed. *No Man's Land*. p. 163 - 92.

⁸² *Ibid.*

⁸³ Showalter. *The Female Malady*. p 172.

⁸⁴ *Ibid.*

Particular criticism of Showalter comes from Laurinda Stryker, in 'Mental Cases, British Shellshock and the Politics of Interpretation'.⁸⁵ Stryker challenges Showalter in her assertions about how doctors treated their shell-shocked patients, citing only two types of treatment, namely those of Lewis R. Yealland and W. H. R. Rivers, which she portrayed as ubiquitous and typical therapies. Stryker argues that there is very little evidence to support the claim for there being only two types of treatment. It will be argued, in chapter three, that these methods were extremes and the exception rather than the norm, both for men and women. Moreover, in regard to her claim that doctors 'dismissed shell shock patients as cowards', it can be revealed that doctors often went to 'great pains to remark upon the courageous, manly nature of the men who suffered breakdown in war, and the genuineness of their disorders'.⁸⁶ Indeed, as Stryker claims, 'military witnesses to the War Office 'Shell-Shock' Committee⁸⁷ feared the effects of classifying shellshock as a disability that was as legitimate as any other; had they fully understood the theories of war neurosis, they might have been reassured'.⁸⁸

War neurosis as constructed in Britain during the First World War did not undermine ideals common to the military ethos and to civilian understandings of manliness and masculinity, but rather built upon and upheld these moral values.⁸⁹

A more potent criticism of Showalter from Stryker is that her argument focuses on gender roles rather than on the 'condition' per se. Showalter maintains that 'without autonomy, humans cannot healthily function; to be

⁸⁵ Laurinda Stryker. 'Mental Cases. British Shellshock and the Politics of Interpretation,' Chapter 7 of Gail Braybon. *Evidence, History and the Great War. Historians and the Impact of 1914 - 1918*. (Oxford and New York: Berghahn Books, 2004) p. 156.

⁸⁶ Laurinda Stryker. 'Mental Cases'. p. 158.

⁸⁷ *War Office Commission of Inquiry into Shellshock*. (London: HMSO, 1922) Hereafter referred to as *WOCIS*.

⁸⁸ Laurinda Stryker. 'Mental Cases'. p. 161.

⁸⁹ *Ibid*.

forced to surrender human agency is to risk psychic trauma.⁹⁰ Stryker argues that Showalter fails to sustain her own argument by claiming, that 'war makes people sick'.⁹¹ This thesis agrees with the comments of Stryker and that war can, and indeed does, make people sick, and it similarly challenges the prevalence of the gender of those involved.

1985 saw two studies by Martin Stone. His thesis, 'The Military and Industrial Roots of Clinical Psychology in Britain, 1900 - 1945', and the chapter 'Shell shock and the Psychologists',⁹² built on the work of Lynch by analysing psychiatric discourse. His main focus, through the politics of shell shock, military and medical management, and the social construction of the condition, was to formulate the impact of treatment on the post-war development of clinical psychology. He concentrated on how specialists and academics developed new theories as a result of their experience as shell shock doctors.

In, 'One History of Shellshock', 1986, R D Richie claims his ambition was to complement 'recent work in the social history of medicine as well as intellectual histories of the Great War by Paul Fussell and Eric Leed'.⁹³

From the premise that extreme psychic reactions to warfare almost certainly existed before the First World War, the dissertation investigates circumstances that caused "shellshock" to "come of age" when it did. Developing the metaphor that a disease "comes of age" when its "ownership" begins to be "negotiated" by a sufficient variety of interested parties, the dissertation argues that the complexities of "shellshock's" history

⁹⁰ Laurinda Stryker. 'Mental Cases'. p. 156.

⁹¹ Elaine Showalter. *Hystories: Historical Epidemics and Modern Media*. (Columbia University Press, 1997) p. 75.

⁹² Martin Stone. 'The Military and Industrial Roots of Clinical Psychology in Britain, 1900 - 1945.' (Unpublished PhD., University of London. 1985), and chapter entitled 'ShellShock and the Psychologists' in W.F. Bynum, R. Porter, and M. Shepherd, (Eds), *The Anatomy of Madness. Essays on the History of Psychiatry*. Vol 2. (New York & London: Tavistock, 1985) pp. 242 - 271.

⁹³ R.D. Richie. 'One History of 'Shellshock''. (Unpublished PhD., University of California. 1986) Abstract.

are neither side issues nor hindrances to understanding; they are vital to it.⁹⁴

Despite viewing shell shock as a 'cultural icon' the work was disappointing, for despite its title, it failed to look at the personal experiences of the soldiers who suffered from the condition. This was, however, to be recognised and excellently rectified by Peter Leese's⁹⁵ study four years later in 1989. In 'A Social and Cultural History of Shell Shock' he claimed that 'despite over a decade of historical research and discussion a limited amount has been discovered about the personal experience of shell shock and its effects on soldiers during and after the Great War'.⁹⁶ He argued that the shell shock experience from the 'perspective of psychological casualties (shows) how entrenched interested parties were, based within their bureaucratic and institutional frameworks', and how 'preoccupied (they were) with the financial and disciplinary implications of the complaint, or the lessons for any future conflict'.⁹⁷ Leese claimed that such restricted views meant that 'war-neurotic ex-servicemen and psychological casualties were treated inadequately and often neglected after the war'.⁹⁸ Leese did much to dispel the myth that soldiers were treated either along the same lines as those of the war poets and other middle-class officers in that they either received psycho-analysis, or, that the other ranks were left to the more severe types treatment such as electric shock therapy as offered by Lewis Yealland.⁹⁹ This is further supported by the more

⁹⁴ *Ibid.*

⁹⁵ P. J. Leese. 'A Social and Cultural History of Shell Shock, with particular reference to the experience of British Soldiers during and after the Great War'. (Unpublished PhD., Open University. 1989) Also P. J. Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War*. (London: Palgrave Macmillan, 2002)

⁹⁶ P. J. Leese. 'A Social and Cultural History of Shell Shock'. Abstract.

⁹⁷ *Ibid.*

⁹⁸ *Ibid.*

⁹⁹ Yealland is reputed with offering a more extreme type of treatment in the form of electric shock therapy, often to the throat and larynx in order to alleviate the symptoms of mutism. See Adrian, E.D. and Yealland, L. 'The Treatment of Some Common War Neuroses' *The Lancet*. Vol. 1 (1917) p. 870, and Yealland, L. *Hysterical Disorders of Warfare*. (London: Macmillan, 1918)

recent contribution from Ben Shephard, who, in '*A War of Nerves*',¹⁰⁰ concurs that most soldiers were left to degenerate in less than adequately converted asylums. This thesis further highlights the personal experience of shell shock and of other war neuroses, but in nurses, and seeks to discover if there were similarities, or disparities, as there was with men, in the type of care and treatment offered both during and after the war years.

Joan Busfield, in *Men, Women and Madness. Understanding Gender and Mental Disorder*, along with Sharon Ouditt, in *Fighting Forces, Writing Women. Identity and Ideology in the First World War* are only two writers who have touched upon the existence of neurosis in women who served in the First World War.¹⁰¹ However, while Joan Busfield goes no further than a cursory mention in a footnote, a concern of literary historian Ouditt, was the loss of women's identities in their anti-war writing, and she cites examples that may be considered indicative of war neurosis. For instance, Ouditt claims that the heroine of Helen Zenna Smith's *Not So Quiet... Stepdaughters of War*, Nell Smith, was 'haunted by processions of mutilated men', and also Vera Brittain, who 'suffered the recurring fear that her own face was disfigured: that she was growing a beard'.¹⁰² Furthermore, Ouditt claims the 'deadpan tones' used by Borden in her writing demonstrates her 'instinct to close down certain sensory perceptions in order to retain a functional level of sanity'.¹⁰³ Ouditt further states that when writing of their First World War experiences many women found that 'ordinary discourse' failed to adequately convey the horrific events of the 'forbidden zone' because those 'events (broke) the frame of what is humanly

¹⁰⁰ Ben Shephard. *A War of Nerves: Soldiers and Psychiatrists 1914 - 1994*. (London: Jonathan Cape, 2002)

¹⁰¹ Sharon Ouditt. *Fighting Forces, Writing Women*; Joan Busfield. *Men, Women and Madness. Understanding Gender and Mental Disorder*. (London: Macmillan Press, 1996) See p. 213, fn 4.

¹⁰² Sharon Ouditt. *Fighting Forces*. p. 77.

¹⁰³ *Ibid.* p. 39.

endurable or capable of being articulated in the language of the well-educated woman.'¹⁰⁴ In so doing suggested how the war saw a gradual mythological restructuring as the 'realities of ugliness and evil displace[d] the abstractions of glory and honour to occupy a permanent place in these women's minds'.¹⁰⁵

One specific and important contribution to the study of war trauma in women, albeit it extends beyond the period of the First World War, but especially relevant to this thesis, is that of *'A Woman's Recovery From the Trauma of War'*.¹⁰⁶ Following the Vietnam War, feminists seized upon the notion that women could suffer from the trauma of war. Editors' Rothblum and Cole put together a collection of twelve essays from feminist therapists and activists in response to a case study of a Navy nurse (Ruth) from Vietnam who was a recovering alcoholic. In one of these essays entitled 'Propping Up the Patriarchy: The Silenced Soldiering of Military Nurses', authors Joy Livingston and Joanna Rankin discuss how 'Ruth', as a military nurse, was 'absolutely essential to the conduct of war' (but) military ideology [...] treats all women as irrelevant [...]. Ruth was therefore in the 'paradoxical position of being used by the military as a nurse, but marginalized and devalued as a woman'.¹⁰⁷ Accordingly, Ruth and her colleagues felt they could not discuss feelings of working in a war zone and when Ruth had a physical ailment it was attributed as psychosomatic. Livingston and Rankin argue this was because there is a 'long history in the military of denying that women have anything to do with combat, and, despite the purpose of mobile army surgical hospitals (MASH) being to put doctors and nurses as close to the front line as possible,

¹⁰⁴ *Ibid.*

¹⁰⁵ *Ibid.* p. 38.

¹⁰⁶ Esther D. Rothblum and Ellen Cole (Eds) *A Woman's Recovery From the Trauma of War. Twelve Responses from Feminist Therapists and Activists*. (London: Haworth Press, 1986)

¹⁰⁷ *Ibid.* p. 108.

propaganda suggests women are there for 'a lark' or a 'romantic adventure'.¹⁰⁸ Yet they add that because women are placed in these forward units and as close to the combat as possible, their experience in war, as nurses, 'becomes as powerful, and as potentially destructive, as the kinds of combat experiences men have'.¹⁰⁹ However, this can never be admitted and so there exists a 'conspiracy of silence' for if the 'reality was exposed, that women do have powerful combat experiences, then that would challenge the masculinity men earn by having combat experience'.¹¹⁰ Furthermore, Livingston and Rankin argue because the ideology is that women are not exposed to combat, nurses struggle, 'even to be recognised as suffering from combat-related illnesses such as post-traumatic stress disorder'.¹¹¹

Yet, concurring with the views of Cynthia Enloe, in 'Does Khaki Become You?' Livingston and Rankin claim many nurses saw the worst of the Vietnam war [through] 'an endless procession of mangled bodies across an operating table'.¹¹² Whilst radical and somewhat overstated in parts, this thesis shares some of the interpretation expressed above. It disagrees with their views regarding a 'conspiracy of silence' but does argue that nurses of the First World War were in a similar paradoxical position of being exposed to the horrors of combat, including those across the operating table, and often to a level that could induce traumatic illnesses, whilst being expected to conduct themselves in a manner befitting their class, status and gender and which may have been at odds with the expression and manifestation of symptoms of breakdown,

¹⁰⁸ *Ibid.* p. 108 - 109.

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

¹¹¹ *Ibid.* p. 111.

¹¹² *Ibid.* See also Cynthia Enloe. *Does Khaki Become You? The Militarization of Women's Lives.* (Boston: South End Press, 1983). p.109.

viewed possibly as a weakness by some, especially if the role of the woman was to be seen as that of 'carer'.

Similarly, Linda van Devanter, a nurse who served in the Vietnam War, pointed out in *Home Before Morning*,¹¹³ that the circumstances of war affect the self-esteem and professional integrity of military nurses. For example, 'nurses in all wars expect to do good, to care, to be useful and save lives. The sort of patients military nurses see are horribly maimed and often they are flown out or evacuated quickly, so they were never seen to recover.'¹¹⁴ Therefore, the degree to which nurses are required to depersonalise and distance themselves in the military can become a huge source of guilt for those who see themselves as caring people. 'To be a caring person who doesn't care is very difficult.'¹¹⁵

The views expressed in Rothblum and Cole's study and also by Devanter are significant to this thesis. Nurses in the First World War worked with the military by dealing with the realities and consequences of war, by witnessing the horrors of the front, seeing thousands of men maimed and injured whilst often not being able to nurse them long enough to see them recover. These are factors that this thesis will argue have implications for the psychological health of the nurse in the First World War just as equally as it has been in other wars.

Nurses as Veterans of Warfare

Given the dreadful environment and the horror that was the war of 1914 - 18 coupled with the stresses and strains of nursing, it was inevitable that some

¹¹³ Lynda Van Devanter. *Home Before Morning. The Story of an Army Nurse in Vietnam*. (New York: Beaufort Books, 1983) Cited in Rothblum and Cole. (Eds) *A Woman's Recovery* p. 112.

¹¹⁴ *Ibid.*

¹¹⁵ *Ibid.*

nurses would be traumatised and develop psychological disorders as a result, and it was similarly inevitable nurses would need caring for, and treating, if the machinery of war was to keep on turning and, ultimately, they would need managing through to recovery and rehabilitation. However, whilst there are studies relating to the treatment and post-war care of physical injuries in the soldier that was disabled by war,¹¹⁶ and those, albeit few, that address the issues of the psychologically injured, there is nothing that relates to the nurses who were injured either physically or psychologically. For example, P J Lynch was one of the first in 1977 to address the issue of caring for shell-shocked male veterans but purely from the perspective of the system that existed within the army.¹¹⁷ Peter Leese followed in 1989 arguing that few, if anyone, had looked at the condition and its experience from the point of view of the soldier.¹¹⁸ In 2001, Deborah Cohen¹¹⁹ explored the treatment of disabled veterans in both Britain and in Germany and more recently Ben Shephard has made a contribution through his study *A War of Nerves. Soldiers and Psychiatrists 1914 - 1994*.¹²⁰

In 2004 historian Peter Barham made a significant contribution by looking specifically at those servicemen who were diagnosed with a 'psychosis'

¹¹⁶ For physical wound treatment and management see for instance the work of Claire E. J. Herrick. 'Of War and Wounds. The Propaganda, Politics and Experience of Medicine in World War I on the Western Front'. (Unpublished PhD., Manchester 1996), and Jeffery Reznick. 'Rest, Recovery, and Rehabilitation: Healing and Identity in Great Britain in the First World War'. (Unpublished PhD., Emory University 1999). For studies relating to the physically disabled of war see Donnelly, J. K. *Treatment and Care of Disabled Soldiers in Two World Wars*. (Unpublished PhD., Open University 1990) and Deborah Cohen. *The War Come Home. Disabled Veterans in Britain and Germany, 1914 - 1939*. (Berkeley: University of California Press, 2001)

¹¹⁷ P. J. Lynch. 'The Exploitation of Courage: Psychiatric Care in the British Army'. (Unpublished MPhil., University of London. 1977)

¹¹⁸ P. J. Leese. 'A Social and Cultural History of Shell Shock, Also P. J. Leese. *Shell Shock. Traumatic Neurosis*.

¹¹⁹ Deborah Cohen. *The War Come Home*.

¹²⁰ Ben Shephard. *A War of Nerves*.

or determined as 'insane' as a result of their war experiences.¹²¹ Commenting on the lack of studies devoted to this class of sufferer, he states

Although they form part of the constituency that is popularly known as the 'shell-shocked', little attention has been paid to them, *for it is the neurasthenic officer whose profile has been most visible in the mental health historiography of the Great War.*¹²²

He further added, 'the irony is that, despite the enormous fascination with shell shock, the psychiatric history and aftermath of the Great War has been told only in a very partial way.'¹²³ This thesis concurs with Barham's view and claims that the historiography will remain incomplete until the plight of the female shell shock victim has been included.

In relation to the issue of repatriation and compensation, in particular the receipt of war pensions, again the numbers of studies that address the plight of the First World War ex-serviceman are few. A Ministry of Pensions' Departmental Committee of Inquiry of 1921 stated that, in 1917, when the Ministry started its work, there were about half a million claimants for pensions, grants and allowances. In 1921 the number had risen to 'nearly three and a half million men, women and children receiving war pensions or allowances and pensions, grants and allowances.'¹²⁴ The problem of repatriating and rehabilitating hundreds of thousands of war-disabled was of considerable concern to contemporaries and was one that was being addressed some two

¹²¹ Peter Barham. *Forgotten Lunatics of the Great War*. (New Haven and London: Yale University Press, 2004)

¹²² *Ibid.* p. 4. (My emphasis).

¹²³ *Ibid.* p. 4-5.

¹²⁴ Ministry of Pensions. *Report of the Departmental Committee of Inquiry into the Machinery of Administration of the Ministry of Pensions*. (London: HMSO 1921) The 'actual numbers are 2,477,800 disabled officers and men of the Army, the Air Force and auxiliary services, and their dependants. 60,550 disabled officers and men of the Navy, auxiliary services, Mercantile Marine, etc., and their dependants. 917,850 widows and orphan children and dependants of deceased officers and men killed or dying after discharge, following upon their war service... (and) 1,475 nurses of the recognised war organisations disabled by service, and the dependants of nurses deceased in consequence of war service'.

years before the armistice of 1918. For instance, in 1916 *The Lancet* was stating that, 'the problem of converting the fighting man who has been crippled by this war by sea or by land into a useful citizen again is one of appalling magnitude',¹²⁵ and the government was to encounter and experience considerable problems dealing with such large numbers of returning servicemen, and women.

Establishing an effective administrative framework, in the form of the Ministry of Pensions, proved both complicated and protracted. Of the few studies that do exist all have explored this complex area from the perspective of the male veteran. The main focus of most of these studies has been that veterans were let down by the government. Stephen Ward's, chapter 'Great Britain: Land Fit for Heroes', and Kimball's 'The Ex-Service Movement in England and Wales 1916-1930',¹²⁶ claim that ex-servicemen were essentially 'betrayed' by the government as their needs were left largely unmet. Phillip Latcham's study, 'Journey's End. Ex-Servicemen and the State during and after the Great War',¹²⁷ whilst not actually claiming veterans were 'betrayed', does argue that the government 'failed' in its duty to provide for them.

A more recent, and stimulating, study is that by Helen Bettinson. This comprehensive study of the creation and work of the Ministry of Pensions, 'Lost Souls in the House of Restoration'? British Ex-Servicemen and War Disability Pensions, 1914- 1930',¹²⁸ claims not to 'confirm or deny the proposition that

¹²⁵ The Future of the War Cripple.' *The Lancet*. (October 7th 1916) 649.

¹²⁶ S. Ward. Chapter entitled 'Great Britain: Land Fit For Heroes Lost.' In Ward, S. (Ed) *The War Generation*. (New York: Kennikat, 1975) and C. Kimball. 'The Ex-Service Movement in England and Wales 1916-1930'. (Unpublished Ph.D., Stanford 1986)

¹²⁷ Phillip Latcham. 'Journey's End. Ex-Servicemen and the State during and after the Great War'. (unpublished PhD., Oxford 1996)

¹²⁸ Helen Bettinson. "Lost Souls in the House of Restoration'? British Ex-Servicemen and War Disability Pensions, 1914- 1930.' (Unpublished PhD., University of East Anglia. 2002).

sick or disabled British veterans were 'betrayed' by their government',¹²⁹ rather it seeks to challenge a number of 'misperceptions and myths', focusing on 'the real and imagined bodies of the war disabled and the agencies responsible for their rehabilitation'.¹³⁰ It argues that the 'problems' that occurred were largely because of the complex bureaucracy of a newly created and evolving Ministry of Pensions, which in turn were exacerbated by the sheer magnitude of applicants. For example, the 'system' was a 'multifaceted one that did not develop in a linear fashion as an inflexible and watertight scheme. It could more accurately be described as an evolving process'.¹³¹ Furthermore, the 'pensioner or would be pensioner [was not] the passive 'lost soul' [...] the vast majority did not seek disablement, but once 'damaged' [...] used their disabilities to get what they thought they deserved' [and while] many quietly accepted the procedures and decisions of the authorities, others negotiated, manipulated or cheated'.¹³²

One objective of this thesis is to examine the plight of the female veteran in her claim for financial compensation through the cases of nurses who were injured or became psychologically ill as a result of war service. The primary reason for including an examination of the pension system is because it is considered an integral part of the aftermath of war. However, in the absence of any former studies in this area, in relation to women, this thesis can only make comparisons with the system that was set up for male veterans. It broadly concurs with Bettinson's view that the Ministry of Pensions was essentially a new, and evolving one, both complicated and bureaucratic, and dealing with such huge numbers of applicants meant many cases were dealt with inappropriately. This thesis will therefore argue that nurses, in their path to

¹²⁹ *Ibid.* p. 2.

¹³⁰ *Ibid.* p. 2

¹³¹ *Ibid.* p. 338.

¹³² *Ibid.* p. 4.

repatriation, were not particularly discriminated against in their struggle to claim a war pension, as might be expected because of their sex, rather they, much like the ex-servicemen, were often at the mercy of a new, uncoordinated and complex system.

In terms of repatriation, the transition from war to home is important for the long-term psychological health of a veteran. Careful management by authorities and a sensitive approach from friends and relatives can alleviate many of the concerns and frustrations experienced by someone who has witnessed the horrors of war. Arguably, with the understanding of the psychological effects of war trauma in its infancy during the First World War period it was likely that the symptoms of many veterans, both men and women, were exacerbated by inadequate facilities and a lack of care and understanding. The more personal experiences of returning nurses will be looked at, through their testimonies and through those of their relatives and peers, in an attempt to see how the women and their families both perceived, and coped with, their homecoming.

Methods and Sources.

At the outbreak of the war the Queen Alexander's Imperial Military Nursing Service (QAIMNS) consisted of three hundred trained nurses ready for immediate action with a reserve of two hundred on call at twenty-four hours notice. A further six hundred trained nurses from civilian hospitals had also been identified for immediate service in the event of war. However, by the end of the war more than 10,000 reserve nurses had apparently been enrolled for

service.¹³³ Another source states 13,124 members of the Queen Alexandra Imperial Military Nursing Service (Reserve) (QAIMNS(r)) were demobilised in February 1919 with a further 10,549 members from the Territorial Forces Nursing Service (TFNS) and over 2,783 members of the Territorial Army Nursing Services (TANS). The women's Voluntary Aid Detachment's (VADs) constituted some 82,857 of the demobilisation figures from April 1920.¹³⁴ The severe shortages in manpower from 1916 and the fact that women were 'needed' as military nurses, meant women were employed as military nurses in the Great War in significant numbers. This study has attempted to gain an insight into the experience of these women from as wide a range of sources as possible, including personal testimony, diaries, and, more importantly, given the nature of this study, from medical records.

The medical experience is of particular importance for this thesis and therefore the primary source materials are the medical records of both soldiers and nurses contained in PIN 26 held at the National Archive in Kew, London. Class PIN 26 is reputed to represent approximately a 2 per cent sample of 22,756 files awarded in the London Region of the Ministry of Pensions.¹³⁵ The files contain comprehensive medical case notes detailing events leading up to the individual's 'breakdown', including the treatment received through to discharge and continuing for the duration of the pension claim. The pension files pertaining to women are numbered from PIN 19985 to 20286 and total

¹³³ Ian Hay. *One Hundred Years of Army Nursing. The Story of the British Army Nursing Services from the Time of Florence Nightingale to the Present Day.* (London: Cassell & Co, 1953.) p. 88.

¹³⁴ *Statistics of the Military Effort of the British Empire During the Great War, 1914-1920.* Published by the War Office. (London: HMSO, 1922)

¹³⁵ This was thought to be the largest holding covering the South East England region after the Ministry of Pensions system was decentralised after 1919. War pensions staff selected every fiftieth file meaning there were an original total of 1,137,800 files for the region. Therefore the London Region represented 60 per cent of the total awards. See Ian. F. W. Beckett. *The First World War. The Essential Guide to Sources in the UK National Archives.* (Kew: Public Record Office, 2002) p. 159. See also E. Jones, I. Palmer and S. Wessely. 'War Pensions (1900 - 1945): changing models of psychological understanding.' *British Journal of Psychology.* Vol. 180 (2002) pp. 376.

302. However, there is no confirmation that these represent a 2 per cent sample.

The individual case files contained in PIN 26 are particularly interesting. Decisions regarding the pensioner were reached based on changing policy, fluctuating administration and differing clinical judgements from various medical authorities. Essentially they reveal a journey on the part of each individual from 'discharge hospital or demobilisation centre, through sickness or disablement, to the successful [or otherwise] award of pension and medical care, sometimes even to death. They are invaluable because they catalogue the bureaucratic processing of pensioners along with their own testimony'.¹³⁶ Bettinson adds that because

Most disabled ex-servicemen did not write about their experiences, their views on the pensions process can only be deduced through their actions and sometimes their statements [and] the registering of an appeal is the clearest indication of dissatisfaction. [Whilst] conversely, the failure to do so might signal either tacit or whole-hearted acceptance of the Ministry's decision.¹³⁷

All three hundred and two records of nurses have been analysed for this thesis, each of which contains personal statements regarding the individual's views of medical treatment, pensions and awards paid, and any form of dissatisfaction with the pensions 'system'. Other sources of material relating to pensions comes from books, pamphlets and journal articles written by those who were involved in the evolution of the pensions system during this period.

The Ministry of Health's class MH106 have also been looked at and is a selection of medical records compiled by the Medical Research Committee and

¹³⁶ Helen Bettinson. "Lost Souls in the House of Restoration". p. 8-9.

¹³⁷ *Ibid.* p. 9.

the British Museum 'during and immediately after the war for use in statistical studies on the treatment of injuries received and diseases contracted by the troops.'¹³⁸ MH106/2207-11 relate specifically to women's services in the war.

The records of nurses are also mentioned in the Administration Reports from No. 34 Casualty Clearing Station, the 2nd and 19th General Hospitals, the 4th Stationary Hospital and the Queen Alexandra's Military Hospitals at Millbank and Catterick. More significant is Class WO399/1-15792, and are the records relating to the nursing services, specifically the QAIMNS and TFNS, and covering the period 1902 - 1922. Personal testimony from Nurses and Voluntary Aid Detachments also comes from the Red Cross Archives in Surrey and from the Imperial War Museum in London. All these case notes are supplemented by the occasional sample from local record offices, as well as from local mental hospitals, namely St. Andrew's Hospital and the Berrywood Asylum in Northampton.

As previously mentioned, primary source materials for this thesis are medical records but the historian's interest in this form of record and in particular the patient's role is relatively recent. The traditional view has been to interpret this type of record from the perspective of the doctor's therapeutic intervention, and similarly, on the scientific and intellectual development that is imparted through the practitioner's narrative. Far less attention has been given to the patient, who, whilst never quite eliminated from the narrative, was considered as the unfortunate victim of some debilitating disease, apparently lending his or her body to the advancement of medical science, but usually secondary to the doctor's role.

¹³⁸ *Ibid.* p. 154.

In 1992 Guenter B. Risse and John Harley Warner acknowledged the 'growing interest among historians in the use of patient records as one source of information about the medical experiences and perceptions of the past.'¹³⁹ They pointed towards the use of the clinical chart and the clinical case history as sources of material that could provide the historian with a rich source of information for

Tracing shifts over time in clinical practice, perception, and discourse; for reconstructing the demographic character of patient populations as well as the texture of hospital life; for understanding the roles played by ethnicity, gender, class, race, and geography in shaping patient care... Describing the benefits that these types of records offered to historians of medicine as 'substantial' they nevertheless cautioned against the idea that they might provide a ...privileged access to clinical reality.¹⁴⁰

Adding,

Patient records are surviving artefacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relationships are expressed.¹⁴¹

Reading and interpreting the patient record means asking questions about its distinct terminology, construction, and the views of its author and audience.

While the basic narrative structure of medical records has attained a level of standardisation over the last century or so, the content and language of that narrative can be seen to have changed considerably. As a result one of the main concerns for the historian is to be aware of the application of a historical methodology referred to as retrospective diagnosis. For example, one temptation for scholars is to 'superimpose a modern disease classification

¹³⁹ Guenter B. Risse and John Harley Warner. 'Reconstructing Clinical Activities: Patient Records in Medical History' *Social History of Medicine*. Vol. 5 No. 2 (August 1992) p. 183. See also, Kathryn Montgomery Hunter. *Doctor's Stories. The Narrative Structure of Medical Knowledge*. (Princeton University Press, 1991) Bryan Turner. (2nd Edition) *Medical Power and Social Knowledge*. (London: Sage, 1996)

¹⁴⁰ Guenter B. Risse and John Harley Warner. 'Reconstructing Clinical Activities. p. 183.

¹⁴¹ *Ibid.* p. 189.

system on past nosology and retrospectively build from patient records a false historical epidemiology that ignores the changing definition and construction of specific disease entities'.¹⁴² Another danger of adopting this strategy is for the historian to use the case notes as if they were accurate and objective accounts of the symptoms observed in the patients they represent and re-assesses them using present day diagnostic categories. Consequently, the historian's use of medical records needs to be careful.

Ludmilla Jordanova similarly emphasises this 'social constructionist' approach by stating

It is a mistake to separate the knowledge claims of medicine from its practices, institutions and so on. All are socially fashioned, and so it may ultimately be more helpful to think in terms of mentalities, modes of thought, and medical culture than in terms of 'knowledge', which implies the exclusion of what is inadmissible.¹⁴³

However, while this study aims to adopt a more social constructionist approach, and concern is given not to treat these medical records purely as legitimate and detached accounts of the persons they represent, it is equally important to afford some credence to the symptoms as they were recorded. For instance, Margaret Higonnet states, 'the instability or, as some would have it, inexpressible nature of trauma is in large part responsible for the problematic nature of war narratives'.¹⁴⁴ She continues

Examining the testimony of medical staff is useful as these texts both observe and participate in the experience of trauma. When their styles display the symptoms of trauma, the effect is both descriptive and expressive. As a result, they participate in the two kinds of knowing [...]. I would reject any polarity between authenticity and artifice - an opposition that (in the context of war

¹⁴² *Ibid.*

¹⁴³ Ludmilla Jordanova. 'The Social Construction of Medical Knowledge'. *Social History of Medicine* Vol. 8, No. 3 (December 1995) 362.

¹⁴⁴ Margaret Higonnet. 'Authenticity and Art' p. 103-4.

literature) has been aligned with the opposition between combatant and non-combatant, between male and female.¹⁴⁵

Chapter Structure

The structure of this thesis begins by re-examining, in chapter two, the nurses' proximity to the fighting lines. The traditional view persists that nurses who worked alongside the British Expeditionary Forces were stationed well away from the front lines and therefore from danger. This chapter questions this view by first looking at the terminology relating to 'front' and 'rear' areas, which reveals a general ambiguity in the use of the terms, and also questions the idea of fixed geographical boundaries that defined the forward areas as 'dangerous' and for men, and the rear areas as 'safe' and for women. This geographical void has allowed for the invention of the idea, largely by feminist historians, that the women had to 'invent' their own 'front' in order to feel included. By providing evidence that reveals nurses were as much a part of the danger that was the First World War, this chapter contests this view. This chapter, whilst acknowledging the dangers for many men who served in the trenches, also challenges the notion of First World War combat as a consistently horrific male experience. Finally, chapter two examines the nurses' experience of this war, experiences that frequently placed them in positions of danger and thus challenging traditional assumptions that they were 'protected'.

Chapter three looks more specifically at the disorders known as shell shock and the war neuroses, as contemporaries called them, and how understanding of these conditions changed rapidly over the period of the war but evolved to the extent that to view them as gender specific is difficult. Shell shock has long been considered a masculine affliction and this chapter firstly

¹⁴⁵ *Ibid.*

questions why this has been the case. It then looks at the nurses' personal suffering of these conditions and what factors precipitated their path to illness, revealing their experience to be not dissimilar to that of the soldiers. Chapter three also looks at the medical authorities response to the nurses' illnesses and how they were cared for and managed within the environment of war and which was male dominated. It asks whether there was any bias on the part of doctors in their care of these women.

Chapter four evaluates the evolution of the pensions system for women. The Ministry of Pensions was new and set up for the purposes of administering and managing the large number of veterans returning from the war. The men of the First World War were entitled to recompense in the form of a War Pension following physical or psychological injury. This chapter examines the course open to the women for compensation and the attitudes of the Pension authorities as they dealt with an increasing number of women who laid claim to a War Pension. It also addresses how many of the nurses adapted and managed their transition back to civilian life following their experiences of war.

In conclusion, this introductory chapter has argued, initially, and through a review of the literature, that women have been excluded from the category of trauma sufferers, and indeed the history of the condition. Shell shock has remained not only in the popular consciousness as a masculine affliction, albeit erroneously, but as the benchmark to which all scholars turn in their analysis of the history war trauma. It is perhaps understandable that any study of shell shock would omit women given its masculine connotations but this thesis feels that by re-examining the history, but with the inclusion of women, a greater understanding of the condition of war trauma can be achieved. This thesis will show that women nurses, not only could, but also should, be included in the

'shell shock story' both conceptually and materially. Contemporaries theorised about the condition in terms of the condition(s) and not according to gender. Furthermore evidence exists within the following chapters to support the fact that women did indeed suffer from shell shock and shell-shock-related conditions. This thesis will show the women's efforts through the testimony of military and medical authorities, and importantly their own, to justify their claims for consideration as shell shock sufferers, by society, the authorities, and the pensions system. While their treatment, though tardy in political and administrative terms, at the medical level shows little evidence of gender bias by medical authorities.

CHAPTER TWO

A Front Line Experience for Nurses

Naturally trench war was not a pleasant experience...
Nevertheless it was not nearly as bad as some would have one
believe.¹

The 'front lines' of the First World War are still generally and traditionally thought of as the most dangerous and, more importantly, exclusively male zones. It was only men who served in or near the trenches and 'at the front' and were subjected to long periods in poor conditions, up to their waists in mud, surrounded by sand bags, barbed wire, and dead bodies, conditions that often saw them enduring extreme cold, short rations, disease, illness, rats and lice and with the ever present fear of danger, injury, maiming and death. This traditional historical perspective is one that was re-created by such famous names as Remarque, Blunden, Jones, Graves and Sassoon,² and are so memorable and potent that it is difficult to discount them when reviewing the First World War experience. Similarly, writers such as John Fuller, John Ellis, Denis Winter and Andy Simpson,³ who view this war as an obscene and horrific a-historical event, perpetuate the idea that the male front line experience was

¹ Tony Ashworth. *Trench Warfare 1914 - 1918. The Live and Let Live System*. (London: Macmillan Press, 1980) p. 226.

² Erich Maria Remarque. *All Quiet on the Western Front*; Edmund Blunden. *Undertones of War*. (Harmondsworth: Penguin, 1928); David Jones. *In Parenthesis*. (Faber and Faber, 1937) Sassoon, is remembered for his heroic deeds, albeit as his alter ego 'Mad Jack', but little is made of the fact that he actually spent less than one month at the front. See Jean Moorcroft Wilson. *Siegfried Sassoon. The Making of a War Poet. A Biography 1886 - 1918*. (London: Duckworth, 1998)

³ See for instance, John Fuller. *Troop Morale and Popular Culture in the British and Dominion Armies 1914 - 1918*. (Oxford University Press, 1991); John Ellis. *Eye-Deep In Hell. The Western Front 1914 - 1918*. (London: Book Club Associates, 1979); Denis Winter. *Death's Men. Soldiers of the Great War*. (Harmondsworth: Penguin, 1979); and Andy Simpson. *Hot Blood and Cold Steel. Life and Death in the Trenches of the First World War*. (London: Tom Donovan Publishing, 1993)

both distinct and paramount and the trench experience was dangerous and widespread. Such writing gives credence to a collective and popular memory supporting the view of this war as one that was constantly horrific for men and comparatively safe for women.⁴

It is still largely accepted that, where women did serve during the First World War, they were limited to the home, or domestic front, or, when in France, they were restricted to the so-called safe areas, or non-combatant zones. Through the research of memoirs, personal testimonies and diaries of women who served during the First World War, many historians⁵ have demonstrated that they took up a variety of roles with the British Expeditionary Forces (BEF) and so it is no longer appropriate to see this war as a largely male dominated experience. Neither is it appropriate to view women's contributions with a traditional gendered perspective, one that sees women just occupying the home front.⁶

⁴ The popular 'images' we have of the First World War are further strengthened by BBC productions such as *Blackadder Goes Forth*, and William Boyd's *The Trench*. See also Paul Fussell. *The Great War and Modern Memory*; Eric J Leed. *No Man's Land*; Modris Ekstein. *The Rites of Spring: The First World War and the Birth of the Modern Age*. (New York: Bantam Press, 1989)

⁵ Lyn MacDonald. *The Roses of No Man's Land*; Claire Tylee. *The Great War and Women's Consciousness. Images of Militarism and Womanhood in Woman's Writing 1914 - 1964*; Sharon Ouditt. *Fighting Forces, Writing Women*; Lynda Tennant. 'Women at the Front during the First World War: The Politics of Class, Gender and Empire'. See also Raitt, S and Tate, T. (Eds) *Women's Fiction and the Great War*; Angela K Smith. *The Second Battlefield*; Susan Grayzel. *Women's Identities at War. Gender, Motherhood and Politics in Britain and France during the First World War*. (University of North Carolina Press, 1999)

⁶ In 1917 the War Office began to put women in uniform; WAAC (Women's Auxilliary Army Corps), and WRN (Women of the Royal Navy) were formed. 1918 saw the creation of the WRAF (Women's Royal Air Force). Some 100,000 women spent time in these units - 57,000 served in the WAAC alone. 12,000 volunteered to go to France. The Army used four main categories: Cookery, medical, clerical and 'miscellaneous' (mostly administrative). See also Martin van Creveld. *Men, Women and War. Do Women Belong in the Front Line?* (London: Cassell, 2001) p. 127.

Apparently, 'boundaries' were created in 1914 to preserve and confirm the status quo of prevailing gender identities. There exists an implicit assumption that 'front line' areas were under constant threat of danger and, therefore, no place for a woman, an assumption that has continued to permeate historical analysis. The same assumption suggests that immediate proximity to these dangerous, exclusively male areas, was responsible for all manner of physical injuries and traumas, and more importantly, the various psychological conditions synonymous with the First World War more commonly known as 'shell shock' or 'war neuroses'. Indeed, it was this idea of 'close proximity' to explosives, or shells, that led to various symptoms of shock and hence the creation of the term shell shock. Therefore conclusions have been made that, since women were kept at a distance and protected from the 'front lines', physical, or psychological casualties amongst women were few or non-existent. Many writers have reiterated this demarcation between the front and rear and, therefore, between male and female experience. This chapter will adopt a revisionist stance and re-examine three key areas surrounding the male and female experience of warfare on the Western Front.

The first section of this chapter, the **Front-line and Rear-line Dichotomy** re-examines the male and female experience on the Western Front by focusing on the language that was used to distinguish the geographical boundaries supposedly occupied by the two genders. It will begin by looking at how women spoke about the front, what going to the front meant for them, and in doing so will challenge the idea put forward by some feminist historians that the women who served in France and Flanders during the First World War had to create

their own 'psychological' front in order to feel a part of it and justify their existence in this male dominated environment. Second, this section will challenge the existence and validity of fixed geographical boundaries that marked out so-called dangerous and safe areas or 'male and female' areas. Numerous terminologies have been used to describe these geographical boundaries, but historians have used them inconsistently and without definition. For instance, the rhetoric includes, 'the front', 'the battle-zone', and 'the danger area', and, 'the rear', 'the safe zone', and 'the quiet zone'. The increasing technological changes associated with the First World War, particularly in relation to weapons of aerial bombardment, challenges the idea of a clear demarcation not only between the home front and the war front, but between forward and rear areas.⁷ It also undermines the idea that only men in the military could claim the authentic experience of being under fire. This chapter will reveal that nurses were in positions prompting experiences that led to significant rates of breakdown confirming that neither danger, nor the experience of war neurosis, was confined to the front line or to men.

The second section, *The Soldiers' Experience* questions the idea of a consistently horrific male experience of warfare by re-examining the nature of campaigns and fighting on the Western Front. Military historians, who focus on strategy and tactics as well as weaponry, have studied the methods of warfare

⁷ The Hague Convention of 1899 and 1907 forbade the attack from air on civilian 'undefended' areas. The Naval Convention of 1907 differed in that it permitted the bombing of areas considered to be 'military works [and] ...depots of arms. In short, one agreement protected undefended areas whilst the other saw anything that served a potential military purpose as a legitimate target. Initially, aircraft was not seen as an offensive weapon and used mainly for reconnaissance. However, later they were equipped with weapons and used against troops or lines of supply. Slowly they were used for the attack of cities. Cited in Susan Grayzel. "'The Souls of Soldiers': Civilians Under Fire in First World War France'. *The Journal of Modern History*. Vol. 78, No. 3 (September 2006) p 591.

employed during the First World War and particularly of those used on the Western Front. Traditional views suggest soldiers spent long periods in appalling conditions suffering severe deprivations and extreme dangers. More recently, revisionist historians, such as Gary Sheffield, Brian Bond, and Ian Beckett⁸ have attempted to challenge, or at minimum, contextualise this traditional 'Lions Led by Donkeys' perspective by putting forward an alternative analysis of the military and political aspects of the First World War, particularly of the Western Front. Their interpretations are based on historical research rather than on the emotion and sentiment that underlies the collective memory. This section will look particularly at the experience of trench warfare, and will argue that life in the trenches was not continuously or permanently horrific.

The third section, **The Nurses' Experience** identifies evidence of the experiences that women underwent as nurses and Voluntary Aid Detachments, commonplace experiences and duties that frequently placed them in positions of danger. This section challenges traditional assumptions that women were protected from the dangerous areas because not only were they subjected to extreme conditions and hardships comparable with those experienced by men, but they were also at risk of physical injury, illness and death and therefore of the psychological conditions commonly known as 'shell shock' and war neuroses.

⁸ Gary D. Sheffield. D. *Forgotten Victory*, See also Brian Bond. *The Unquiet Western Front*; and Ian. F. W. Beckett. *The Great War 1914 - 1918*. (London: Longman, 2001)

The Front and Rear Dichotomy

There is little doubt that when women left the shores of Britain in 1914 for France, they were not simply going to France, they were going to the 'front'. This highlights a clear distinction between the divide that was the 'home' and the 'front' of France and Flanders, and the 'sense of unreality of one another's world - of the disconnection between home and front'.⁹ From their positions at home, women, like men, expressed their perceptions of the front in terms of 'mystery, darkness, fantasy, myth and abstraction'.¹⁰ In her letters to her fiancée, Vera Brittain worried that the war

Was dividing us as I had so long feared it would, making real values seem unreal, and causing the qualities which mattered most to appear unimportant. [...] (the war had thrown up) a barrier of indescribable experience between men and women.¹¹

The transition from the shores of Britain to those of France, as with other theatres of war, was such an obvious and palpable change as to be like no other, and, as a unique and unreal experience, it was the same for both men and women. Going to war was like going to another world regardless of gender. Furthermore there was a very real and tangible sense of the disparity and disconnection between the two worlds of the home and the front and this was evident in the writing of both men and women. Vera Brittain's fiancée, Roland, wrote

Do I seem very much of a phantom in the void to you? I must. You seem to me rather like a character in a book or someone whom one has dreamt of and never seen.¹²

⁹ Susan Kingsley Kent, *Making Peace: The Reconstruction of Gender in Inter-war Britain*. (Princeton University Press, 1993) p. 53.

¹⁰ *Ibid.*

¹¹ Vera Brittain. *Testament of Youth*. p. 143.

¹² *Ibid.* p. 216.

For the women who left Britain, France and Flanders was the Western Front, it was the war, and many women considered themselves on 'active service' the moment they left the shores of Britain. Equally, when they described their route to the front it was with the same sense of either adventure, or trepidation, as witnessed in the comments of the soldiers. For instance, after being asked, in 1916, to go to Serbia to do war work Elsie Bowerman, commented 'it is what I've been dying to do, ever since the war started [...]. It is really like a chance to go to the front [...]. It is too thrilling for words. [...] I am nearly mad with joy'.¹³ Similarly, Ishobel Ross recorded upon hearing that she had been selected to join the Scottish Women's Hospital Unit

Three cheers! Got word today that we are to report to Victoria Station on Tuesday morning. The Unit are coming up on Monday to the Wilton Hotel. We are leaving from Southampton on Thursday.¹⁴

Writing later in 1933 Vera Brittain was to lament, and enthuse, about the days prior to her enlisting. 'Come back, magic days! I was sorrowful, anxious, frustrated, lonely - but how vividly alive!',¹⁵

Clare Tylee has argued that seeing the war as an 'alluring adventure' served to both deny it as a possible dangerous enterprise but also to place it on a footing with the action of their male counterparts.¹⁶ Tylee relates to the comment of Nurse Violetta Thurstan from 1915. 'One tastes the joy of comradeship to the full. [...] One could see the poetry of war [...] the zest [...] the

¹³ Letter from Elsie Bowerman to her mother. Dated 5th July 1916. Elsie Bowerman Collection. Fawcett Library, London. Cited in Susan Kingsley Kent. *Making Peace*. p. 51.

¹⁴ Ishobel Ross. *Little Grey Partridge. The First World War Diary of Ishobel Ross who served with the Scottish Women's Hospital Unit in Serbia*. (Aberdeen University Press, 1988) p. 4.

¹⁵ Vera Brittain. *Testament of Youth*. p. 291.

¹⁶ Claire Tylee. *The Great War and Women's Consciousness*. p. 76.

delight [...] the keen hunger, the rough food sweetened by the sauce of danger'.¹⁷

The idea of sleeping in tents, living off rations and performing 'demanding' work was considered attractive to some. Irene Rathbone's diary would suggest she was fairly upbeat upon arriving in France despite the content of her comments.

What a lot one learns over here in an hour. For instance, I hadn't realised that for weeks Boulogne was bombed almost nightly...that Abbeville was such a danger spot that scarcely a civilian was left, and about 18 WAACS had been killed - all this and more we gathered once on this side of the channel.¹⁸

Whilst on the other hand May Sinclair seemed more aware of the realities of war.

I'll confess now that I dreaded Ostend more than anything. We had been told that there were horrors upon horrors in Ostend. [...] Those five weeks of frightful anticipation when I knew I must go out to the War; the going to bed, night after night, drugged with horror, black horror that creeps like poison through your nerves; the falling asleep and forgetting it; ...ever since I knew that I must certainly go out with this expedition, I had been living in black funk; in shameful and appalling terror. [...] Every night before I went to sleep I saw an interminable spectacle of horrors: trunks without heads, heads without trunks, limbs tangled in intestines, corpses by every roadside, murders, mutilations, my friends shot dead before my very eyes.¹⁹

Following her first encounter with the wounded and the dead this member of the First Aid Nursing Yeomanry (FANY) remarked

There was no romance or triumph here, no wild war cry and exaltation - just these men, dirty and muddy and footsore,

¹⁷ Violetta Thurstan. *Field Hospital and Flying Column: Being the Journal of an English Nursing Sister in Belgium and Russia*. (London: Putnams, 1915) p. 174-5.

¹⁸ Irene Rathbone. General Diary. Entry for June 1918. Imperial War Museum.

¹⁹ May Sinclair. *A Journal of Impressions in Belgium*. (New York, 1915) p. 4-7 and 14.

bringing in their comrades, broken and maimed and moaning ...or very quiet.²⁰

Such comments are interesting, for despite protestations from the military that 'women were not invited to join the army and scarcely invited to help it in the field'²¹ or that all 'military and medical authorities insisted that the FANY(First Aid Nursing Yeomanry) would not be allowed to serve at or near the front,'²² these women did not appear to think they were going to any other place than where the action was. They were going to the front; they were going to the war. The same comments not only suggest a degree of acquiescence for the realities of war but for their part as integral personnel. It is difficult to intimate from these statements that these women were thinking they were going somewhere 'outside' of the war in order to do their bit, or that their role was less significant.

This is in contrast to the views of some feminist historians who have argued that women felt 'outside' of the action, so much so, that they were compelled to justify their existence in this male dominated environment by creating their own and 'imagined' front. A phrase coined by American nurse, Mary Borden,²³ has promoted this idea. The 'Forbidden Zone' is a phrase frequently referred to by feminist historians to denote an area in which women were not allowed to venture, a hypothetical 'divide' between the front and the

²⁰ Anon. A FANY in France. *Nursing Adventures*. (London: 1917) p. 132.

²¹ Sharon Ouditt. *Fighting Forces*, p. 8.

²² Ann Summers. *Angels and Citizens*. p. 276.

²³ Mary Borden. *The Forbidden Zone*. (London: Heinemann, 1929) Borden first volunteered with the French Red Cross and then set up her own hospital under French military command, first at Ypres and then at the Somme.

rear, the dangerous and the safe, the male and the female. It was because women apparently felt distanced by this 'forbidden zone' that historians have argued that women needed to justify their existence and to invent their own front. However, Borden states that it was so called 'because the strip of land immediately behind the zone of fire where I was stationed went by that name in the French Army. We were moved up and down *inside* it'.²⁴ Accordingly,

Our hospital unit was shifted from Flanders to the Somme, then to Champagne, and then back again to Belgium, but we never left '*La Zone Interdite*'.²⁵

Feminist and literary historians have, in the opinion of this study, adopted this phrase and used it with a degree of literary licence to support their own views and purpose, thereby authenticating the myth of separate or distinct experiences of men and women's war experience. Yet it is interesting to read it in its original context, for as a nurse serving in the war, far from feeling alienated and marginalized, as the feminist argument suggests, Borden clearly felt, and stated, she was at the heart of the danger.

This has been a common theme amongst feminist historians as they attempt to deconstruct women's use of language and imagery in order to demonstrate how they defined their 'own' front, because they apparently felt they could never be a part of the 'real' front, or the area where men were. In her thesis *A Civilising Mission*, Lynda Dennant acknowledges the image of the front as one of 'muddy trenches and barbed wire with men trying to stay alive against the odds', an image, which she says, has been 'mythologised in contemporary

²⁴ *Ibid.* Preface. (My emphasis)

²⁵ *Ibid.* (Emphasis in the original)

imagination', adding, 'it was a place from which women were altogether excluded'.²⁶ However, while she accepts there was a blurring between the front and rear lines she goes on to write

Women arrived at the front with a preconceived image of what war should be, and that was very much associated with the battlefield. Being at the front brought women to the 'real' war, but even at the front the 'heart of war' could seem far away unless the battlefield images, either soldiers, guns and hardship, were present.²⁷

This thesis would argue that, as nurses serving on the Western Front, they were very rarely apart from 'the soldiers, guns and hardships'. Dennant aligns with other feminist historians in suggesting that this image of being separate and marginalized, apparently held by women who went to the front, prompted some of them to be embarrassed and surprised at their circumstances, so much so that many 'created' their own 'front' in order to justify their presence. She claims there was a need for the women to 'locate themselves at the heart of the war' because they believed they were excluded from it otherwise. This thesis argues against the notion that nurses felt they were excluded and therefore had to invent their own front in order to feel a part of it. While they may not have been in the trenches they soon recognised that their own distinct role enabled them to witness the war at first hand because war at the front was much more than a trench experience. The trenches were in the forward or front line area, but the trench was NOT the front. By and large, when relating to the 'front' there is an immediate association with trenches that

²⁶ Lynda Dennant . 'A Civilising Mission. p. 96.

²⁷ *Ibid.* p. 117.

ignores the several miles of surrounding ground, and occupying any part of this ground also meant a susceptibility to the traumas and horrors of war.

Susan Kingsley Kent has argued that ‘...direct contact with the war or with its victims was articulated in sober, constrained, sharp, and clear terms. It seemed both natural and obvious that the women, who witnessed war at first hand, would view and describe it in this way. It was as if, in making the transition from home to front, the individual had received a secret knowledge, knowledge that transformed the consciousness, the senses, the very soul of the initiate, who was thereby ushered into a wholly different existence.’²⁸ For instance, May Sinclair described her reaction to the front lines as

If something had been looking for you, waiting for you, from all eternity out here; something that you had been looking for; and, when you are getting nearer, it begins calling to you; it draws your heart out to it all day long. [...] Its urgency, indeed, is so great that if you miss it you will have missed reality itself.²⁹

For her the reality was all too evident as she described her arrival on a hospital ward.

By the clear light and nakedness of the great hall [she saw]] rows upon rows of bound and bandaged bodies. It is utterly removed and unlike anything that you have experienced before [...] you are in another world, and under its strange impact you are given new senses and a new soul.³⁰

This thesis agrees that women did speak with a degree of clarity as well as with a subdued and sombre tone, but this was in response to both the seriousness and the realisation of that which they were experiencing and of the acceptance

²⁸ Susan Kingsley Kent. *Making Peace* p. 52.

²⁹ May Sinclair. *A Journal of Impressions* p. 2.

³⁰ *Ibid.*

of the positions they held. The tone and the degree of confidence in the writing was evident *because* of their location, and their unique position in the field of military medicine, which meant they did not have to defend themselves, and their writing authenticates this experience. Sinclair did not feel the need to justify or excuse her existence in this place. For her this was the front, and it was the war. She did not feel the need to differentiate her experience from that of a soldier's. The testimony of women, whilst not located in the trenches, demonstrates that they did not feel they were any less at the front. Furthermore, nurses, and VADs were uniquely placed to see things directly because they were nursing alongside the Royal Army Medical Corps (RAMC).

This is a view that has been echoed by Sarah Brady in her study, 'Nursing in Cardiff during the First World War. A Study of the Interaction between Women, War and Medicine in a Provincial City'.³¹

Women who were working or training as nurses during the First World War were part of an exclusive group of civilian women, as they came into direct contact with military casualties. They were not only more closely involved in the public sphere of war than the majority of their contemporaries; they were already part of another patriarchal circle, that of medicine.³²

Furthermore, Henriette Donner has doubted whether the VADs' 'predisposition toward work would have sustained the VADs without concrete, repeatable emotional compensation arising from the work and from the moral context in which it was carried out.' Accordingly

VAD work took place in the context of war [and] war magically illuminated the setting in which the work took place. The ever present possibility of death heightened a sense of existence.

³¹ Sarah Brady. 'Nursing in Cardiff during the First World War'. p. 1.

³² *Ibid.*

Shared dangers produced a feeling of equality. The total dependence of the comrade in battle, the wounded in the camp hospital, produced mutual affection and love. At the end of the day, both men and women experienced a sense of control; they had been tested and had not failed.³³

Kingsley Kent further reiterates how 'connected' the nurses were to the war and the fighting by 'sharing the experiences of the men at the front [and how this] meant subjecting oneself to harrowing smells, sounds, and sights, which women recorded in extraordinary detail'.³⁴ She also cites the case of a Women's Army Auxiliary Corps (WAAC) member who similarly recorded

That horrible smell - the battlefield smell (made up of) putrescent water stale poison gas, and the effluvia of dead bodies. [...] It was revolting, sickening. It got into one's inside, so that one remained conscious of it even in one's sleep. It penetrated everything - clothing, blankets; one's very body reeked of it. Nor could one grow accustomed to it as one could to other things.³⁵

Elsie Bowerman, who served with the Scottish Women's Hospital in Serbia, also described the smell, suggesting close proximity to the battle. Her diary entry reads,

Hospital only equipped for 100 - nightmare of a day - one ward just straw - man laid on without taking clothes off. Terrible sights and sounds - lots of very bad cases - gangrene - smell at times almost unbearable - a strange sickly odour quite unlike anything else, which seems to permeate everything and stick in one's nostrils, even when one is out in the fresh air. Operations continuously all day and night till 5 a.m. - nurses up nearly all night.³⁶

³³ Henriette Donner. "Under the Cross - Why V.A.D.s Performed the Filthiest Task in the Dirtiest War: Red Cross Women Volunteers, 1914 - 1918' *Journal of Social History*. Vol. 30, No. 3 (Spring 1997). p. 695.

³⁴ Susan Kingsley Kent. *Making Peace* p. 59.

³⁵ Anon. *WAAC: The Woman's Story of the War*. (London: 1930). p. 199 - 200.

³⁶ Elsie Bowerman Diary, 1st January 1917. (Elsie Bowerman Collection, Fawcett Library) Cited in Kingsley Kent, *Making Peace* p. 59.

Briefly, this section has challenged the notion of there being a clear distinction in terms of the language which describes the front and rear lines, or, the dangerous and the safe areas. The front lines cannot always be described as the most dangerous and the rear cannot be described as safe. Ultimately, there existed a blurring of the two zones. More importantly, the suggestion that nurses 'created' their own 'front' in order to feel a part of the war has also been re-examined. Nurses, working within the military and the medical spheres were uniquely placed both geographical and metaphysically to the extent that their justification and rationalisation of their location in this war was unnecessary. Their experience, alongside that of the soldier, regardless of the location, will now be examined in more detail in the following two sections.

The Soldiers' Experience.

In terms of the geographical location of the Western Front the terms used to describe the so-called safe and dangerous areas are numerous and commonplace. Words such as, 'in the field', 'the firing line', 'at the front', 'on the front', 'battle zone', 'combat zone', 'danger zone', 'forward area', 'active zone', 'battle front', 'fire-swept zone', 'zone of destruction' and conversely, the 'rear area', 'safe area', 'quiet zone', 'non-combatant zone'. In relation to the Great War these terms are all used with the implicit assumption that they clearly relate to one side of the line or the other. They are evident throughout contemporary personal testimony, memoirs, war literature, and, more recently, historians' accounts. Since military maps show 'lines' of trenches it is understandable that such terminology has arisen especially as these lines of trenches were largely static. Yet during so-called static trench warfare the objective was always to

move forward to gain the opponent's ground and, although comparatively small, some gains meant that geographical boundaries did change. Furthermore, advances in technology and therefore of weaponry meant firepower could extend far beyond these lines and what might have been clearly defined boundaries could become blurred. In short, the geographical area of the Western Front has been divided into the 'front', signifying 'dangerous' and 'male', and 'rear' signifying 'safe' and 'female'. While there is a general acceptance of a 'front line' and a 'rear line', further analysis of military movement on the Western Front reveals no such distinction of any clear boundaries in terms of the threat of danger.

The war on the Western Front has become synonymous with industrialised and pointless slaughter emanating from the early years of the war which did, indeed, see its fair share of disasters such as the Retreat from Mons and actions like those seen at Neuve Chapel, Aubers Ridge and Loos.³⁷ It is similarly remembered as a war involving barbed wire, mud, mass bombardments, disease and misery. These views of the war are mainly founded on the collective memory of soldiers and from the personal testimonies of those more famous soldiers such as the poets who perceived the war up to this point as one consisting of blunders, largely orchestrated or mismanaged by 'incompetent generals'. This section explores what it believes to be misconceptions about the war in regard to the omnipresent danger of the 'front

³⁷ Regrettably, some military historians have supported this view including Dominic Graham and Shelford Bidwell. *Fire-Power: British Army Weapons and Theories of War, 1904 - 1945*. (London Allen and Unwin, 1982) and Tim Travers. *The Killing Ground: The British Army, The Western Front and the Emergence of Modern Warfare 1900 - 1918*. (London: Routledge, 1993) It is accepted that some of those earlier disasters were attributable to faulty tactics but in terms of technology and weaponry it took over a year for the BEF to be in a state of preparedness.

line' and the trenches and the over-representation of danger being a constant for men.

John Fuller traditionally claims that 'time in the front line and in close support was generally time spent in trenches' and 'time in the trenches was of course the hardest part of the infantryman's service, [...] the mud, the rain, the cold, the shells, the lice, and the rats'.³⁸ However, he subsequently claims that 'once an infantryman had arrived with a 'front-line' unit, his life fell into five phases. He would spend part of his time 'in the front line, [another] in close support, [...] a third at some distance, a fourth phase [...] when the brigade [...] moved, [and a] fifth was divisional rest'.³⁹ Therefore, men rarely spent more than a few days in the forward front line trench positions. A typical stretch of duty was a month at the front. This was made up of 'four days in the front line, four in support, eight in reserve and the remainder in rest'.⁴⁰ There were anomalies but, generally, only a few men from a division served in the trenches at any time.⁴¹ 'Being in the trenches occupied only a part of an infantryman's time, while fighting in a battle was a rare event.'⁴² This was further dependent upon which sector of the line they were posted. In total, an infantryman spent only one fifth of his time in the most forward part of the trench system. The front

³⁸ John Fuller. *Troop Morale*. p. 58-59.

³⁹ *Ibid.*

⁴⁰ Denis Winter. *Death's Men*. p 81.

⁴¹ This is also confirmed by Gary D. Sheffield, *Forgotten Victory*. p. 150, who cites the diary of Charles Carrington. Having analysed his diary Carrington discovered that in 1916 he spent 101 days 'under fire', 65 of which were in 'front-line trenches, and 36 in supporting positions close at hand.' A further 120 days were spent in reserve, and 73 in rest. Of the remaining 72 days, 17 were spent at home on furlough or 'leave'...and 21 at various instructional schools. The remaining time was spent travelling or in depot camp. Charles Edmonds. (C. Carrington) *A Subaltern's War*. (London: Peter Davis, 1929) p. 120.

⁴² Gary D. Sheffield, *Forgotten Victory*. p. 151.

line experience for soldiers was therefore variable, alternating between periods of intense fighting and inertia.

The war began in 1914 as a war of movement, but rapidly settled into a static war after four months. The trench system stretched for some four hundred and seventy miles, representing a shallow 'S' from the North Sea to Switzerland. It passed through various types of terrain as a consequence, which often made large-scale battles difficult.⁴³ Trench warfare, as described by Tony Ashworth, essentially comprised of both large-scale battles, fought intermittently, and continuous 'small-scale attacks where each side aggressed each other in a multitude of ways'⁴⁴ Ashworth distinguishes the two types of warfare.

The former were the massive, dramatic episodes of the war: the battles of the Somme, of Passchendaele, Verdun and many more; but the latter was the ceaseless struggle in trenches, which occurred not only *within* the intervals between large battles but also *throughout* a given battle, such as the Somme, but elsewhere in the line.⁴⁵

Ashworth felt this distinction was significant enough to focus almost entirely on the small-scale events in his book, *Trench Warfare 1914-1918. The Live and Let Live System*, published in 1980. His concern was for the

Less spectacular, routine or normal trench warfare, which, unlike large battles, was going on at all times of the war, on some part of the line [and which he referred to as] simply [...] trench warfare.⁴⁶

⁴³ Terrain in Flanders was particularly flat and became waterlogged, giving rise to the infamous mud sodden ground.

⁴⁴ Tony Ashworth, *Trench Warfare*. p. 2.

⁴⁵ *Ibid.* (Emphasis in the original)

⁴⁶ *Ibid.*

He argued that the 'live and let live' system was the characteristic practice that made up 'trench warfare'. This is a departure from the ideas and notions commonly held relating to fighting and the trench experience of World War One. Our perception and images of the front lines and the trenches, as places of horror, constant danger, fear, filth and death, have been 'fed into' by the memoirists of the First World War and, in particular, from the anti-war literature of the nineteen twenties and thirties. In support of his own argument against the anti-war literature, Brian Bond (2002) cites historian Correlli Barnett (1970) who published a critique of British anti-war literature of the nineteen twenties, accusing the anti-war writers of focusing obsessively on 'the horrors' of combat and therefore 'distorting the complex reality of military experience'.⁴⁷

The image of trench warfare has remained with us: 'To the mind of the modern reader, fighting in the First World War is all horror and misery'.⁴⁸ Ford Madox Ford, writing in 1916 described the fighting as 'a million men, moving one against the other ...impelled by an invisible moral force into a Hell of fear that surely cannot have had a parallel in this world'.⁴⁹ In a 1973 study, trench warfare is described as

The intensification of combat was mutual and progressive, and seemingly obeyed mathematical rather than human laws. Hence the inhumanity of its conditions and the helplessness which the individual subjected to those laws so often felt.⁵⁰

⁴⁷ Correlli Barnett. 'A Military Historian's View of the Literature of the Great War'. *Transaction of the Royal Society of Literature*. Vol. 36, (1970) 1-18. Cited in Bond. *The Unquiet Western Front*. p. 27.

⁴⁸ Niall Ferguson, N. *The Pity of War*. (Harmondsworth: Penguin, 1999) p. 340.

⁴⁹ *Ibid.*

⁵⁰ C. Messenger. *Trench Fighting, 1914 - 1918*, (London: Pan/Ballantyne, 1973) Cited in Tony Ashworth *Trench Warfare*. p. 14.

Yet Ashworth argues that this picture of helpless combatants, passively enduring and powerless to resist such 'laws', does not do justice to those soldiers who were more resourceful in adapting to their trench environment. While it represents 'some part of the trench war experience', it does not describe the 'whole' or 'average' war experience.⁵¹ There is an important point to be made in relation to the front and rear line dichotomy, between 'active' sectors, which correspond to the traditional notions of trench warfare, and the sectors that were described as 'cushy', which was a term used to describe 'any comfortable state'⁵² and referred to those sectors where 'reciprocal violence of enemies was small in volume and perfunctory in performance.'⁵³ Here, 'life was relatively safe, tolerable, even comfortable, and greatly contrasted with life on an active sector, where continuity and zeal marked the fighting'.⁵⁴ Continuing the point Ashworth quotes Lt. Wyn Griffiths, infantry officer of the 38th Division.

A 'profound difference' existed between sectors where 'a perfunctory showing of the daily discourtesies of war' predominated, and sectors 'whose quality took the form of a permanent manifestation of evil'.⁵⁵

Little is made of this 'profound difference' in traditional historical analysis of the First World War and trench warfare, although trench fighters often referred to it both 'figuratively and factually'.⁵⁶ Winston Churchill, when commanding a battalion of the 9th Division, wrote to his wife saying, 'It is a very quiet part of the line [...]. The casualties run only 5 or 6 a day on the Front of the

⁵¹ *Ibid.*

⁵² J. Brophy, and E. Partridge. *The Long Trail*, (London: Andre Deutsch, 1965) p. 107.

⁵³ Tony Ashworth. *Trench Warfare* p. 15. See also Gary D Sheffield. *Forgotten Victory* p. 151.

⁵⁴ Tony Ashworth. *Trench Warfare* p. 15.

⁵⁵ Lt. Griffiths, W. *Up to Mametz*. (London: Faber & Faber, 1931). p.71 - 73.

⁵⁶ Tony Ashworth. *Trench Warfare*. p. 15.

division which is no more than is lost in one battalion of the Guards'.⁵⁷ It was deemed to be even quieter still in other parts of the line. A battalion of the 48th Division 'had only one officer casualty from April 1915 to Spring 1916 while holding a series of quiet fronts'.⁵⁸ Responding to the 'disenchanted' authors of anti-war literature, plentiful in the thirties, an ex-infantry officer of the 63rd division remarked that they were distorting the reality of trench war, 'which was, more accurately, a mingling of active and quiet sectors where 'boredom' and 'inactivity' made up 'nine tenths' of the life of the infantry soldier'.⁵⁹

The difference between active and quiet fronts is hidden by the statistical treatment of trench war casualties and further distorts the mental picture we have of trench warfare. The official history describes a period between May to September 1915 as 'a period of trench warfare with a steady toll of 300 casualties a day'.⁶⁰ As an arithmetical mean this figure does not explain whether these casualties were lost on one day, every day, some days, or whether they were distributed between sectors and units. By continuing to employ casualty statistics in such a manner some historians feed into our distorted pictures of trench warfare. Martin Middlebrook for instance comments that trench warfare in the first half of 1916 was responsible for a battalion losing

⁵⁷ Martin Gilbert. *Winston S. Churchill*. (London: Heinemann, 1972) p. 1372.

⁵⁸ Crutwell, C. R. M. F. *The War Service of the 1/4th Berkshire Regiment* (T.F.). (Oxford: Basil Blackwell, 1922) p. 46.

⁵⁹ D. Jerrold. *The Lie About the War*. (London: Faber & Faber, 1930) Tony Ashworth comments that Jerrold '...overstated his case' and the assertion that '...most trench fighters were bored for most of the time is as inaccurate as the contrary that most were fighting for most of the time.' He claims it is important to distinguish between sectors and 'there was neither boredom on active sectors nor continual struggle on quiet sectors.' Cited in Tony Ashworth. *Trench Warfare*. p. 17.

⁶⁰ Edmonds, J. *History of the Great War, Military Operations, France and Belgium, 1915*, (London: Macmillan, 1928) p. 83.

about 30 men each month through death and wounds.⁶¹ Using statistics in such a way gives rise to the notion that trench warfare 'had a uniform intensity and continuity which, in fact, it did not'.⁶²

It also needs to be borne in mind that there may be a distinction between contemporary and retrospective accounts of trench warfare. The former are accounts written from the trenches shortly before publication in informal dispatches and were more representative of the large and small-scale events. They were keen to explain the differences in sectors and often described the particulars of the 'cushy' Front. The latter rely on selections rather than representative accounts of trench warfare that are often seen in memoirs and autobiographical accounts, and often written by the disillusioned interwar writers. One exception was that written by Edmund Blunden.⁶³ According to Cyril Falls, Blunden's *Undertones of War* is 'almost a perfect picture of the small events which made up the siege warfare of France and Flanders'.⁶⁴ Furthermore, Blunden openly refers his reader to the 'live and let live' system, which operated in trench warfare. Although not coined by Blunden, the phrase did appear as early as 1915 in the dispatches of Ian Hay.⁶⁵ The 'live and let live system' was essentially a

⁶¹ Martin Middlebrook. *The First day on the Somme*. (London: Allen Lane, 1971) p. 35.

⁶² Tony Ashworth. *Trench Warfare*. p 16.

⁶³ Edmund Blunden. *Undertones of War*.

⁶⁴ Cyril Falls. *War Books*. (London: Peter Davis, 1930) pp. 182-3.

⁶⁵ Ian Hay. *The First Hundred Thousand*. (London: Corgi, 1976) It also appeared in various other inter war and post war publications. As 'One felt that the recent occupants of the sector had erred in the direction of a laissez-faire policy', in Siegfried Sassoon. *Sherston's Progress*. (London: Folio Society, 1974) p. 174. As a 'principle of laissez-faire' in Robert Ross. *The Fifty First in France*. (London: Hodder and Stoughton, 1918) p. 210. As 'rest and let rest' in *The War History of the Sixth Battalion The South Staffordshire Regiment*. (London: Heinemann, 1924) As 'let sleeping dogs lie' and 'mutual obligation element' in D. V. Kelly. *39 Months*. (London: Ernst Benn, 1930) p. 122, and p. 9 respectively. As 'tacit truces' in P. MacGill. *The Great Push*.

Truce where enemies stopped fighting by agreement for a period of time: the British let the Germans live provided the Germans let them live in return. [It] denoted a process of reciprocal exchange among antagonists, where each diminished each other's risk of death, discomfort and injury by a deliberate restriction of aggressive activity, but only on condition that the other required the restraint.⁶⁶

As a result of the live and let live system, which allowed for 'truces' between groups of individuals on the one hand and 'hundreds of soldiers: infantrymen, gunners, trench-mortar crews and so forth'⁶⁷ on the other, new troops on their first trench tour were often surprised at their first introduction to warfare. According to one officer of the 41st Division 'Probably the most outstanding impression gained was the prevailing quietude. It was difficult to believe that there was a war on and this was really the front line'.⁶⁸ Therefore a sector could be either active or quiet depending on the attitude of the units. While some soldiers were disposed to live quietly, another was 'active' because the soldiers wanted to fight. Furthermore, truces were mobile and not fixed geographically. 'At any time on the western front, some sectors were active,

(London: Herbert Jenkins, 1916) p. 87. As 'mutual understanding' in L. M. Newton. *The Story of the Twelfth*. (Tasmania: Walsh and Sons, 1925) p. 173, and 'characteristic trench warfare, sort of take the thick with the thin, compromise, and be mighty glad to be alive' in R. G. V. M. Bland, *The Sixth Welsh (TF) in France. 1914 - 1918*. (Cardiff, 1920) p. 81.

⁶⁶ Tony Ashworth. *Trench Warfare*. p. 19. Accordingly, 'the 'profound difference' between the quiet sector and the active sector was, therefore, the exchange of peace, according to the rules of live and let live on the former, and the exchange of aggression according to the rules of kill or be killed - the high command policy for official trench warfare - upon the latter. ...Truces were usually tacit, but always unofficial and illicit. The agreement between antagonists was unspoken and expressed in certain actions - or non-actions - which were meaningful to front fighters but not always to others. Truces were illegal at all times for they were neither created nor legitimated by authority but explicitly forbidden. The unofficial policy of live and let live was the antithesis of the official kill or be killed.'

⁶⁷ Tony Ashworth. *Trench Warfare*. p. 20.

⁶⁸ R. O. Russel, *The History of the 11th (Lewisham) Battalion The Queen's Own Royal West Kent Regiment*, London: Lewisham Newspaper Company, 1934) p. 36.

some quiet, [and] the pattern changed frequently as units of different dispositions passed among the sectors.⁶⁹

While it is not denied that aspects of trench warfare were traumatic, horrific, and dangerous on a mass scale, it should be remembered that this was not the norm all the time. The pictures and images we hold of trench warfare are not typical, or average. There was no true, common or conventional war experience. Indeed, many soldiers' accounts of war relate to its surrealism. Thus, there is a contradiction between the images of trench war as an, 'obscenity of death and degradation, found in the poems of Wilfred Owen',⁷⁰ and the images as suggested in this chapter. As Ashworth comments, the live and let live system was 'endemic to trench warfare [and is] insufficiently researched [to the point that] one can know neither how men endured the war nor the nature of the war experience, without also knowing how trench fighters controlled some conditions of their existence.'⁷¹ Therefore, the implication of a 'system' suggests the front was much more than the trenches and a typical system of trenches, in terms of their depth, often stretched back almost a mile or more, consisting as they did not just of the 'forward' trench, but reserve and supply trenches conjoined by communication trenches. The overall depth of the British, including the French and German trench systems, varied but the British trench system averaged a minimum of 1000 yards. The experiences of soldiers positioned within the trench system would vary. The 'front line' soldier's experiences would be different from those of a soldier placed in the

⁶⁹ Tony Ashworth. *Trench Warfare*. pp. 20/21.

⁷⁰ *Ibid.* p. 22.

⁷¹ Tony Ashworth. *Trench Warfare*. pp. 22/23.

communication trench or the reserve trench, and similarly, the experience of an infantryman in the first months of the war would be different again from that of the latter months. Life in some trenches was generally bleak and depressing but not all trenches, or indeed areas, were so. The strategies employed by the army also meant that the forward trenches were not always those of most danger. In the latter period of the war, in 1917 for example, there was a general move towards 'defence in depth', which meant that the front line trenches were thinned out in favour of placing more men in the rear, and in general, from a division of 20,000, only 2000 would be positioned in the trenches. It is therefore unwise to make assumptions about trench warfare and the trench experience as being the exclusively dangerous zone it was purported to be.

More recently, historian Hew Strachan has argued that trench warfare, rather than an area of danger, was actually a prime factor in the *conservation* of lives during the First World War, and, based on analysis of casualty figures argues that, exposure in open ground was considerably more dangerous.

Trenches created health problems but they saved lives. To speak of the horror of the trenches is to substitute hyperbole for common sense: the war would have been far more horrific if there had been no trenches. They protected flesh and blood from the worst effects of the firepower revolution of the late nineteenth century. [...] The dangers arose when men left the embrace of the trenches to go over the top, and when war was fluid and mobile.⁷²

⁷² Hew Strachan. *The First World War*. (New York: Simon and Schuster, 2003) pp. 159-160. For a similar revisionist perspective of the First World War see also Roger Chickering and Stig Forster. *Great War. Total War. Combat and Mobilisation on the Western Front, 1914-1918*. (Cambridge University Press, 2000)

This poses an interesting point for the safety of women, whose role frequently saw them in situations and environments where cover, in the form of a trench, was not available.

Apart from views about the trenches, which have been embedded in the popular conscience, similar ideas exist concerning the first two years of the war. Notions of incompetence and futility leading to mass slaughter and culminating in the battle(s) of the Somme starting on the 1st July 1916 have persisted throughout the generations. Prior and Wilson have posed this same question, 'why has the image of the infantry plodding shoulder to shoulder to their doom exercised such an iron grip on our vision of the battle?' and attempt an answer thus.

For the patriots and the perplexed, the Haig haters and the Haig admirers, for the 'westerners' and for those for whom the Western Front was a synonym for a bloody shambles, the first day of the Somme became the necessary image of the war. By the time later writers made their appearance the conventional image was so strongly embedded that it possessed the status on an established fact, beyond criticism or investigation. When, rarely, an historian did gain an inkling of the real story (as with Farrar-Hockley) he seemed reluctant to believe what he had found, and re-embraced the received wisdom as swiftly as possible.⁷³

They went on to add that the 'established portrait of the battle was derived from Buchan and other early writers on the Somme. The portrait seemed to them particularly appropriate because it resonated with their view of the virtues

⁷³ Robin Prior and Trevor Wilson. *The Somme*. (New Haven and London: Yale University Press, 2005) pp.116-7.

possessed by the British infantry - steadiness under fire and unflinching bravery in the face of disaster.⁷⁴ Likewise, of the Somme, Paddy Griffith writes

It is worth reiterating that 1 July was always seen as exceptional by almost everyone who had anything to do with it. It was the 'Bloody Sunday' or the 'Tiananmen Square' which stood out from the less dramatic, less deadly, but nevertheless far more significant and corrosive structural (or background) violence all around it. It was a bizarre aberration which would never recur, but which has indelibly marked the public imagination.⁷⁵

Similarly, statistics based on research reveal that the BEF was only 'heavily engaged in major battles for little more than thirty days between the Christmas fraternisations of 1914 and 30th June 1916'.⁷⁶ Furthermore, the battle of the Somme saw some thirty-three infantry divisions involved, constituting about half of the BEF and some were sent in twice, but the actual front lines of the battle were held by only half of those divisions again. Hence, during the battle approximately one quarter of the BEF was actively engaged at any one time.⁷⁷ The battle of the Somme saw a 'total casualty list of something like 33 per cent of all the infantry available for the battle, but the public seems to have run away with the idea that this was a habitual scale of loss in every day of every battle.'⁷⁸

⁷⁴ *Ibid.*

⁷⁵ Paddy Griffiths. *Battle Tactics of the Western Front. The British Army's Art of Attack, 1916 - 1918*. (Yale University Press, 1994) p. 15.

⁷⁶ *Ibid.* p. 11.

⁷⁷ *Ibid.* p. 16.

⁷⁸ *Ibid.* p. 15. 'On any given day there might be less than half a dozen such attacks on the entire twenty-seven-mile frontage of the battle, or in other words an army with something like 250,000 infantry might be attacking with no more than 5,000 combatants, or 2 per cent of its strength'.

Additionally, the weaponry, in becoming increasingly more advanced, meant that so-called danger zones were extended beyond the front lines. This is a fact supported by Prior and Wilson, who commented that casualties of the Somme could result from, 'unsubdued machine guns and artillery (which) could decimate formations well behind the British line.'⁷⁹

Although the exact number of casualties suffered by the British *behind their own front line* cannot be calculated, it was probably around 30 per cent of all British casualties suffered on the 1 July. [...] The killing zone then did not just encompass the width of no man's land, it continued back some thousands of yards into British positions.⁸⁰

While the range, weight and accuracy of the weaponry increased, with field artillery extending its range to 6,000 meters and the mobile heavy artillery extending its range to some 10,000 meters, the 'scale of the battle was thus increased from a few miles to several score'.⁸¹ The battle of Arras in 1917 is noted as the battle that benefited from such improved weaponry. Notwithstanding the heavy losses of soldiers from such firepower it also remains that the range was capable of maiming and killing several non-combatants, men or women, who, arguably would not have been in the immediate vicinity of the front line. It is also clear that huge numbers of men received injuries as a result of the periods spent in the trenches, but equally injuries could be received in areas other than the trenches. Therefore, danger was not confined to the trenches and neither was the experience of war neurosis, a condition that depended, it was thought, on having served in the

⁷⁹ Prior and Wilson. *The Somme*. pp. 115-116. 'This was the case in the area of the 32 Division where enemy domination of the debouches from Authuille Wood proved devastating to the follow up formations.' p. 89.

⁸⁰ *Ibid.* (Emphasis in the original).

⁸¹ M. Howard. 'Men Against Fire: The Doctrine of the Offensive in 1914' In Paret, P. (Ed) *Makers of the Modern Strategy - Machiavelli to the Nuclear Age* (Oxford: Clarendon Press, 1991) p. 511.

front lines. This chapter will now turn to look at the experience for women, of whom a significant number went on to suffer both physical and mental injuries in the course of carrying out their duties.

The Nurses' Experience.

Women were employed as military nurses in the Great War in significant numbers: One source states 13,124 members of the Queen Alexandra Imperial Military Nursing Service Reserve (QAIMNS(r)) were demobilised in February 1919 with a further 10,549 members of the Territorial Forces Nursing Service (TFNS). Women Voluntary Aid Detachments (VADs) constituted some 82,857 of the demobilised figures from April 1920.⁸² Treating soldiers in combat zones has always been essential for the conduct of war and women have traditionally taken on this role. Since nurses were required by the military to alleviate the needs of the wounded and sick soldier they were posted to areas where they could be easily accessible and this necessarily placed them close to 'forward' areas.

Attempts were made to prepare the groups of women who went out to France. Training and examinations consisted of elements of first aid and topics relating specifically to physical illness. Training also included some medical and scientific understanding but essentially consisted of domestic and housekeeping duties. Ishobel Ross, who served with the Scottish Women's

⁸² *Statistics of the Military Effort of the British Empire during the Great War. 1914 - 1920.* (1922).

Hospitals Unit, recalled her journey out to Salonika, 'we had tea, to "cement" the Unit', [and] 'Dr Bennett lectured us on the minor horrors of war'.⁸³

Nurses in the First World War were often posted to serve in Base Hospitals, Stationary Hospitals, Casualty Clearing Stations and on Ambulance Trains. By the end of the first year of the war there were hospitals at Le Havre, Etretat, Rouen, Boulogne, Wimereaux, Versailles, Le Treport, Dieppe, and Abbeville.⁸⁴ During 1915 the number of nursing staff in France increased from 1000 to 2869, which included 709 VAD members.⁸⁵ Nurses were posted to Casualty Clearing Stations and in 1915 the number of these stations increased from nine to twenty nine.⁸⁶ Nurses were supplied to some field ambulances. In 1916 the number of hospitals and other units had grown to twenty-four General Hospitals, three Isolation Hospitals, three Stationary Hospitals, twenty nine Casualty Clearing Stations, twenty two Ambulance Trains, twelve Ambulance Barges and twelve Hospital Ships. All these were staffed with nurses.⁸⁷

Early in the war, Casualty Clearing Stations were known as hospitals largely because they were stationary, and often situated in buildings. They were renamed 'stations' in 1915 so as to make clear their limited, and mobile, function,⁸⁸ because of their proximity to danger. For instance, in the case of

⁸³ Ishobel Ross. *Little Grey Partridge*. pp. 6-7

⁸⁴ Elizabeth Haldane. *The British Nurse in Peace and War*. (London: John Murray, 1923) p. 191.

⁸⁵ *Ibid.* p. 191.

⁸⁶ *Ibid.* p. 192.

⁸⁷ *Ibid.* p. 197.

⁸⁸ Nicholas Bosanquet. Paper submitted for '1914-1918 The War Experienced'. Peter Liddle Collection, University of Leeds. Also see Chapter 33 in Hugh Cecil & Peter Liddle. (Eds) *Facing Armageddon. The First World War Experienced*. (London: Leo Cooper, 1996) p. 455.

transportation of the sick and wounded from Field Ambulances to Casualty

Clearing stations

If a battle ends in the enemy being repulsed, the Clearing hospital advances and takes over the wounded direct from the Field Ambulances. If the result of the battle has not been decisive, and another attack is feared, the necessity exists of clearing the Field Ambulances of wounded at once: but the Clearing Hospital under these circumstances, would be unable to advance as the lines must be left unhindered in case any retirement should become necessary.⁸⁹

Initially, Officers, N.C.O.s, (Non Commissioned Officer) including Medical Officers, with additional support drawn from Male Voluntary Aid Detachments, staffed these stations. The wounded would then be transported via rail, road, (or water) to temporary hospitals, Rest Stations and General of Base Hospitals, all of which were staffed by female nurses and VADs. However, it was clear that the nurses who staffed these clearing stations felt they were nightmarish places to work, for here they

Had to endure air raids and shellfire constantly, [and] from July onwards the advanced units suffered *continuously* night after night. The sisters' huts were sandbagged and they themselves were given helmets to wear. The most terrifying experiences were perhaps those of the nursing staff at Brandhoek in August, when a staff nurse, T.F.N.S., was killed, and at Zuydecoo [sic] in November, when definite raids were made on hospitals. Any cases of nervousness were reported at once, so that nurses might be released.⁹⁰

In confirmation Lyn Macdonald writes

Specialist surgical teams of doctors, nurses and anaesthetists stood by ready to move quickly to where they were most

⁸⁹'The Organisation of the Individual Units of the Medical Services in the Territorial Force'. Women at Work Collection. Imperial War Museum B.R.C.S. 1.2/13. [No Date]

⁹⁰ Elizabeth Haldane. *The British Nurse*. p. 214.

needed. Operating centres were sent forward, near the line, to deal speedily with the seriously injured who would otherwise not have survived the ambulance journey to the casualty clearing stations. It all looked very neat on paper, where the crosses denoting the medical units were drawn thick on the map as far back as Doullens.⁹¹

Following the battles of the Somme sixty-eight nurses were sent to the front as reinforcements for Casualty Clearing Stations. Nurse Julia Adam who served with the QAIMNS(r) was in France between August 1914 and August 1917. She was stationed at a CCS in the 'Somme area' thereby suggesting how far forward she was posted and the element of risk she likely faced.⁹² 'Trained nurses were sent to the stations to help with the dressings of the men arriving straight from the front on emergency trains, and at Havre and Rouen the work was exceedingly heavy, each hospital having as many as 2,000 patients and receiving two train-loads a day.'⁹³ In August 1916 Bethune was heavily shelled and the Casualty Clearing Station was hit. 'Sisters on duty in the operating theatre were wounded with flying bits of glass'.⁹⁴ Similarly, two casualty clearing stations by the name of 'Edgehill' and 'South Midland' were 'badly bombed, and one sister was slightly wounded by a bomb that killed one of her patients and wounded two others.'⁹⁵

Similarly, nurses could be the victims of gas attacks whilst serving in Casualty Clearing Stations. Nurse Violet Barugh was stationed with 29th

⁹¹ Lyn MacDonald. *The Roses of No-Man's Land*. p. 160.

⁹² NA PIN 26/19985. Julia Adam.

⁹³ Elizabeth Haldane. *The British Nurse*. p. 205.

⁹⁴ *Ibid.* p. 206.

⁹⁵ *Ibid.*

Casualty Clearing Station in August 1916 at Bapaume when it was subjected to a 'British Gas Attack', the unfortunate consequence of it being blown back from the lines. Nurse Barugh went on to develop asthmatic and bronchial symptoms.⁹⁶

Air raids on Casualty Clearing Stations were not uncommon and would often result in casualties and even fatalities amongst the nurses. For example, '(o)n March 21st, 1918, at 58 CCS., Lillers, Sisters' K Maxey, TFNS., E. Andrews, TFNS., Acting Sister M. A. Brown, QAIMNS(r)., and Acting Sister M. D. Lestwick, QAIMNS(r), were crossing a railway line going from their quarters to the hospital to duty.

A raid was going on and a bomb fell, which unfortunately killed Sister Andrews and seriously wounded Sister Maxey. The others decided that one should remain with the two who had been hit and that the other should return to the C.C.S. to get help. The whole time a series of explosions were going on from an ammunition train which had been hit. After this experience Miss Lestwick and Miss Brown worked all night in the operating-theatre, (sic) displaying the most wonderful courage.⁹⁷

Brittain was also to write of her experience amid an air raid whilst trying to tend to wounded,

For nearly a month the camp resembled a Gustave Dore [sic] illustration of Dante's *Inferno*. Sisters flying from the captured Casualty Clearing Stations crowded into our quarters; often completely without belongings.⁹⁸

Women were also employed to drive the wounded in ambulance cars and were used to staff the ambulance trains that convoyed the wounded

⁹⁶ NA PIN 26/2000 Violet Barugh.

⁹⁷ Elizabeth Haldane. *The British Nurse*. p. 227.

⁹⁸ Vera Brittain. *Testament of Youth*. p. 412.

between base camps and rail stations. Sister Jentie Paterson describes how she, along with several others

Are the furthest up lot of sisters except those on the trains which have penetrated to within a mile or two of the lines. Last week one such train was under fire while they were moving in the wounded....⁹⁹

Indeed, the British Red Cross Society and the Order of St John issued a pamphlet in 1917 entitled 'Our Work' in which it was described that,

Six fully equipped convoys of 50 ambulances cars each are working with the British Army on the front lines. Their usual duty is to convey the wounded from the field hospital to the clearing hospital, and thence to the hospital train. Sometimes, however, they go right up to the first-aid posts, and they frequently have to face a damaging shell-fire. [...] They carry the wounded and sick from the trains to the Hospitals, and thence to the hospital ships. A hundred ambulances are constantly at work at Boulogne, 70 at Etaples, others at Calais, St Omer, Hesdin, Le Treport, Etretat, Havre and Rouen. Le Treport, the last base to be handed over to the Red Cross by the Army, is entirely served by women drivers.¹⁰⁰

Elizabeth Haldane commented that the work on the ambulance-trains was 'very strenuous, as they were frequently loaded under shell-fire.'¹⁰¹

One of the units at Achiet Le Grand in the 3rd Army Casualty Clearing-station started work soon after 5 'o' clock on the morning of March 21st. There was a heavy barrage and the whole district was under heavy shell-fire. The huts and the tents were penetrated by pieces of shell. By 9am all patients were on stretchers ready for evacuation, when orders came that it was to admit patients. The work was carried on till 5pm, when the sisters were told that they must leave by 7pm. for No. 3 C.C.S. They arrived there, at Grevillers, at 8pm, and were ready to go on night duty when they received orders to go at once by motor-bus to 56 C.C.S at Edgehill. They arrived at 10 p.m. on the 22nd.

⁹⁹ Unpublished letters of Sr. Jentie Paterson. 'Letter to Martha' dated 16th November 1914. Imperial War Museum.

¹⁰⁰ 'The British Red Cross Society and the Order of St. John. Our Work'. Women at Work Collection. Imperial War Museum B.R.C.S. 1/2 (1917)

¹⁰¹ Elizabeth Haldane. *The British Nurse*. p. 225.

On the 23rd they worked in the wards and operating-theatres, and in the afternoon they left for Abbeville.¹⁰²

Indeed Sister A Collins, who served with the QAIMNS in France between 1915 and 1918 and again from 1918 to 1921, is reported to have suffered from severe fright and shock following the bombing of No. 4 Ambulance Train she was travelling on whilst on duty on May 18th 1918. The 'whole train was riddled with shrapnel and several coaches were destroyed'.¹⁰³

Whether in mobile units such as Casualty Clearing Stations, or on ambulance trains, nurses were exposed to significant risks. More nurses served in Base and Stationary hospitals and there were many located across the Western Front. There were many hospitals along the south end of the road from Bar-le-Duc to Verdun for instance, also known as 'The Sacred Way'.¹⁰⁴ One hospital in particular, set up in March 1915, was the British Urgency Cases Hospital at Revigny and was where VAD Winifred Kenyon was stationed. Two of her diary entries for 1916 read

26th February -The biggest battle ever known is going on now. We guessed that an attack on Verdun was planned, as the fact that the Germans tried to cut the railway all pointed to it [...]. There has been the most tremendous attack conceivable, huge guns first, blowing everything to pieces, and men beyond all count [...]. [...] All trenches on both sides were blown to pieces...and they say that their bodies are lying in heaps. [...] Men, guns etc etc pouring along the roads.

10th March - For ten days we have been up to our eyes in work, at least 20 blesses [wounded] arriving most days and as many going out most days. We in the theatre are practically never finished, nine or more ops a day [...]. The work here is terrible.

¹⁰² *Ibid.* p. 224.

¹⁰³ NA PIN 26/20038. A Collins. A month later she was admitted to hospital in Wimereux suffering from a nervous breakdown and then transferred to St. Vincent's hospital in London. She stated that she had pain in her left side, which commenced immediately after the above event and has had three attacks of this pain since.

¹⁰⁴ Malcolm Brown. *Verdun. 1916.* (Tempus, 1999) p. 81.

Such wounds and a great many cases of gas gangrene and in spite of amputations, we have had many deaths. It is simply awful, for the number of wounded is impossible to cope with and they lie unattended to for days and there are no hospitals nearer than Bar, as Clermont has been shelled.¹⁰⁵ As the fighting around Verdun intensified in 1916 surrounding towns such as Nancy in Meurthe-et-Moselle was "constantly menaced" by either long-range artillery or aircraft "from dawn until night".¹⁰⁶

Women were often stationed in towns and areas that were considered to be away from danger. However, such places as Poperinghe and Etaples, thought to be comparatively safer areas frequently witnessed the war at close hand. Poperinghe, for instance, was described as having a 'large civilian population doing a roaring trade in many goods, for the place is alive with our troops'.¹⁰⁷ Winter described it as a

Mecca, a town bustling with mess presidents shopping, leave men returning, divisionally billeted men and men on a day out. Omelettes, brothels and silk-embroidered postcards, in that order, were the chief objects of search.¹⁰⁸

Nevertheless they were often the sites of incident. A diary entry dated September 23rd 1917 by Capt. J. C Dunn stated, 'A few shells are fired into the town at times, there was a burst of shrapnel near the Post Office during my visit'.¹⁰⁹

Supposedly located far away from the danger of the front lines women were assumed to have escaped much injury by being stationed in the

¹⁰⁵ Diary of Nurse Winifred Kenyon. Imperial War Museum Department of Documents.

¹⁰⁶ Cited by Susan Grayzel. "The Souls of Soldiers": p. 600.

¹⁰⁷ Capt. J. C. Dunn. *The War the Infantry Knew, 1914 - 1919*, (Abacus Books, 1987) p. 391.

¹⁰⁸ Denis Winter. *Death's Men*. p. 153.

¹⁰⁹ Capt. J. C. Dunn. *The War the Infantry Knew*. p. 391.

comparative safety of places like Poperinghe. *The Times* newspaper reported in 1916 of the 'recent bombing of hospitals in France [...], [when] [...] it was difficult to estimate what the devoted women in those institutions endured'.¹¹⁰ For instance, nurse Webster, aged 34, was a sister with the QAIMNS. She had seen service in the Mediterranean from July 1915 to March 1916 and then in France from March 1916 to January 1919. She was in Poperinghe on 17th August 1917 on duty with 61 CCS when she received what was described as a 'bomb wound to her right leg'.¹¹¹ She is stated to have been 'struck by a piece of shell in an air raid' which caused a 'lacerating wound to the right tibia - not involving bone or muscle'.¹¹²

Similarly, nurse Eileen King who enlisted in 1914 and landed in France in June 1915 to be stationed in St. Omer for about 7 months and then at Wimereux and Poperinghe, wrote of her experience of bombardment.

This was close to the line and we were subject to constant air raids, on many occasions [sic] bombs dropping in close vicinity [...]. It was nerve racking and all [...] were under constant strain; sometimes planes came over two or three times in one night. In November 1917 four bombs fell [...] killing and wounding over 100 soldiers. I received wounds in both my legs but did not become unconscious. [...] I was in a nervous state and for six weeks my memory is [sic] clear but subsequent events are vague. The doctors said it was a case of delayed shock because six weeks after the wound I suffered such a severe reaction that I was delirious for four weeks and even when I did recover I could not concentrate or settle my mind on even the lightest work. I do not remember leaving France but was told that I was taken to the Hospital ship on two occasions but was too ill to travel.¹¹³

¹¹⁰ *The Times*, 28th March 1916, p. 10.

¹¹¹ NA PIN 26/20273. Isabella Webster.

¹¹² *Ibid.*

¹¹³ NA PIN 26/20141. Eileen King.

Elizabeth Haldane similarly confirmed

The most severe of the many air-raids were during the latter part of May and June, though they continued until October (1918). For the safety of the sisters the tents in which they slept were sunk and protected by sandbags, or else trenches and dug-outs were provided large enough for the beds to be placed in them. All nurses were provided with gas-masks and helmets. Where hospitals were unprepared, nurses were sometimes sent to sleep in the woods or caves. The raids were the greatest tax on the physical strength of the nurses. For after a strenuous day's work their rest at night was broken by dreadful raids lasting often for several hours, if not all night. The raiders would return four or five times at short intervals and fly so low that they could make use of their machine guns.¹¹⁴

Etaples, also on the coast, served as a base camp and was considered to be a 'safe zone'. Etaples was described as the largest of the base camps, and resembling 'a huge grassless field of sand, holding tents for 100,000 men'.¹¹⁵ VAD Elizabeth Paterson Whyham was on duty during an air raid in Etaples on 30th May 1918, but sustained severe injuries, partly the result of 'multiple gun shot wounds' involving her right wrist, left foot and left lumbar region. Further description reveals she experienced 'pain on right side over site of large haematoma resulting from being pinned down and crushed by an iron beam'.¹¹⁶ Elizabeth's service record states she had joined as a Red Cross VAD in 1915 and served 'at home' from October 1915 to January 1916 before being sent to France in January 1916 until May 1918. Indeed, Vera Brittain also recorded the news about the shelling of a hospital in Etaples from a friend.

The hospital next door, she told me, had suffered the worst, and several Canadian Sisters had been killed. At 24 General one of

¹¹⁴ Elizabeth Haldane. *The British Nurse*. p. 226.

¹¹⁵ Denis Winter. *Death's Men*. p. 72.

¹¹⁶ NA PIN 26/20277. Elizabeth Paterson Wyham.

the death-dealing bombs had fallen on ward 17, where I had nursed the pneumonias on night duty; it had shattered the hut, together with several patients, and wounded the VAD in charge, who was in hospital with a fractured skull. The Sisters' quarters were no longer safe after dark, she concluded, and they all had to spend their night in trenches in the woods.¹¹⁷

Also at Etaples was Nurse Alice Emma Dixey joined as a VAD and served from November 1914 to October 1916 and then again from March 1917 to March 1919. During her second period of service she was sent to No. 24 General Hospital at Etaples and after a bout of influenza was sent to the Sick Sisters' Hospital at Villitano, Le Touquet. Her records report that in 1918 'the air raids were so bad and the hospital was so continually bombed [...]. [...] bombed nearly every day'.¹¹⁸

Danger was, therefore, a real factor for many women despite the view that steps were taken to protect them. The military had always maintained they were positioned in safe areas. The notion that nurses were not protected, or immune from the dangers of warfare, is demonstrated in this article from the *Nursing Mirror* as early as 1914 when concern was raised for the case of an injured nurse.

The injury, of course, was accidental, but although nurses are non-combatants, the incident shows that they do not enjoy absolute immunity from the risks run by the other branches of the Army.¹¹⁹

¹¹⁷ Vera Brittain. *Testament of Youth* p. 432-433.

¹¹⁸ NA PIN 26/20052. A. E. Dixey.

¹¹⁹ The *Nursing Mirror*. Vol XIX, No 493. (September 5th 1914) p. 423.

Although deaths amongst nurses were not common, and there were some 302 reported deaths of nurses between 1914 and 1918.¹²⁰ This next case serves to highlight just how extreme the danger was for some nurses. A commentator at the funeral of Miss Bell, an eighteen-year-old nurse describes her demise. 'She was attending the wounded in the firing line when a shell smashed both her legs'.¹²¹ Contemporary opinion, however, remained cognisant of the fact that women could, and did, face considerable risks and dangers to the point where questions were raised in parliament about the plight of nurses. For example, P. A. Harris asked the then Pensions Minister, Sir A Griffith-Boscawen.

Is the hon. and gallant Gentleman aware there are many women who have been overseas and have suffered from being under fire...? Does he consider it right that women should be in a worse position than men when they volunteer for services overseas? ¹²²

Conclusions

In conclusion, clear demarcation between the 'front lines' as being areas of intense and extreme danger and the rear areas as being those of comparable safety is questionable. Firstly, the trench experience, despite being exalted as the male experience, was not always one of constant danger. Ashworth has argued that the trench system was one of both active and quiet areas and men employed a 'live and let live' system. The extent of the trench system and how far back it stretched, combined with the tactics of elasticity of defence, meant

¹²⁰ 'Deaths of Nurses and VADs Reported on Service between 4th August 1914 and 1st April 1920.' Statistics of the Military War Effort of the British Empire during the Great War, 1914 - 1920. Published by the War Office. London: HMSO. (1922) See Appendix Item No. 8. p. 248.

¹²¹ *The Nursing Mirror*. Vol XX, No. 501. (October 31st, 1914) p. 67.

¹²² *Hansard*. 17th October 1918. pp. 277-8.

that the most forward trench was not necessarily the worst place to be. There were large areas of the front lines that were free of danger for long periods and so-called active sectors tended to see rare and infrequent action. Often, greater numbers of men were placed in the reserve and the support trenches and the enemy knew this. Firepower would therefore be concentrated in these rear trenches and beyond. This implies that more danger was faced at the 'rear' areas, and which were not that far, geographically, from the so-called 'safe' areas. In addition, and contrary to existing historical analysis, it transpires they were also, and frequently, subjected to shelling and bombing raids and were injured, maimed and sometimes killed as a result.

The fact that air raids, bombings and shelling occurred in the safe areas further supports the ambiguity in the demarcation of forward and rear areas. More recent analysis of the trench system suggests that rather than being a place of constant danger it offered a form of protection that was not available in open ground. Accepting this argument means there was a sense in which nurses could be considered more at risk than men as the majority of their work was carried out in areas that were 'open' and therefore damaged from bombardment and shelling.

In addition to the obvious dangers from shelling and bombardment, nursing in such an environment meant they endured extreme hardships on a daily basis amid demanding conditions, and they were expected to deal with the worst of warfare. This was because the military cannot function without the facilities to put wounded men back in the forward areas and nursing and nurses

became a vital component of the military medical machine. Based on the premise of treating the wounded as quickly as possible to ensure the machinery of warfare kept moving, the location of First Aid Posts through to Casualty Clearing Stations and Base and Stationary Hospitals, as set up by the Royal Army Medical Corps, was ordered and organised such so as to be as close to the fighting as was possible. This was clear in the case of Casualty Clearing Stations, which, because of the mutable nature of warfare during 1914 - 18, meant they became mobile units. The character of the work in these units meant they were necessarily difficult places to work, both for the ever-present likelihood of shellfire but also for the type of injuries treated there compounded by the necessity and demand to work for long hours. This work fell to the medical staffs that were stationed in these units, many of whom were nurses.

Ultimately, nurses did not serve in the trenches and neither did they need to be in the trenches to experience the worst horrors. Yet they were located in positions which could be claimed to be 'at the heart' of the war on the Western Front. The nurse's experience of warfare on the Western Front cannot be held, therefore, to be so vastly different from that experienced by many soldiers, except where the experience meant serving in a 'trench'. The argument put forward by historians that nurses had to 'invent' their own front in order to feel a part of the First World War experience is therefore challenged. The nurse's experience can be validated in terms of the frequent and extreme dangers they faced. They did not have to justify their existence in this male dominated environment, or construct their own 'front' in order to feel a part of it. It should therefore be expected that many of these nurses were as potentially

vulnerable to suffer from the war neuroses, as were men. It is to the experience of war neurosis in nurses that this thesis will now turn.

CHAPTER THREE

'The report on her transfer was Shell Shock'¹ The Nurses' Experience of War Trauma

There are no men here, so why should I be a woman? There are heads and knees and mangled testicles. There are chests with holes as big as your fist, and pulpy thighs, shapeless; and stumps where legs once were fastened. There are eyes - eyes of sick dogs, sick cats, blind eyes, eyes of delirium; and mouths that cannot articulate, and parts of faces, - the nose gone, or the jaw. There are these things but no men; so how could I be a woman here and not die of it?²

I was trapped in their horror. I saw and admitted the triumph of ugliness and evil, and knew that wherever I went afterwards, I would take my own Bedlam with me.³

These accounts have been described as 'images of Hell, of neurosis'.⁴ At first glance they describe the trauma and the injuries suffered by many of the soldiers who, through exposure to the horrors of battle, were horribly maimed and disfigured. For some of the soldiers the intolerable nature of such physical and psychological traumas meant they went on to suffer from a 'war neurosis', the most commonly known of which was 'shell shock' and which became a major concern in the First World War. Yet, while shell shock has received much attention from historians who have attempted to explain its complex political, social, military, medical and gendered connotations,⁵ it remains, in historical interpretation as well as in popular belief, a disorder supposedly resulting from

¹ NA PIN 26/20035 Mary Cleverly.

² Mary Borden. *The Forbidden Zone*. p. 60.

³ Leslie Smith. *Four Years Out Of Life*. (London: Allan, 1931) p. 93.

⁴ Sharon Ouditt. *Fighting Forces*, p. 38.

⁵ See for instance the work of Peter Leese, *The Social and Cultural Impact of Shellshock*; Martin Stone, *The Military and Industrial Roots of Clinical Psychology in Britain*, and Elaine Showalter, *The Female Malady*.

'trench' warfare and is therefore seen as a masculine affliction. To suggest otherwise poses a considerable challenge and the idea that women suffered from shell shock, or war neurosis, is one that has not been examined in any detail. However, while the accounts at the beginning of this chapter do indeed depict images of hell for war-torn soldiers, the narratives used here, and which equally represent a 'hell' and 'neurosis', are, in this instance, those of women.

In the first few months of the war shell shock in soldiers did not present as much of a problem, but by December 1914 it accounted for the apparent nervous, or mental, breakdown in seven to ten per cent of officers and three to four per cent of ranks in Boulogne hospitals, an event considered by the authorities sufficient enough to prompt an investigation.⁶ During the 'early battles of Ypres the problem worsened and by late 1916 it had become acute'.⁷ Another source of statistics, specifically medical, states that approximately 80,000 cases of shell shock passed through army hospitals during the war years and some 300,000 ended up in UK institutions.⁸

⁶ Although these figures are considered unreliable, they are as per the statistics compiled by Maj. Gen. MacPherson et al., *The Official History of the War Medical Services - Diseases of War. Volume II*. (London: HMSO, 1923) reveal, a total of 936 cases of 'Functional Nervous Diseases amongst Imperial Troops, Aug. to Dec. 1914'. pp. 1-2. See also J.J. Mitchell and G. M. Smith. *History of the Great War Medical Services: Casualty and Medical Statistics of the Great War*. (London: HMSO, 1931) p. 310. (Hereafter referred to as *HGWMS*) The Army Medical Services (AMS) sent Queen's Square neurologist, William Aldren Turner, to France to report on what was happening.

⁷ Martin Stone. 'Shellshock and the Psychologists'. Chapter 11 in W.F. Bynum, R. Porter, and M. Shepherd. (Eds) *The Anatomy of Madness: Essays on the History of Psychiatry*. Vol. II. (New York: 1985) p. 248 - 249.

⁸ J.J. Mitchell and G. M. Smith. *HGWMS*. Vol. 2, p. 7. Cited in Stone. 'Shellshock and the Psychologists'. p. 249. In 1921 there were still some 65,000 receiving pensions for 'neurasthenic disablement', and in 1936, 36 per cent of ex-servicemen receiving disability pensions were listed as 'psychiatric casualties'. These figures are, however, considered to be incomplete.

In the previous chapter it was seen that nurses and female voluntary aid detachments were exposed to the dangers of shelling and bombing raids and to the horrors of battle. Yet in traditional historical analysis nurses have rarely been, if at all, referred to as suffering from war neurosis, least of all as shell-shocked, and of the several studies that focus on this condition women have not been mentioned. However, in this chapter it will be argued that contemporaries during the First World War were not averse to referring to the women who served alongside the allied forces, particularly nurses, as suffering from a war neurosis and in some cases did indeed refer to them as 'shell shocked' when completing their medical case notes or supporting their cause for compensation, and, their peers similarly referred to them with the same 'diagnostic' terms and labels as those used for soldiers. The concern of this chapter, therefore, is to focus on the experience of war neurosis in the nurses who served close to the fighting and the extent to which, and how, contemporaries recognised such conditions in these women. It will look at the plight of the nurse in her path towards psychological illness in order to examine the extent to which this was similar to that experienced by soldiers, and, in so doing, will challenge well-established ideas about war neurosis and war induced psychological trauma being the preserve of soldiers. It will question why it is that historians and other scholars have failed to include women in their analysis of this subject so far and will do so by focusing on three main areas.

Firstly, it will look at the phenomenon that was known as 'shell shock', the term that was to become the embodiment of war neurosis, but particularly how medical authorities sought to explain and deal with it. The question of

whether nurses suffered from shell shock will be posed and analysed within the framework of contemporary debates by medical authorities about shell shock. It will look at what medical authorities claimed were the symptomatic precedents of shell shock, and although a condition seen most frequently in men at this time, will argue that their diagnostic narratives were not necessarily confined to men. It will demonstrate that explanations and theories regarding the nature and phenomenon of shell shock, and the war neuroses in general, were continually re-evaluated and developed from early on in the war. Moreover, these explanations extended to include familiar diagnostic labels deemed by the medical authorities as more appropriate for the collection of symptoms they were seeing in these patients, and which, would ultimately include those whose war experience exposed them to the worst horrors of battle as well as those who were not necessarily the victims of shell blasts.

Secondly, but equally important, and also within the category of the war neuroses, is the condition known as 'Disordered Action of the Heart' or DAH. Described by contemporaries also as a 'chief malady'⁹ a significant number of nurses were labelled with this diagnosis. Referred to also as 'Soldier's Heart' this section will examine the history and nature of this condition, highlighting similarities in terms of understanding, between this disorder and that of shell shock, and will reveal the extent to which it was used as a diagnosis for women as well as for men. In so doing it will further challenge the notion that 'war neurosis' in the First World War was the preserve of men.

⁹ Thomas Lewis. *The Soldier's Heart and the Effort Syndrome*. (London: Shaw and Sons, 1918) p. 1.

Finally, once they had 'broken down', nurses, like soldiers, required care, medical treatment and management if they were to be returned to duty or be discharged. Soldiers received this through a network of treatment centres that began with the Regimental Aid Post (RAP) through to designated hospitals and centres, such as base and stationary hospitals and several studies exist which document how this system operated for wounded or sick soldiers and the types of treatment and care that was offered.¹⁰ Principally, but unfortunately, much of what is known and remembered about methods of treatment for psychological disorders comes from historians Eric Leed and Elaine Showalter, who have claimed that treatment methods were based on class. For instance, officers were reputedly offered treatment that included rest and the 'new' 'psychoanalytical' practices, or 'talking cure', while the ranks were supposedly subjected to the somewhat coercive and punitive methods, which chiefly took the form of faradisation. In view of this, this section will first establish if a similar network of treatment centres was set up for sick nurses and will then examine the types of treatment and care they received for their symptoms in an effort to challenge the claims of Leed and Showalter. Of central importance is whether the care and treatment afforded the nurses was delivered in a consistent and unbiased manner given they worked in what was essentially a male dominated system and environment. It is surmised that treatment and management of the nurse from her initial collapse or 'breakdown', through to convalescence and a return to duty, or, to or being evacuated home, would depend on a variety of

¹⁰ For physical wound treatment and management see for instance the work of Claire E. J. Herrick. 'Of War and Wounds. The Propaganda, Politics and Experience of Medicine in World War I on the Western Front'. (PhD. Manchester 1996), and also Jeffery Reznick. 'Rest, Recovery, and Rehabilitation. For treatment and management of psychological disorders in soldiers see Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War*; Peter Barham. *Forgotten Lunatics*; and Ben Shephard. *A War of Nerves*.

factors but, ultimately, on the severity of the disorder, although additional factors such as the attitude of the attending doctor(s) may also have had a bearing on her case. This chapter will now turn to look at the framework in which contemporary medical authorities sought to understand the concept of shell shock and war neurosis, and how it was that women were located within this framework.

The Shell Shock Debate and the Nurses' Experience of War Trauma.

On the whole the term shell shock was a singularly appropriate one that accorded with the bio-medical approach dominant before 1914, which was that mental illness had organic origins, i.e., that it was the result of disease or physical injury.¹¹ So initially, when soldiers injured from shell blasts, displayed uncharacteristic behaviour and symptoms reminiscent of 'shock', typically through a range of physical and mental disabilities, such as 'paralyses and contractures of the ...(limbs), loss of sight, speech and hearing, ...mental fugues, ...obsessive behaviour, amnesia, [...] sleeplessness, and terrifying nightmares',¹² it was concluded that exposure, or close proximity, to the forces of high explosives of the front lines was responsible. Additionally, the accompanying noxious gases reputedly damaged the nervous system and were therefore also cited as a causal factor for these various behavioural disorders.¹³

¹¹ For an understanding of this concept in relation to 'Shell Shock' see Harold Merskey. 'Shell Shock' Chapter 15 in Berrios, G. and Freeman, H. *150 Years of British Psychiatry 1841-1991*. The Royal College of Psychiatrists. (London: 1993) pp. 245 - 267.

¹² Martin Stone. 'Shellshock and the Psychologists'. p. 251.

¹³ This model was particularly promoted by Sir Frederick Mott. 'A Microscopic Examination of the Brains of Two Dead Men of Commotio-Cerebri (Shellshock)'. *Journal of the Royal Army Medical Corps*. Vol 26. (1916) 612 - 615.

However, the Inspector of Army Neurological Hospitals, Dr. Charles Myers,¹⁴ realised very early on in the war that this theory was fundamentally flawed. Writing in *The Lancet*, first in 1915 and again in 1916, he described cases of soldiers who had been 'blown up' and indeed went on to display symptoms of amnesia, blindness, paralysis and speech disorders, but felt there were inconsistencies in the cases he treated because they did not fit with the bio-medical approach. He claimed, for example, that the senses of taste, smell and sight were often damaged, but not the hearing.¹⁵ This inevitably raised questions in view of the fact that explosions were always accompanied by enormous productions of noise along with the release of odourless gases. He therefore opened his mind to the idea of a psychological origin.

Other contemporary medical authorities similarly began to recognise the term's ambiguous nature as it became apparent that symptoms of shell shock 'were occurring in soldiers who had not been directly exposed to a shell blast.'¹⁶ Consulting Neurologist Lieutenant Colonel Gordon Holmes claimed he was seeing many cases where it was clear that close proximity to serious shell blasts was not the obvious cause. For example, he stated he was witness to, 'frequent examples of gross hysterical conditions which were associated with trivial bullet and shell wounds'¹⁷ and related to two cases of stretcher-bearers who were not wounded and 'not "blown over" by a shell, [but] were tired out and

¹⁴ Myers treated some of the first cases in 1914 and continued until the end of 1917.

¹⁵ Charles S. Myers. 'A Contribution to the Study of Shell Shock'. *The Lancet*. Vol. 1. (1915) pp. 316-320, and Charles S. Myers. 'Contributions to the Study of Shell Shock'. *The Lancet*, Vol 1. (1916) pp. 65-69.

¹⁶ Martin Stone. 'Shellshock and the Psychologists'. p. 252.

¹⁷ MacPherson, *et al.* (Eds) *Official History of the the War*. p. 8.

dispirited.¹⁸ Concurring with this view, *The Lancet*, in 1915, was to record the concerns of neurologists in general, who felt they were being

Consulted by an increased number (of cases) on account of many nerve symptoms of ill defined character. Some of these cases present symptoms analogous to those of milder epilepsy... Far more frequently an accurate diagnosis is not possible, or, at least, a diagnosis which will harmonise with any definite lesion. The condition resembles that which has long been familiar in the law courts in claims after railway accidents, to which it has been convenient to apply the term "shock".¹⁹

By 1915, the condition had taken on epidemic proportions and this 'new' phenomenon had been propelled firmly in to the limelight. Indeed the increase in numbers of men presenting with this 'new disorder' also prompted it to take on a peculiar 'rise in status', which led military and political authorities to raise questions, included those of morale, cowardice and malingering. Military authorities, naturally became fearful of the ensuing panic, one that was created and further compounded by not only what medical authorities claimed were 'misconceptions' about the disease, but also their apparent inability to treat it. Accordingly, a 'misguided public opinion had raised the psycho-neuroses to the dignity of a new war disease, before which doctors seemed well-nigh helpless'.²⁰ This was further complicated by the view of some doctors that the fear of returning to the fighting was enough in itself to trigger symptoms in some individuals. For example, Ernest White, Consultant in Mental Diseases to the Western Command, stated

I have seen quite a number with all the tremors of Shell Shock who have never been near the fighting line, and many who have

¹⁸ *Ibid.* p. 9.

¹⁹ 'War and Nervous Breakdown'. *The Lancet*. January 23rd (1915) p. 189.

²⁰ MacPherson, *et al.* (Eds) *Official History of the the War*. p. 9.

never been out of the country. Their symptoms have arisen from fright, worry, and nerve (troubles) [...] self-induced.²¹

As a consequence, shell shock

Wrought untold evil amongst patients, and undoubtedly precipitated a breakdown in a certain type of man who might otherwise have held himself together, ...to the soldier's mind it was as much an entity as scarlet fever, with the further addition that, being incurable, shell shock was more to be dreaded.²²

A review of the problem was therefore crucial, and in an attempt to quell the panic, and because it did not satisfactorily explain the symptoms they were seeing, specialists, including A.F. Hurst, Physician at Guy's and Officer in Charge of the Special Neurological Hospital at Seale Hayne, advocated that the 'condition commonly described as 'Shell-Shock' is a syndrome in varying proportions of hysteria, psychasthenia and neurasthenia, [and] 'the term should be discarded'.²³ Psychologist Henry Head similarly rejected shell shock as a disease term on the grounds of it being 'a heterogeneous collection of different nervous affections from concussion to sheer funk, which have merely this much in common that nervous control has at last given way.'²⁴ William Aldren Turner,²⁵ also suggested shell shock was essentially 'nervous and mental breakdown due to shock, fatigue, exposure, and the other conditions incidental

²¹ Ernest W. White. 'Observations on Shellshock and Neurasthenia in the Hospitals in the Western Command' *British Medical Journal*. April 13th (1918) pp. 421- 422.

²² MacPherson, *et al.* (Eds) *Official History of the the War*. p. 9.

²³ *Report of the War Office Committee of Enquiry into "Shell-Shock"*. (London: HMSO, 1922) Hereafter referred to as *WOCIS*. p.23.

²⁴ Henry Head. *The Lancet*. (1916) Cited by Harold Merskey. p.252.

²⁵ William Aldren Turner. 'Arrangements for the Care of Cases of Nervous and Mental Shock coming from Overseas'. *The Lancet*. May 27th (1916) p. 1073. In 1916, Turner was temporary Lieutenant-Colonel, RAMC., Physician to King's College Hospital and to the National Hospital for the Paralysed and Epileptic, London.

to a campaign.'²⁶ Turner, like many other specialists, was rapidly arriving at the view that, 'Shell shock is a misleading and bungling term, covering several different disorders which were familiar before the war, viz. Neurasthenia'.²⁷

In consequence, a 'General Routine Order No. 2384'²⁸ was issued which stated

In no circumstances whatever will the expression 'shell shock' be used verbally or be recorded in any regimental or other casualty report, or in any hospital or other medical document.²⁹

The reasoning behind this was, while it may have been easier for a medical officer to write the word shell shock on a medical card, it might be subsequently 'discovered at the base hospital that the casualty was simply suffering from strain and exhaustion, which a few days of rest and nourishing food would put right. But having been diagnosed as a shell shock case and - with no overt intention of malingering - sincerely believing that shell shock was the basis of his trouble, he might continue to complain of the symptoms'.³⁰ Historian, Ian Whitehead, claims that this practice also reflected the apparent inexperience and lack of confidence on the part of many doctors to make firm diagnoses when it came to mental collapse, preferring not to attach the stigma of 'mental'

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ General Routine Order No. 2384. 'Classification and Disposal of Officers and Other Ranks who without any Visible Wound become Non-Effective from Physical Conditions Claimed or Presumed to have originated from the Effects of British or Enemy Weapons in Action'. Cited in Lyn Macdonald. *Roses of No-Man's Land*. p. 218.

²⁹ *Ibid.*

³⁰ *Ibid.* p.218 - 219.

to the individual.³¹ There was, as a result, the more general use of 'blanket terms', one of which was 'Not Yet Diagnosed - Nervous' (NYD-N). Nurse Gertrude Carter was diagnosed as 'N.Y.D.Mental' after she presented with symptoms of 'general malaise, headache, myalgia, sore throat and cough'.³² Examination revealed her physical signs were 'otherwise negative' apart from 'congestion of the pharynx, suffusion of the conjunctiva, and a rapid pulse.' She had earlier, and whilst standing by her bed, 'suddenly collapsed and complained of severe headache and pains in the back. Respirations were rapid and moaning. No cough. Throat and chest clear. Head retracted; neck stiff, marked Kernig sign³³. Abdomen negative. [...] Lumbar puncture revealed clear fluid under no increased tension. Globulin slightly increased. Cell count normal. Culture sterile. Blood culture sterile. Urine negative.'³⁴ Three days later she 'appeared better' stating the 'pain was gone' and she 'seemed less stuporous'. However, shortly after noon, she developed a 'low muttering, incoherent delirium. Tried to get out of bed and had to be restrained. Not violent.' When seen later in the day by a neurologist she was described as being in a 'negativistic state, muttering to herself, the general trend of which was incoherent and unsystematized. The patient's attention could not be obtained.'³⁵ She was transferred to No. 2 General Hospital Neurological for observation. Similarly, nurse Ethel Andrews was simply classified as 'NYD'

³¹ Ian Whitehead. 'The British Medical Officer on the Western Front. The Training of Doctors for War', in Cooter, R., Harrison, M., and Sturdy, S., (Eds) *Medicine and Modern Warfare*. (Amsterdam: Rodopi, 1999) p. 173.

³² NA MH106/2207 Gertrude Carter.

³³ Kernig Sign - a symptom of meningitis in which the hamstring muscles in the legs are so stiff that the patient is unable to extend his legs at the knee when the thighs are held at a right angle to the body. [V Kernig. (1840-1917), Russian physician]. Oxford Concise Medical Dictionary. (Oxford University Press, 1998).

³⁴ NA MH106/2207 Gertrude Carter.

³⁵ *Ibid.*

after she presented as 'seriously ill' in August 1917 whilst serving in Salonika. An extensive record of symptoms including 'anaemic, debilitated, headache, backache, general malaise',³⁶ followed by investigations, which revealed, 'no abdominal pain, no diarrhoea, slight rigor, temperature 103, pulse 96, spleen palpable, blood parasite found' led to her being later diagnosed with malaria.

These cases are significant because they do not fit neatly with the idea that the diagnostic term, NYD and NYD-N, was applied by doctors who lacked experience or confidence. On the contrary it appears, at least in these cases, to indicate, through a considerably thorough medical investigation, an attempt to arrive at a diagnosis. The lack of a diagnosis in the early stages is both cautionary and more likely due to a lack of knowledge and the decision to send for observation, in the former case, is perhaps the only wise option.

Historian Peter Barham states that, at least at Napsbury War Hospital, 'diagnostic norms were suspended'. Many of the cases were classified as 'neurasthenia', which functioned, in effect, as a form of non-diagnosis, or *salle d'attente*.³⁷ Symptoms, now under the revised headings of neurasthenia and hysteria, became much broader and now included 'recurrent dreams and nightmares, hallucinations and insomnia as well as paralysis, hysterical gait, tics or stereotypical movements, fits, mental regression, somnambulism and severe depression'.³⁸ Cases appeared to become less severe, or acute, and were less those of hysterical conversion, and more often those of fatigue and

³⁶ NA PIN 26/19990 Ethel Andrews.

³⁷ Peter Barham. *Forgotten Lunatics* . p. 80.

³⁸ Peter Leese. *The Social and Cultural Impact of Shell Shock*. p. 95.

anxiety, nervous exhaustion and chronic fatigue. Indicative of the symptoms most commonly presented after 1916 were lethargy, fatigue, headaches, memory loss, shaking and tremors. For example, whereas previously the symptoms reported by volunteer Pte. Frank Beckson, for example, of 'forgetfulness and loss of memory, headaches, tremor, shaking, trembling and difficulty in sleeping'³⁹ following injuries from shrapnel coupled with the trauma of being buried by a shell explosion meant he would have been labelled as shell shocked, meant he was now diagnosed as suffering from 'neurasthenia'. This was also the case of Pte. Frank Aaron, who experienced symptoms of deafness, headaches, tremor, difficulty in sleeping, dreams of war, and jumpiness.⁴⁰ The diagnosis of neurasthenia was similarly applied to Pte. George Bowen who complained of 'fatigue, lethargy, and palpitations' after receiving a gunshot wound to the right thigh. Previously, his recollection that 'something happened in the shape of a shock to his head when in the trenches',⁴¹ would have resulted in him being referring to as shell-shocked.

By 1916, 'a clearer picture of war neurosis began to emerge and it soon became obvious, even to civilian observers, that artillery shells alone were not responsible for the increasing number of 'breakdowns' in soldiers, but rather the general atrocious conditions of the Western Front itself'.⁴² Since direct exposure to artillery shells was not the reason for 'shell shock' and the idea was firmly in

³⁹ NA PIN 26/1225. Pte. Frank Beckson.

⁴⁰ NA PIN 26/204. Pte. Frank Aaron.

⁴¹ NA PIN 26/1721. George Bowen.

⁴² Bogacz. 'War Neurosis and Cultural Change in England, 1914-1922: The Work of the War Office Committee of Enquiry into Shell-Shock.' *Journal of Contemporary History*. Vol 24. (1989) p. 234.

dispute this led to medical authorities striving for more suitable explanations and theories as to the causality of so-called shell shock. As the war progressed, these proposed theories allowed for medical authorities to develop an understanding and amend their practice whilst at the same time prompted a 'militarisation' of the symptoms. For instance, R.G. Rows, neurologist and senior physician at the Maghull Hospital in Merseyside, claimed

The breakdown follows from some incidents which disturb the patients so that they could not carry on in the line and had to come down; not merely the bursting of a shell, but a scene of horror or a period of exhaustion.⁴³

Similarly, Aldren Turner also ventured a preliminary taxonomy and identified groups, similarly within the context of conflict, one of which he described as being

Attributable to exhaustion of the nervous system resulting from physical and nervous strain, sleeplessness, fear, anxiety, and harassing sights and experiences.⁴⁴

Another group he similarly identified as comprising of 'cases of mental breakdown - the milder as well as the more severe psychoses - mental confusion, mania, melancholia and delusional and hallucinatory psychoses'.⁴⁵

In 1922, the *Report of the War Office Committee Enquiry into Shell-Shock*, led by Lord Southborough, saw an attempt by the government to draw a line under the whole experience that shell shock had created and began by

⁴³ *WOCIS*. p.70-71.

⁴⁴ William Aldren Turner. 'Arrangements for the Care of Cases of Nervous and Mental Shock coming from Overseas'. p. 1073. (Symptoms occurring through lack of sleep have been identified elsewhere. Denis Winter claimed, '(t)here occurred a mental depression and physical sluggishness which came from lack of sleep' and '...sleeplessness gave to a man a Kafka-like sense of unreality and de-personalisation...') Denis Winter. *Death's Men*. pp. 100-1.

⁴⁵ William Aldren Turner. 'Arrangements for the Care of Cases of Nervous and Mental Shock'. p. 1073. See also the recent work of Peter Barham. *Forgotten Lunatics*, who explores the cases of servicemen who suffered from the psychoses rather than neuroses.

stating that shell shock had 'signified in the popular mind that the patient had been exposed to, and had suffered from, the physical effects of explosion of projectiles'.⁴⁶

The general sentiment of the public during the war found its expression in the statement that every man apparently physically capable should be sent to the Front, but at the same time there was much anxious solicitude as to the incapacitated, and such was the appeal of the term "shell shock" that this class of case excited more general interest, attention, and sympathy than any other, so much so that it became a most desirable complaint from which to suffer. ...To the relatives of a soldier who had broken down mentally, or who by reason of an inherently timorous disposition could not face the military life, [...] the use of the term "shell-shock" came as a great relief.⁴⁷

As regards the cases of 'shell-shock' the War Office Committee claimed

There could be little doubt that included under this heading there were cases of many and various conditions. For instance disorders such as hysteria, anxiety neurosis, and mental troubles of many kinds; and, the Committee are in agreement with the bulk of opinion in saying that all these conditions can be regarded as reactions of the individual under stress of environmental circumstances.⁴⁸

Furthermore, the general view surmised by the medical profession who were interviewed during the course of the enquiry was that in the majority of cases,

The change from civil life brought about by enlistment and physical training was sufficient to cause neurasthenic and hysterical symptoms, and that the wear and tear of a prolonged campaign of trench warfare with its terrible hardships and anxieties, and of attack and perhaps repulse, produced a condition in the mind and body properly falling under the term "war neurosis".⁴⁹

⁴⁶ *WOCIS*. p. 2.

⁴⁷ *WOCIS*. p. 4.

⁴⁸ *WOCIS*. p. 4.

⁴⁹ *WOCIS*. p. 3.

However, while a 'combination of factors had led to a loose and indiscriminate use of the term',⁵⁰ and despite the somewhat conservative and moralistic protestations of the War Office Committee, it nevertheless remained the favoured label to describe war torn personnel regardless of their gender. For example, in 1918, long after the medical and military authorities had 'outlawed' its usage, government officials themselves were still using it. P.A. Harris asked the pensions Minister, Sir A. Griffith-Boscawen

Whether members of the Women's Army Auxiliary Corps, the Women's Royal Navy Corps, and the Women's Auxiliary Flying Corps who are incapacitated because of service overseas either through *Shell Shock* or other causes are entitled to pensions...⁵¹

Similarly, the relatives and peers of nurse Mary Cleverly also used the term freely to describe how, in February 1920, and whilst on duty, she suffered an attack of 'acute mental disorder, necessitating her removal to Bethlem Hospital.'⁵² Her notes record,

On February 23rd (1920) she reported sleeplessness, and was on the Nurses' Sick Floor. On February 25th, she was transferred to Christian Ward and on February 27th to Bethlem Hospital. The report on her transfer was "Shell Shock..."⁵³

Later, in support of her claim for a pension, Mary Cleverly's sister had written to the Ministry of Pensions stating,

I presume there is sufficient medical evidence to prove the initial breakdown was caused by shell shock - due to service in the Great War?⁵⁴

⁵⁰ *WOCIS*. p. 3.

⁵¹ *Hansard*. 'Women's War Services (Pensions)' 17th October (1918) p. 277. (My emphasis)

⁵² NA PIN 26/20035 Nurse Mary Cleverly.

⁵³ *Ibid.*

⁵⁴ *Ibid.* (Emphasis in the original)

These changes concerning the history of shell shock within the early years of the war clearly open up the debate so that it not only encompasses sufferers whose service saw them engaged on, or near, the battlefields, and not necessarily in the trenches, but it also incorporated the cause of many physical and psychological traumas to the experiences of warfare in general. This immediately permits the inclusion of women, and whilst the majority of persons affected were indeed soldiers, nurses were also suffering. For example, the case of Elizabeth Whyham, mentioned previously in chapter two, details how this nurse sustained 'multiple gun shot wounds and a large haematoma [bruising] resulting from being pinned down and crushed by an iron beam.'⁵⁵ Her medical records state that she went on to complain of being 'rundown, [...] easily tired, [and] [...] lack[ing] energy', and the cause given as, 'nervous symptoms due to shock, [...] still suffers from effects of nervous shock sustained at time of injury, [...] slight tremor of eyelids and hands'.⁵⁶

Nurse Eileen King's account also describes her experience of 'illness' following a bombardment.

This was close to the line and we were subject to constant air raids, on many occasions (sic) bombs dropping in close vicinity [...]. It was nerve racking and all ...were under constant strain; sometimes planes came over two or three times in one night. In November 1917 four bombs fell [...] killing and wounding over 100 soldiers. I received wounds in both my legs but did not become unconscious. [...] I was in a nervous state and for six weeks my memory is clear but subsequent events are vague. The doctors said it was a case of delayed *shock* because six weeks after the wound I suffered such a severe reaction that I was delirious for four weeks and even when I did recover I could not concentrate or settle my mind on even the lightest work. I do

⁵⁵ NA PIN 26/20277. Elizabeth Paterson Whyham.

⁵⁶ *Ibid.*

not remember leaving France but was told that I was taken to the Hospital ship on two occasions but was too ill to travel.⁵⁷

Nurse Isma Brown, who joined the QAIMNS(r) and served as a trained nurse for over three years in England and then on board a hospital ship in Egypt and Mesopotamia, was diagnosed with 'Exhaustion Psychosis', her doctor adding that her 'nervous breakdown' was due to her 'military service' in Gallipoli, Mesopotamia, France and India.⁵⁸ 'Miss Isma Brown is suffering from an attack of acute mania, due in my opinion, to the strain of her war service as a nurse'.⁵⁹ Similarly, Nurse Mary Cleverly's [mentioned previously] medical practitioner, Dr. Culford, reiterated what he felt to be the cause of her breakdown.

When questioned about her experiences in Salonica [sic] she became emotional and refused to tell about them, but admitted that she used to have nightmares about them and dreaded going to sleep. In my experience this reaction is diagnostic of those cases in which the stress of war has played an active part in inducing mental breakdown.⁶⁰

Further theories, as to the cause of breakdown, emerged and included that from anatomist, G. Elliot-Smith and psychologist Tom Pear, both dedicated members of R.G. Rows' team at Maghull, who felt that by far one of the greatest factors was the

Intense and repeated emotion. By this is meant not only experiences of fear or of sympathy with suffering comrades, in

⁵⁷ NA PIN 26/20141. Eileen King. (My emphasis)

⁵⁸ NA PIN 26/20016. Nurse Isma Brown.

⁵⁹ *Ibid.*

⁶⁰ NA PIN 26/20035 Nurse Mary Cleverley.

short, those conditions the manifestations of which might cause the man in the trenches to be spoken of as “emotional,” but also other mental states associated with general excitement, anxiety, remorse for major or minor errors, anger, elation, depression and that complex but very real state, the fear of being afraid.⁶¹

The ‘intense and repeated emotion’,⁶² and the ‘experience of fear or of sympathy with suffering comrades,’ along with ‘other mental states’,⁶³ although cited here as a common factor for the breakdown of soldiers, were quite obviously, and naturally present amongst nurses especially when subjected to bombing raids. Vera Brittain was to record:

After days of continuous heavy duty and scamped, inadequate meals, our nerves were none too reliable, and I don’t suppose I was the only member of the staff whose teeth chattered with sheer terror as we groped our way to our individual huts in response to the order to scatter ...One young sister, who had previously been shelled at a Casualty Clearing Station, lost her nerve and rushed screaming through the Mess; two others seized her and forcibly put her to bed, holding her down while the raid lasted to prevent her from causing a panic. I knew that I was more frightened than I had ever been in my life.⁶⁴

Helen Zenna Smith also writes of the fear, of an anticipated bombing raid, and of its consequences.

We sit there in semi-darkness waiting. It is not the most pleasant sensation in the world sitting in a shelter waiting for bombs to drop. Even though the odds are a hundred to one against a direct hit, it is a nasty feeling [...] like anticipating a dentist’s drill, or making a speech in public, or hearing a burglar trying an insecure window-catch. The trench is like a slaughterhouse. All round me are girls lying dead or dying. Some are wounded. The wounded are trying to staunch one another’s blood. A few are shell-shocked. One scales the side of the shelter frantically, scrabbling her toes into the earth like a maddened animal, then

⁶¹ Elliot-Smith, G. and Pear, T. *Shellshock and its Lessons*. (Manchester University Press, 1917) p. 6.

⁶² *Ibid.*

⁶³ *Ibid.*

⁶⁴ Vera Brittain. *Testament of Youth*. p. 417.

runs shrieking into the night. The casualties are heavy. Ten dead, two missing, twenty-four injured. Four are unhurt, and of these three are shell-shocked. I am the only woman out of forty to escape.⁶⁵

Although a fictional account, Helen Zenna Smith's writing is based on actual testimony and intimates at the risks faced by nurses. Further evidence that confirms nurses were frequently injured in such air raids comes from the case of Nurse Isabella Webster, a sister with the Queen Alexandra's Imperial Military Nursing Service (QAIMNS) who was the victim of an air raid. Whilst on duty with 61 Casualty Clearing Station at Poperinghe on 17th August 1917, she received a 'bomb wound to her right leg' after having been 'struck by a piece of shell in an air raid' which caused a 'lacerating wound to the right tibia'.⁶⁶ Similarly, VAD Edith Oswald suffered badly in the air raids of October 1917 and spoke of her 'fear' which could be excessive and uncontrollable, and which eventually led to her suffering symptoms redolent of shock. Returning to duty in the Spring Offensive of 1918 it was not long before she was caught up in the raids again.

Last night about 11.30 just as I was dozing off the guns started. My heart gave one jump, and then started rattling away just as it used to and I shook from head to foot. However, I soon got all right so I must be all right again and got in to my things calmly enough and went along to a bedroom with three Canadian Sisters. (sic) Then we all went downstairs but it was evidently a false alarm, for nothing more happened. I am surely much better - after all it is the fear of fear that is the worst to bear.⁶⁷

⁶⁵ From the novel *Not So Quiet...* author Evadne Price's (Pseudonym - Helen Zenna Smith) heroine 'Nell' describes an air raid and its consequences as the trench the women Ambulance Drivers are sheltering in is bombed. Helen Zenna Smith. *Not So Quiet*. p. 234 - 238.

⁶⁶ NA PIN 26/20273. Isabella Webster.

⁶⁷ Unpublished diaries of Mrs E Briggs Constable (nee Edith Oswald) LC. Cited by Linda Dennant. 'A Civilising Mission?' p. 125.

Elliot-Smith and Pear also claimed that the soldier could be subject to such 'adverse stimuli for days, and sometimes weeks, with no respite offered in the form of sleep'.⁶⁸ Sleep was considered important, for without it

The usual mental conditions associated with loss of sleep then rapidly supervene: pains and unpleasant organic sensations, hyperaesthesia, irritability, emotional instability, inability to fix the attention successfully upon important matters for any length of time, loss of the power of inhibition and self control.⁶⁹

They stated that 'bodily hardship, such as exposure to cold and wet, hunger, and the irritation from vermin, can only aggravate the condition further'.⁷⁰ Once more this allows for the inclusion of the female sufferer as the lack of sleep, and its consequences, was also a significant problem for nurses, particularly qualified nurses, who were few in number. The pressure upon them, along with the demands, and indeed expectations, especially under such extreme conditions, to remain on duty was great, and many went without rest or sleep. Elizabeth Haldane was to record in her 1923 account of nursing in the First World War, *The British Nurse in Peace and War*.

When we think of what happened in the "Retreat," the constant and terrifying air-raids and continual work carried out under shell-fire, we cannot but marvel at what the nurses went through [...]. Nurses often worked five days and nights under shell-fire with practically no sleep and dealing with thousands of patients.⁷¹

She added that the nurses on duty in the bases were often required to work 'fifteen and eighteen hours a day with time off only for meals.'⁷²

⁶⁸ Elliot Smith, G and Pear, T. *Shell Shock and its Lessons*. p. 6.

⁶⁹ *Ibid.* p. 7.

⁷⁰ *Ibid.*

⁷¹ Elizabeth Haldane. *The British Nurse*. p. 224.

⁷² *Ibid.* p. 227.

The civilians had to be cared for also in the recaptured towns, the wounded, gassed, old and helpless men and women, some with large and filthy bed-sores. The work was not appreciably lessened till the end of December. Then there were the returned prisoners to care for. These came in thousands to the hospitals, scantily clothed and in a pitiable state of weakness, starvation, and filth, some hardly recognizable as men. They had terrible tales to tell, and in one hospital alone thirty-nine men died within two days of admission. The nurses on ambulance-trains had heavy and depressing work carrying 600 men of all nations suffering from wounds, influenza, dysentery, and all kinds of sickness.⁷³

Similarly, during the period of the Spring Offensive in 1918, nurses

Had very little sleep for over a week, and for nine days were not more than twenty-four hours in the same place. They left their units hurriedly by road, and after going some miles, the patients having been brought on, they would stop and work for twelve hours in the open, and before they could rest they had to move on again as quickly as possible, driving all night and halting in the early morning to attend to patients.⁷⁴

Indeed, the records of Julia Adam, a nurse with the QAIMNS(r) who served in France at intervals of nine or twelve months from 1914 to 1917, claim the cause and origin of her disorder was 'overwork'. Nurse Adam had served in a Casualty Clearing Station in 'the Somme area', during which time she had also been reported as 'missing',⁷⁵ and the case of QAIMNS Sarah Buckley, confirms the same for nurses who served at home, for whilst on duty at Millbank in London claims that in preparation for the incoming wounded she worked 'fifteen hours out of twenty'.⁷⁶

⁷³ *Ibid.* p. 228.

⁷⁴ Elizabeth Haldane. *The British Nurse*. pp. 224/5.

⁷⁵ NA PIN 26/19985. Julia Adam.

⁷⁶ NA PIN 26/20019 Sarah Buckley.

Therefore the excessive demands in terms of work were frequently cited as the causes for illnesses amongst the nurses. Nurse Elizabeth Armstrong served with the British Red Cross Society (BRCS), and joined for service with the 3rd Scottish Hospital in 1916 before going to Trouville in 1918. She was discharged within six months due to 'overwork'.⁷⁷ Similarly, and during the battle of Verdun, Nurse Winifred Kenyon also found herself suffering from the consequences of tiredness and lack of sleep. After assisting with numerous operations, her diary entry for March 24th 1916 records

Work has been harder than ever for us in the theatre this week. 19 ops on Monday and I found I had a temperature of 101, but of course didn't say so, and anyhow I haven't felt feverish since. But what with hard work and not sleeping I was feeling absolutely done on Wed. eve, I was told to stay in bed next day. I slept almost all day, but am still in bed now, really very thankful, but hating it all the same when everyone is so busy. It IS rotten breaking down like this, but I think I shall be allowed on duty tomorrow all right.⁷⁸

The expectation to work even harder would follow heavy battles. After the battles of the Somme, when casualty figures were higher, the pressures upon nurses to continue working were considerable. Aware of the pressures upon them to keep going, testimonies suggest many nurses worked whilst feeling ill and often until the point of collapse. Many only went off duty when severely ill. However, sometimes the need for nurses was so urgent that some were called from their sick beds. QAIMNS(r) Alice Welch was diagnosed with Debility whilst on duty on a hospital ship in Dieppe between May 1915 and May 1917. Following a bout of influenza in 1918, which necessitated in her retiring to

⁷⁷ NA PIN 26/ 19991. Elizabeth Armstrong.

⁷⁸ Diary of Nurse Winifred Kenyon. Imperial War Museum Department of Documents.

bed for two days, she was unfortunately required to continue with the nursing duties and 'had to keep getting up as she was the only nurse on duty'.⁷⁹

The case of Alice Dixey is particularly illustrative of the difficulties faced by nurses. Nurse Dixey enlisted for duty in 1914 and had worked at home for three years before being sent to France. She had worked on both day and night shifts, worked with cases of dysentery, typhus and various infectious cases and herself had worked with broken chilblains. She served in France at the 24th General Hospital at Etaples but after a bout of influenza in 1917 was sent to a hospital at Plaga for a period of rest. However, in 1918

The air raids were so bad and the hospital was so continually bombed that her sleep was again affected and the terrifying dreams returned. She got very thin and was unable to sleep at all. [...] The hospital was bombed nearly every day and the matron was somewhat worried as to her state of health... She returned to hospital at a time when the German wounded prisoners were being brought in straight from the battlefield with their first rough field dressings.⁸⁰

After being diagnosed with rheumatism, apparently the result of extreme cold she was brought to England, demobilised at Folkestone on the 28th March 1919 and finally diagnosed with neurasthenia. Her records add

She states that she suffered very badly for a long time from insomnia and terrifying dreams. At the slightest worry the battle scenes and all the unpleasant sights she had witnessed would come back in her dreams.⁸¹

Alice Dixey's experience was not particularly unique and demonstrates the extreme conditions and excessive demands placed on nurses to the point

⁷⁹ NA PIN 26/20274. Alice Welch.

⁸⁰ NA PIN 26/20052. Alice Dixey.

⁸¹ *Ibid.*

where she, like many others, became first physically ill, then psychologically ill, from her nursing experiences during the First World War.

More and more medical authorities saw breakdown as being the result of the 'conditions of warfare' per se. Turner's classification, namely that the trauma of warfare could be the result of 'exhaustion of the nervous system resulting from physical and nervous strain, sleeplessness, fear, anxiety, and harassing sights and experiences'⁸² further lent itself to the inclusion of female sufferers. Their role as medical personnel made them vulnerable for several reasons. Historian, Angela K. Smith, has stated that while the men and women who made up the medical personnel, 'did not for the most part, operate in the line of fire, [...] they were very often close enough to experience the activity of the front line in a unique way. The soldiers they treated [...] had regularly come from direct action',⁸³ and while the nurses

Were not soldiers, did not experience actual combat, [they] were still exposed to many of its most disturbing results. They were firsthand witnesses of the carnage.⁸⁴

For the nurses who served during wartime, especially in areas close to the fighting, it was obvious they would come in to contact with disturbing sights, sounds and horrific injuries. Naturally, there was an element of anxiety, on the nurses' part, in wondering how they would deal with these horrific sights and sounds of injured and maimed men. Nurse Nora Pemberton, writing very early

⁸² William Aldren Turner. 'Arrangements for the Care of Cases of Nervous and Mental Shock'. p. 1073.

⁸³ Angela K. Smith. *The Second Battlefield*. p. 70.

⁸⁴ *Ibid.*

in the war, appeared quite sanguine about what sights lay ahead of her after arriving at the front. Writing to her parents, she proudly commented. 'I am thankful to say it has not affected my nerve in the very least, and the sights and what is much worse, the smells leave me untouched from a nurse's point of view, and I have been able to handle anything and see anything without flinching'.⁸⁵ Elsie Bowerman who served with the Scottish Women's Hospitals appeared less than positive when writing of her experiences in 1917 when 147 wounded arrived.

Hospital only equipped for 100 - nightmare of a day - one ward just straw - men laid on without taking clothes off. Terrible sights and sounds - lots of very bad cases - gangrene - smell at time almost unbearable - a strange sickly odour quite unlike anything else, which seems to permeate everything and stick in one's nostrils, even when one is out in the fresh air. Operations continuously all day and night till 5 a.m. - nurses up nearly all night'.⁸⁶

Dr. Elsie Inglis, also of the Scottish Women's Hospital, described, after having listened to the distressing sounds of hungry soldiers who could not be fed, of them 'coughing and moaning all night'⁸⁷ and stated that she and her colleagues 'hid our heads under the blanket to shut out the sound'.⁸⁸ In some cases injuries were so great they showed 'how near a man can come to death without being killed'⁸⁹. Claire Elise Tisdall, VAD Ambulance Nurse with the London District Ambulance Service described

The worst case I saw - and it still haunts me - was of a man being carried past us. It was at night, and in the dim light I

⁸⁵ Pemberton. Letter to Father, dated 2nd November 1914. Imperial War Museum Department of Documents. (Emphasis in the original)

⁸⁶ Elsie Bowerman Diary, 1st January 1917. Elsie Bowerman Collection, Fawcett Library.

⁸⁷ Cited in Susan Kingsley Kent. *Making Peace*. p.59.

⁸⁸ *Ibid*.

⁸⁹ Diary Entry of Dr. D. B. Reardon. (1st Harvard Medical Unit). 31st July 1915. Cited in Lyn MacDonald. *The Roses of No-man's Land*. p. 88.

thought that his face was covered with a black cloth. But as he came nearer I was horrified to realise that the whole lower half of his face had been completely blown off and what had appeared to be a black cloth was a huge gaping hole.⁹⁰

It was therefore extremely likely that witnessing such bloodshed would have an adverse affect on an individual's mental composure, and which for some may have had lasting effects. Vera Brittain has stated of her experience:

After seeing some of the dreadful things I have to see here, I feel I shall never be the same person again, and wonder if, when the War does end, I shall have forgotten how to laugh. ...Some of the things in our ward are so horrible that it seems as if no merciful dispensation of the Universe could allow them and one's consciousness to exist at the same time.⁹¹

Brittain goes on to recall a particularly difficult incident:

One day last week I came away from a really terrible amputation dressing I had been assisting at - it was the first after the operation - with my hands covered with blood and my mind full of passionate fury at the wickedness of war, and I wished I had never been born.⁹²

Mary Borden's personal experiences of the sights she witnessed are evident at the beginning of this chapter as she refers to wounds as 'holes as big as your fist, and pulpy thighs.'⁹³ Yet they were not the only time she had to encounter traumatic sights. On another occasion she describes

A man stretched on the table. His brain came off in my hands when I lifted the bandage from his head. When the dresser came back I said: 'His brain came off on the bandage.' 'It's only one half of his brain' he said, looking into the man's skull. 'The rest is here.'⁹⁴

⁹⁰ Claire Elise Tisdall. VAD. Cited by MacDonald. *The Roses of No-Man's Land*. p. 165.

⁹¹ Vera Brittain. *Testament of Youth*. p. 215.

⁹² *Ibid.* pp. 215 - 216.

⁹³ Mary Borden. *The Forbidden Zone*. p. 60.

⁹⁴ *Ibid.* pp. 142 - 143.

In an effort to cope with these sights, which she saw on a regular basis, she describes in her chapter 'Moonlight' of how she referred to the men, her patients, and of the wards, as the damaged parts of their bodies. 'You can watch her plying her trade here any day. She is shameless. [...] She lies with the Heads and the Knees and the festering Abdomens'.⁹⁵

For many nurses, like Mary Borden, the act of allowing themselves to see the soldier as a person was to allow themselves to become emotionally attached and hence liable to become distressed at his plight. Alternatively, to see him, as the 'broken' part of his body was to remain detached and for some was a way of remaining in control. For instance, Borden saw this as a way of dealing with the horror of what she was seeing every day. It was, for her, a way of 'immunising' herself from breaking down whilst on duty and it has been explained as a 'physical and mental fragmentation'.⁹⁶ Such emotional detachment and disaffectedness might, arguably, be behind the psychological breakdown of many of these women. Borden goes on to describe how the nurse becomes a dehumanised woman, and in so doing alludes to her own psychological distress. 'She is a harlot in the pay of War and she amuses herself with the wreckage of men. She cohorts with decay, is addicted to blood, cohabits with mutilations, and her delight is the refuse of suffering bodies.'⁹⁷

⁹⁵ *Ibid.* p. 62.

⁹⁶ Sharon Ouditt. *Fighting Forces*. p. 38.

⁹⁷ Mary Borden. *The Forbidden Zone*. p. 62.

Susan Kingsley Kent has written of this type of detachment. She states that 'normal' life for nurses like Brittain and Irene Rathbone's protagonist, 'Joan', (Joan was based on Rathbone's own experiences), required them to change the dressings of men like 'McIvor, the jaw-case, who, when his innumerable and complicated bandages were removed, revealed flat holes plugged with gauze where a nose had been, and pendulous shapeless lips. The stench that rushed forth as the last dressing dropped off was just humanly endurable, and only just.'⁹⁸ While this, and similar tasks performed by the nurses, may be described as normal, 'Joan' felt that in hardening herself to these sights and sounds and to her duties meant she had 'adjusted herself inwardly and outwardly to the conditions in which her life must now be lived - conditions which, if they could not be accepted as normal, would mean her defeat.'⁹⁹

Hence, there was a sense in which both soldiers *and* nurses fought against the likelihood of breakdown, but it may be argued the pressure upon nurses, and particularly military nurses, to remain in control and *not* to breakdown was even greater as they needed to maintain their position, and composure, as the 'carer'. The military nurse must nurse her patients back to health for return to the fighting if appropriate, or 'patch them up' sufficiently well for them to be moved to the next hospital, but whether they are able to 'care' for those patients presents the nurse with a paradox. It is argued that to be a carer, who then cannot, or should not, care renders the individual redundant and

⁹⁸ Susan Kingsley Kent. *Making Peace*. p.60.

⁹⁹ *Ibid.*

means they could 'experience an erosion of their own subject identities'.¹⁰⁰ This perception of their own role and its 'uselessness' in these dire circumstances has been discussed as a factor in the likelihood of causing emotional stress in nurses. For instance, it has been claimed by Vietnam nurse Linda van Devanter that the circumstances of war affect the self-esteem of military nurses. For example

Nurses in all wars expect to do good, to care, to be useful and save lives. The sort of patients military nurses see are horribly maimed and often they are flown out or evacuated quickly, so they were never seen to recover.¹⁰¹

Devanter claims that the degree to which nurses are required to 'depersonalise and distance themselves in the military can become a huge source of guilt for those who see themselves as caring people'.¹⁰² This is particularly relevant to military nurses. Hence, 'to be a caring person who doesn't [or cannot] care is very difficult.'¹⁰³

Yet, conversely some of the testimonies of nurses, specifically those cited by Lyn MacDonald suggest less of a 'detached' approach, and more concern for their charges. Nurse Kit Dodsworth, for instance, a VAD at the No. 12 General Hospital in Rouen, recalled the case of 'Baby Jock' a seventeen year old who had a small gunshot wound to his arm, which had healed quickly and he had therefore received notice of his return to the line.

¹⁰⁰ Sharon Ouditt. *Fighting Forces*. p. 38.

¹⁰¹ Lynda Van Devanter. *Home Before Morning*. Cited in Esther D. Rothblum and Ellen Cole (Eds) *A Woman's Recovery From the Trauma of War*. p. 112-113.

¹⁰² *Ibid.*

¹⁰³ *Ibid.*

Poor little fellow! He was only seventeen and had thought himself exceedingly clever when he had succeeded in fooling the recruiting people about his age. Now he was regretting it sadly. He sat down on an empty bed and cried like a baby. He simply could not face going over the top again. I did my best to comfort him and eventually all I could do was promise to be at the gate to say goodbye that night. When they went past he was singing with the rest. I couldn't bear to look at them. As soon as the draft had gone by I rushed back to my tent to cry in private. It all seemed so futile. We were doing our best to get them well and then they had to go back and get another wound, or worse. After he went back to the line I heard from him, and it was a great relief to know that he had been sent to the ammunitions column. I felt much happier when I knew that he was in no great danger.¹⁰⁴

However, Henriette Donner argues that caring in this way might be the undoing for some nurses, for despite 'a lot of routinizing, [...] it proved to be useless as protection against consuming feelings. Most VADs fought a hopeless battle against empathy'.¹⁰⁵ Citing from the diary of Marjorie Starr, Donner supports this claim by selecting the comment, 'I got through the night without any more special excitement,' and, 'I got through the night without death, ...the dressings take it out of one if you are a bit sympathetic'.¹⁰⁶ Donner adds that as much as Starr tried 'not to take a personal interest in her charges and her work, she [Starr] felt broken by each death' for 'was it not her duty to keep them alive?'.¹⁰⁷

Finally,

She was unable to get used to death. Her sense of personal responsibility, hence failure, caught up with her and she had to be sent to work in the kitchen for one month - which she found humiliating and unrewarding.¹⁰⁸

¹⁰⁴ Lyn Macdonald. *The Roses of No-Man's Land*. p. 99.

¹⁰⁵ Henriette Donner. 'Under the Cross'. p. 696.

¹⁰⁶ Imperial War Museum Document Section. (Unnumbered) M Starr. Cited in Henriette Donner. 'Under the Cross' p. 696.

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.*

Ostensibly, the pressure upon nurses to remain 'responsible' and 'in control' at all costs was evident in the comments of a Matron in a letter to the *Nursing Mirror* in 1914. For the nurse, to fall ill, physically or psychologically, was considered a failing, and was, for some, a source of guilt and a psychological burden, which arguably could have led to psychological disorder or illness.

I should very much like to call your attention to a paragraph which appeared in The Standard. It stated in the course of an article describing the experience of two sisters who were attending to the wounded during the siege of Antwerp, but who had only had one week's training as nurses, that the regular nurses were perfectly trained in all the sciences of hospital work, but were not equal to the sort of terror which accompanies bombardment. The following sentence is put in to the mouth of one of the sisters. 'Give me women accustomed to hunt. Why that night a nurse sat for eight hours in a corner of the cellar and screamed.' When I read it I felt very indignant on the nurses behalf, but I happened to have in my house a Belgian soldier who was in Antwerp at this time, and who, being wounded and in the hospital the Germans had shelled could tell me something about it. I asked him if the nurses screamed and lost their heads. He says that, being in such chaos as everybody was there, when the Germans began to shell the hospital, he could not differentiate between trained and untrained nurses, but that it is a fact the staff, however composed did scream for hours on end. It is to me, a nurse, well nigh unbelievable that a nurse can under any circumstances lose her head to such an extent, and it seems to point to the necessity of very great care in the selection of nurses for active duty.¹⁰⁹

The search for reliable nurses saw some unofficial recruitment campaigns being selective as they stressed the need for those who would not 'breakdown' when they were most needed.

People subject to splitting headaches and bilious attacks or such like minor ailments on the least change taking place in their

¹⁰⁹ The *Nursing Mirror*. Vol., XX, No., 507 December 12th, (1914) p. 197.

ordinary habits of life are unsuitable applicants, and even if accepted would only give trouble to others by breaking down just when their services were most required.¹¹⁰

The comment of VAD Edith Oswald highlights, for her, how the pressure to stay calm and responsible was paramount.

I am not actually afraid of death - but I dreaded getting the wind up when I am on duty - having those helpless men dependent on one - however everyone tells me it is the very fact that keeps you from becoming nervous.¹¹¹

Vera Brittain recalls her feelings following a 'strenuous evening, after a month's work at the 1st London General'.

I nearly fainted in the ward and had to be put to bed in a Sister's cubicle at the hospital. I was intensely surprised and humiliated by this weakness, of which I was never before been guilty and was not to repeat. Probably the grim, suppurating wounds of the men in the huge ward were partly responsible, although, as I was to learn later in France, they were by no means the worst wounds that a man could receive without immediately qualifying for the mercy of death.¹¹²

She added that she knew she was to see the doctor the next morning, 'and lay awake half the night in terror lest I should be found medically unfit to nurse.'¹¹³

For some women, the experience of warfare and of serving alongside the BEF was to have a profound, and in some cases, a lasting effect. Brittain recalled that she went on to suffer from

Persistent dreams of Roland and Edward - the one missing and purposely hiding his identity because facially mutilated, the other suffering some odd psychological complex which made him turn

¹¹⁰ The *Nursing Mirror*. Vol. XIX No, 493. September 5th (1914). p. 425.

¹¹¹ Unpublished diaries of Mrs E Briggs Constable (nee Oswald) LC. Cited by Dennent. 'A Civilising Mission. p. 125.

¹¹² Vera Brittain. *Testament of Youth*. p. 220.

¹¹³ *Ibid.*

against us all... - I endured none of those nightmare recapitulations of hospital sounds and sights of which other wartime nurses complained for two or three years. Only the horrible delusion, first experienced after the flight from Girton, that my face was changing, persisted until it became a permanent, fixed obsession.¹¹⁴

Furthermore, she wrote that the

Hallucinations and dreams and insomnia are normal symptoms of over fatigue and excessive strain, and that, had I consulted an intelligent doctor immediately after the War, I might have been spared the exhausting battle against nervous breakdown which I waged for eighteen months...But no one, least of all myself, realised how near I had drifted to the borderland of craziness. I was ashamed, to the point of agony, of the sinister transformation which seemed, every time I looked in the glass, to be impending on my face...the illusion...that I was developing a beard.. Nothing has ever made me realise more clearly the thinness of the barrier between normality and insanity than the persistent growth, like an obscene, overshadowing fungus, of these dark hallucinations.¹¹⁵

Ultimately, Brittain, exhausted and

Dizzy from work and indecision, I sat up in bed listening for an air raid and gazing stupidly at the flickering shadows cast by the candle lantern[...] Through my brain ran perpetually a short sentence which - having become, like the men, liable to sudden light-headed intervals - I could not immediately identify with anything that I had read. "The strain all along", I repeated dully, "is very great [...] very great". What exactly did those words describe? The enemy within shelling distance - refugee Sisters crowding in with nerves all awry - bright moonlight, and aeroplanes carrying machine-guns - ambulance trains jolting noisily into the siding, all day, all night - gassed men on stretchers, clawing the air - dying men, reeking with mud and foul green-stained bandages, shrieking and writhing in a grotesque travesty of manhood - dead men with fixed empty eyes and shiny, yellow faces [...] Yes, perhaps the strain all along *had* been very great.¹¹⁶

¹¹⁴ *Ibid.* p. 496.

¹¹⁵ *Ibid.* p. 496 - 497.

¹¹⁶ *Ibid.* p. 423. (Emphasis in the original)

Brittain claims she came close to what she understood to be insanity. Arguably, her experiences are suggestive, and indeed indicative, of a war neurosis. In this she was not alone, and there were some nurses who would go on to suffer to the point of 'insanity', or psychosis. In a somewhat sinister account from the Manchester Royal Lunatic Hospital in Cheadle it is revealed that concern was voiced as to how best to accommodate 'lunatic officers'. It was proposed to distribute the lunatic officers in different places, and as 'dormitory accommodation only will be provided, it is obvious that patients cannot be admitted under this arrangement who are noisy, excited, of faulty or destructive habits'.¹¹⁷ Most of these officers

Were of the lower ranks, mainly lieutenants and second lieutenants, but there were quite a few captains and majors, a couple of lieutenant colonels, and a brigadier general ...*along with a score or so nurses.*¹¹⁸

This section has seen a re-examination of the history of shell shock from a medical perspective, and in so doing has raised two specific issues, which challenges the notion that shell shock was a masculine disorder. Firstly, in view of the panic that was emerging from the prospect of a 'new' and frightening disorder, a revised understanding and theorising on the part of contemporary medical authorities allowed for the inclusion of female sufferers. Nurses, as a result of their experiences, were diagnosed using the same criteria as used for traumatised soldiers. Secondly, the term shell shock, despite being outlawed by army and medical authorities, retained its place as an iconic disorder,

¹¹⁷ Peter Barham. *Forgotten Lunatics*. p. 255.

¹¹⁸ *Ibid.* p. 255. (My emphasis)

specifically for the public, to the extent that it was used freely to identify war neurotic nurses as well as soldiers. This chapter will now turn to examine another disorder known as Disordered Action of the Heart, and which will be highlighted as equally prevalent amongst nurses as it was amongst soldiers, despite commonly being referred to as 'Soldier's Heart'.

Soldier's Heart/Nurse's Heart?

Sandra Gilbert has stated that women developed a very different kind of 'soldier's heart' in these years, (for) 'wearing the pants' in the family or even 'stepping into his shoes' had finally become a real possibility for them'.¹¹⁹ This statement has some resonance in the context of war neuroses, as many nurses experienced symptoms that would prompt physicians to diagnose them with 'Soldier's Heart' or Disordered Action of the Heart. Disordered Action of the Heart, or DAH, presented as a disorder of 'comparable epidemic proportions'¹²⁰ to that of shell shock. It saw 'numbers of men discharged from the Army and Navy and pensioned up to the last day of May 1918 in excess of 36,569 cases and was third only to 'wounds and injuries' which stood at 138,699 and 'chest complaints' at 41,155.¹²¹ The number given for 'Nervous disease' was 21,228.¹²²

¹¹⁹ Sandra Gilbert. 'Soldier's Heart' p. 443.

¹²⁰ *Reveille*. August (1918) As cited in Lewis. *The Soldier's Heart and the Effort Syndrome*. p. 1. Similarly, according to a return supplied to the Statutory Committee appointed under the Naval and Military War Pensions Act of 1915, which presented the number of disabled soldiers and sailors discharged from service from the beginning of the war up to and including May 31st, 1916 - out of a total of 33,919 men discharged, approximately 7.4 per cent (2,503 cases) were discharged for diseases of the heart alone. *Board of Trade and Labour Gazette*. May (1915) p. 161.

¹²¹ *Ibid.*

¹²² *Ibid.*

The disorder, DAH, commonly known as Soldier's Heart, was reputedly first described by Jacob DaCosta as 'irritable heart'¹²³ and was similarly observed during the Crimean War, during the South African War and, again, in soldiers returning from India. It became known as 'Soldier's Heart', DAH and also as the 'Effort Syndrome' in the First World War and the years preceding the First World War saw several schools of thought attempting to offer explanations for this apparent 'new syndrome'. Concern was sufficient to prompt the British Government to form a committee of enquiry in 1864, and theories about causes ranged from the effect of the old style kit worn by soldiers, the effects of drill and the soldier's way of life, the possibility of latent, unsuspected cardiac conditions brought on by the physical and mental demands of military life, to the consequences of cigarette smoking and 'self-abuse'.¹²⁴ Not unlike the situation regarding shell shock, the First World War was to begin with specific questions as to the aetiology of 'Soldier's Heart' remaining unanswered.

The disorder was characterised by symptoms of palpitations or rapid heartbeat, pre-cordial pain and fatigue.¹²⁵ Fatigue was deemed to be the universal complaint and the symptoms, if found in a healthy subject, were often the result of strenuous exercise. During the First World War physician James

¹²³ J. M. DaCosta. 'On Irritable Heart' *American Journal of Medical Science*. Vol. 61. (1871) pp. 17 - 52. Cited by Charles F. Wooley, 'From Irritable Heart to Mitral Valve Prolapse: World War I, the British Experience and Thomas Lewis'. *The American Journal of Cardiology*. Vol. 58. October 1st (1986) p. 844.

¹²⁴ R. D. Macgregor. Letter to *The Lancet*. Vol. 1. April 1st (1916) This correspondent to the *Lancet* pointed out, with reference to the claim for cigarette smoking, 'the suggestion that such a habit was a major cause of the soldier's heart becomes untenable when one considers the incidence of this syndrome among the Indian Armed Forces, many of which, for religious reasons, did not smoke at all'.

¹²⁵ The sensation of chest pain was common and felt to the left side of the chest, or precordium.

Mackenzie,¹²⁶ described a group of symptomatic persons who formed a considerable proportion of the community but 'recognised by every practitioner'.¹²⁷ Charles Wooley has commented on his findings.

Although physicians called this group neurasthenic, he (Mackenzie) disdained the term as a 'cloak for ignorance'. The persons were spare and thin, had evanescent mitral and tricuspid systolic murmurs, with varying heart rate and rhythm. He had never seen heart failure occur in any of these cases.¹²⁸

Mackenzie's findings, developed whilst in practice, helped to formulate an understanding of the condition and he was pivotal in setting up the Mount Vernon Heart Hospital in Hampstead for the specific purpose of dealing with military and medical cardiac problems. Mackenzie is reputed as being the founder of the 'Cardiac Club' and Thomas Lewis was to become a member. Thomas Lewis is the name most associated with research in to 'Soldier's Heart'.

Lewis went on to become consulting physician on diseases of the heart to the military hospitals and to the Eastern Command. His research was to culminate in several articles on the subject but specifically *The Soldier's Heart and the Effort Syndrome* in 1918 and *Diseases of the Heart* in 1943.¹²⁹ He formulated his theory of Disordered Action of the Heart based on observations made whilst at Hampstead. He surmised

¹²⁶ James Mackenzie, a cardiologist is reputed with using the 'clinical polygraph to obtain graphic records and investigated the venous and arterial pulse.' Charles F Wooley. 'From Irritable Heart to Mitral Valve Prolapse: World War I, the British Experience and James Mackenzie.' *The American Journal of Cardiology*. Vol. 57 (February 15th 1986) p. 464.

¹²⁷ Charles F Wooley. 'From Irritable Heart to Mitral Valve Prolapse: World War I, the British Experience and James Mackenzie.' p. 464.

¹²⁸ *Ibid.*

¹²⁹ Thomas Lewis. *Soldier's Heart and Effort Syndrome*. Thomas Lewis. *Diseases of the Heart*. (London: Macmillan and Co, Ltd, 1943)

When a healthy man takes exercise, and this exercise is sufficiently stressful or prolonged, he becomes aware at the time of the effort, or after it has ceased, of certain symptoms and he presents certain physical signs. The most notable of his symptoms is breathlessness, a symptom that comes during the exercise and continues with diminishing intensity for a variable period afterwards. During the exercise, consciousness of the heartbeat may come, giddiness or actual fainting or fatigue may be added... In cases of extreme effort, pain over the precordial region [...] may be felt. [...] A large number of patients, especially soldier patients, who come under observation, report sick, or are regarded as sick, because they notice or present such a series of symptoms and signs.¹³⁰

Known also as the 'Effort Syndrome', Lewis described it as 'not peculiarly a soldier's malady, [for] it is only just permissible to speak of it as specially a soldier's malady; its apparent frequency in soldiers is chiefly, if it is not entirely, due to its unveiling by circumstances which the civilian does not meet. It is a common condition amongst the civilian populace; it affects children and women as well as grown men',¹³¹ adding his reasoning for its increased prevalence.

When the young manhood of a whole nation is placed suddenly under arms, its whole habit of life, its housing, dietary and clothing, its times of rest and work, the nature of its employment changed, when with little or no preparation it is submitted by such a war as this to enforced training of a strenuous kind...then the manhood is submitted to a most dramatic test. Who then can affect surprise if many men fail when so tested?¹³²

The leading article of the *Lancet*, in 1916, was also suggesting, 'it is undoubtedly due to the constant strain of modern warfare, added to, in the case of officers, by the great sense of responsibility which is ever felt by them'.¹³³

¹³⁰ Thomas Lewis. *The Soldier's Heart and the Effort Syndrome*. p. 4.

¹³¹ *Ibid.* p. 8.

¹³² *Ibid.* p. 7.

¹³³ Leading article, 'Soldier's Heart'. *The Lancet* Vol. 1 (1916) p. 93.

Reputedly, while the disease continued to be reported in civilian life, and, after the war, it was essentially a 'disease' of soldiers at war. From this the assumption has been that all sufferers of DAH were soldiers, confirmed by the comment from Lewis, that 'the term "disordered action of the heart," or "D.A.H." as it is spoken and written in abbreviation, is purely an Army term'.¹³⁴ Historians, such as Allen J Christophers, have been quick to substantiate this claim, stating 'those affected were almost exclusively members of the British Expeditionary Force and almost all were in France,'¹³⁵ citing, in the process, figures for this claim. For example, the number of men discharged from the British army and Royal Navy and receiving a pension before 1918 on account of 'heart cases' was 36,569 or 10.2 per cent of the total number of casualties.¹³⁶

Yet, while these figures do support a large number of male sufferers, more recent research claims, that of 22,756 First World War soldier pension files contained in PIN 26, where the diagnosis was given as a single entity, only 1,149 were found to be cases of Disordered Action of the Heart, which equates to 5 per cent.¹³⁷ A similar analysis, conducted during research for this thesis, of the nurses contained in this same collection finds 10 cases of DAH, which calculates to 3 per cent. In addition, debility in soldiers accounted for 568 cases, or 2.5 per cent, while a similar analysis of debility in nurses reveals 11 cases, or 3.6 per cent. It therefore is interesting to see that a comparable proportion of nurses were described as suffering with DAH, for despite being

¹³⁴ Thomas Lewis. *The Soldier's Heart and the Effort Syndrome*. p. 2.

¹³⁵ Allen J Christophers. 'The Epidemic of Heart Disease Amongst British Soldiers During the First World War'. *War and Society* Vol. 15, No. 1 (May 1997) p. 53.

¹³⁶ Allen J Christophers. 'The Epidemic of Heart Disease' p. 54.

¹³⁷ Edgar Jones, Ian Palmer and Simon Wessley. 'War Pensions (1900-1945): changing models of psychological understanding.' *British Journal of Psychiatry*. (180, 2002). pp. 374 - 379.

described as 'chiefly a soldier's malady' and 'an army term' it is clear it affected a large number of nurses, and Lewis's theories and subsequent classifications may highlight why.

DAH shares a similar history to that of shell shock, for as in the case of shell shock there were similar objections to the use of the term DAH. It was frequently confused with the term VDH, or, Valvular Disorder of the Heart and, therefore, could be too readily used as a blanket term under which more serious heart disorders or organic cardiac disorders might be confused.¹³⁸ Consequently, Lewis, along with other medical authorities on the subject, argued against the haphazard way in which the two terms were used, suggesting they were erroneous labels for two other conditions - undetected organic heart disease and neurasthenia. In the

Case of neurasthenia, DAH simply represents the individual's obsessional interest with his somatic states. Cardiac events offer a favourite target, because they are both ominous (and therefore worth worrying about) and perpetually available. It would be better if this term was abolished and simple neurasthenia adopted in its place'.¹³⁹

Looking at cases of soldiers diagnosed with the term it is easy to see why Lewis held such objections. For example, Private Arthur Albert Brooks, aged twenty-two years when he volunteered in March 1917, was sent to France

¹³⁸ *Ibid.* pp. 3-5. DAH was not infrequently confused with VDH (Valvular Disorder of the Heart). Lewis' objections were because of the 'careless and perfunctory manner in which (they) had been used for front line work'. pp.3-5. He argued, that 'of the DAH group... the number in which lesions were discovered was not great', and of VDH, 'is in general use to include all manner of heart affections, valvular and otherwise, and includes the greater part of all patients who present systolic murmurs, irrespective of the origin of these murmurs.

¹³⁹ British Medical Association. *Special Clinical Meeting of the Section on Medicine: War Neuroses. The Lancet*. Vol. 1. (1919). pp. 709 - 720.

with the Royal Army Service Corps. His records show that he was 'engaged in heavy work but not any involvement in forward areas or the trenches'. However, he 'wrenched [an] old fracture of [the] arm', after which he began complaining of 'headaches, tremors, giddiness, sleeplessness and nightmares.'¹⁴⁰ He was diagnosed as 'DAH'. Similarly, Private Edwin Henry Burr, aged thirty-five years when he enlisted as a volunteer in 1917, served with the Labour Corps but did not go to France. His records state, 'unable to digest his food, sleeplessness, headaches, pains in stomach, pain in legs, some DAH'.¹⁴¹

Lewis's classifications encompassed those of, firstly, a 'constitutional weakness, nervous or physical or both', secondly, those who may be 'regarded as played out by exposure, hard continuous work, disturbed sleep and by constant strain and jar to body and nervous system which work in the front line brings',¹⁴² and finally, a group that comprised of 'patients who may be regarded as exhibiting delayed convalescence from acute illnesses such as rheumatic fever, pneumonia, pleurisy, dysentery, trench fever, severe influenza or tonsillitis'.¹⁴³ Medical officers were able to fit many of the nurses within these classifications. For instance, Nurse Mabel Louise Jones, a Staff Nurse in the TFNS served in France from April 1917 to July 1918 and was discharged in 1919 with a diagnosis of neurasthenia and DAH, which was found to be the result of a 'nervous breakdown while at the War'. In France she was admitted to a hospital on account of influenza and was reported to be 'debilitated and

¹⁴⁰ NA PIN 26/1975. Arthur Albert Brooks.

¹⁴¹ NA PIN 26/2300 Edwin Henry Burr.

¹⁴² Thomas Lewis. *The Soldier's Heart and the Effort Syndrome*. p. 6.

¹⁴³ *Ibid.*

anaemic' after complaining of a 'dull ache on left side if any exertion (sic), poor circulation in hands, dyspnoea on exertion, smothering feeling if lying down at night, easily fatigued, ...nervous in traffic, with occasional headaches.¹⁴⁴

Nurse Violet Forrest served as a VAD and is reported as developing 'fainting attacks, dyspnoea, precordial pain, (and) palpitations' whilst nursing in France.¹⁴⁵ She was described as 'run down and anaemic',¹⁴⁶ after having laryngitis in March 1919, and therefore diagnosed with DAH, as was Sister Annie Geraldine Wasson, who also complained of symptoms which included 'shortness of breath, precordial pain, palpitations (and) irregular action of the heart on exertion'¹⁴⁷ following influenza. Although her symptoms fit with the criteria for a diagnosis of DAH, she was nevertheless diagnosed with 'Debility after Influenza', which was claimed to be aggravated by 'strenuous duties as a nursing sister on nursing service'.¹⁴⁸

Similarly Sister Alice Ayers served a total of three and a half years with the QAIMNS. Her records state that she had an attack of influenza on 25th February 1919, which was followed by 'Dilatation of the Heart with aortic and mitral murmurs'.¹⁴⁹ Her symptoms included 'shortness of breath, palpitations, (and) pain in the region of the heart and a sense of fullness in the throat. Easily

¹⁴⁴ NA PIN 26/ 20131 Mabel Louise Jones.

¹⁴⁵ NA PIN 26/20070 Violet Lucy Forrest.

¹⁴⁶ *Ibid.*

¹⁴⁷ NA PIN 26/20271 Annie Geraldine Wasson.

¹⁴⁸ *Ibid.*

¹⁴⁹ NA PIN 26/19996 Alice Ayers.

exhausted on exertion, swelling of ankles at night and fainting attacks.¹⁵⁰ The resulting diagnosis was given first as 'Debility following Influenza' and then as 'DAH'.¹⁵¹ DAH was therefore clearly a diagnosis that physicians held no compunction in giving to nurses.

Nurse Ernestine Algar, saw service with the BEF for almost four years and was in France between August 1917 and November 1918. Her repeated attacks of 'septic throat and rheumatism' were thought to be due to 'exposure and excessive strain on active service'.¹⁵² Similarly, Mary Sexton, who served in the 1st Eastern General Hospital in Cambridge as a staff nurse with the TFNS for six months was invalided out on account of 'rheumatoid arthritis' after complaining of 'swelling and pain in [the] joints of hands and wrists, ankles and knees'.¹⁵³ Her condition was held to be 'attributable to Military Service' and 'specifically to nursing duties and exposure'.¹⁵⁴

Similarly, Sarah Annie Buckley who served as a nurse at the Royal Southern Hospital in Liverpool before her enlistment as a Staff Nurse with the QAIMNS. She then served a total of two years including a period in the Dardanelles when her records reveal that whilst on route to Egypt she developed a strangulated hernia requiring surgery, which had been performed

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.* Debility is described as a condition in which there is no actual disease, but in which all the functions of the body are performed, if not imperfectly, at all events with less than their accustomed vigour. The patient has no actual complaint; his heart, and lungs, and kidneys, and so on, are, as far as he knows, healthy, but still he feels that he is "below par" and he is not "up to the mark... feels queer all over.

¹⁵² NA PIN 26/19987. Ernestine May Algar.

¹⁵³ Private Collection. Mary Sexton. (Nurse 13706).

¹⁵⁴ *Ibid.*

in May of 1915. In August of the same year she was reported as 'improving but still run down'. A Medical Board in September 1921 revealed her to be complaining of 'shortness of breath on exertion, fainting and dizziness, including a cough with expectoration.' She claimed to 'sleep badly' needing to have the 'lamp lit'. She was described as 'very nervous' and her general condition as 'poor' with 'marked anaemia' and diagnosed with DAH.¹⁵⁵

The term 'exposure' was, perhaps, a somewhat ambiguous one, and was applied to cases where the weather appeared to have been a precipitating factor. Nurse Blackmore served as a VAD with the 4th Southern General Hospital for seventeen months. In 1918 she reported symptoms of 'pain running down [her] left arm, [...] much worse at night, [...] sometimes better and sometimes worse but always worse in bad weather. She was described first, as 'debilitated', [with] some aching in lower limbs,' and later, as having 'neuritis', which was recorded as 'attributable (and) contracted in the service - (the result of) exposure to wet coming and going from billet'.¹⁵⁶ Equally, Sarah Brown was the nursing sister at the Queens Park Military Hospital in May 1916 when two hundred of its beds were given over to soldiers, leaving the remaining three hundred for civilians. Nurse Brown was apparently in charge of all five hundred beds and was made deputy night sister to the soldiers' wards. In August 1917 she moved to the Fylde Hospital where the set up was much the same and, again, she was night sister from March 1918 to March 1919. In March 1919 she

¹⁵⁵ NA PIN 26/ 20019 Annie Buckley.

¹⁵⁶ NA PIN 26/20011. E Blackmore.

was described as 'laid up', which was attributed to the 'wet, draughts, exposure, [and] a fall in the ice'.¹⁵⁷

The weather, or exposure to it, was also recorded as a factor in the following two cases. Sister Clara Anderson, who saw service in Alexandria, Egypt in 1916, is reported as having a 'sudden seizure with convulsions, [was] unconscious and [had] paralysis on right side [with] aphasia'¹⁵⁸. Her attack at this time was recorded as 'DAH' and being due to 'climatic conditions in Egypt'.¹⁵⁹ Sister Elizabeth Agnes John, serving in Salonika, found the weather particularly difficult. As the sister in charge of three lines of tents she described her camp as 'in a very bad state during the winter' and 'one was perpetually wading about in mud and slush', and she was 'obliged to go in and out from one to the other in all weather to look after the patients'.¹⁶⁰ Diagnosed with DAH, she further stated

On one occasion during the winter of 1918 in the severe weather my tent was completely blown-down in the early hours of the morning, and I had to get out as best and quickly as I could with the amount of clothing I could find in a hurry in the pouring rain.¹⁶¹

DAH was clearly a diagnosis, under the description put forward by Lewis that medical officers felt suitable for the nurses who presented to them. It was also held to be appropriate for cases of infectious illness or where periods of

¹⁵⁷ NA PIN 26/20017. Sarah Brown.

¹⁵⁸ NA PIN 26/19988 Clara Anderson. Aphasia is described as a 'disorder of language affecting the generation and content of speech...*Oxford Concise Medical Dictionary*. [2nd Ed] (Oxford University Press, 1998).

¹⁵⁹ NA PIN 26/19988 Clara Anderson.

¹⁶⁰ Private collection. Elizabeth Agnes John. (Nurse 44062).

¹⁶¹ *Ibid.*

convalescence meant the nurse was debilitated and recovery delayed. Infectious conditions were common and suffered by many nurses in the course of their duties, and similarly cited by medical authorities as a causal factor leading to a diagnosis of DAH.¹⁶² In the course of her duties Alice Dixey [mentioned previously] suffered a common complaint. She developed septic fingers.

All the fingers were treated and one nail taken off... she returned to hospital and went straight to night duty but almost immediately after was ill practically the whole time and resigned very soon after.¹⁶³

Whilst viewed, perhaps, as an everyday hazard for many of these nurses, it nevertheless reveals that psychological strain was not the only concern to nurses and in the case of physical illness, could in turn lead to psychological distress and disorders. Sepsis, along with other factors in the everyday course of their duties could, for some, precipitate psychological illness. In short, some apparent minor ailments were to be the 'last straw' and saw them removed from duty. Sepsis was the frequent cause of infection and illness for nurses as they assisted in the treatment of gangrenous wounds. Gladys Stanford, a VAD at the Highfield Hospital in Southampton describes how

We used to soak the wounds in saline. [...] There was one very badly wounded leg; you had to lift it up, take away a part of the mattress, [...] and soak the leg in this fluid. I got a very bad septic hand doing that because the VADs didn't wear rubber gloves. Only the Sister wore gloves, and if you got the slightest prick it always went septic. If you knew that you had pricked yourself

¹⁶² For a statistical analysis of the range of disorders found within the 302 files held under NA/PIN 26 (19985 - 20286) Briefly, analysis of the pension records reveals tuberculosis, as a single diagnosis, accounted for 39 out of the 302 cases (13per cent) For the nurses who served with the Eastern Expeditionary Forces, Malaria, as a single diagnosis, was a concern accounting for 12 of 302 cases (4per cent) Other disorders included anaemia, arthritis, bronchitis, dysentery, rheumatism and varicose veins.

¹⁶³ *Ibid.*

you had to soak the scratch in your off-duty time in disinfectant. [...] I was putting my hands into a bath of solution where this septic leg had been soaking. I certainly got the infection from that.¹⁶⁴

Lyn Macdonald has stated that when every pair of hands was needed it was very difficult for nurses to go off sick. With 'too much work, too little sleep and precious little time to snatch a meal before they were too exhausted to eat it - the nurses' minor ailments often turned into major ones.'¹⁶⁵ Macdonald's opinion was that with early treatment Gladys Stanford's ailment might have meant three days off duty. As it was, she was 'ill for three months and at one point it seemed as if she might lose the hand altogether.'¹⁶⁶ She adds, 'no one could spare time to look after sick nurses and she went home to Cranbourne in Dorset where the family doctor ...was called in to lance her swollen hand.'¹⁶⁷ The question of treatment will be discussed later in this chapter.

Nurse Mary Frances Bealin served with the QAIMNS and saw service with the 36th and 44th Casualty Clearing Stations, which were located in Brielen and Colincamps during the latter part of the war. Nurse Bealin 'accidentally pricked her thumb with a safety pin whilst dressing a case. [Treatment involved] several incisions to thumb and wrist [but there occurred] some necrosis of the proximal and distal digits [and] presents some permanent limitation of

¹⁶⁴ Gladys Stanford. VAD. Cited in Lyn Macdonald. *Roses of No-Man's Land*. p. 169.

¹⁶⁵ Lyn Macdonald. *Roses of No-Man's Land*. p. 169.

¹⁶⁶ *Ibid.*

¹⁶⁷ *Ibid.*

movement.’¹⁶⁸ All these cases of physical ill health were deemed to have led to a diagnosis of DAH.

Finally, the case of Ethel Clarke, a VAD who had ‘acute follicular tonsillitis’¹⁶⁹ in May 1916 whilst in Boulogne, highlights how a diagnosis of DAH could fit within Lewis’s criteria following a period of physical illness. On admission to Vincent’s Square Hospital, London, Nurse Clark presented with

Slight tenderness in the anterior triangle of her neck. There is some pain on deglutition (swallowing), which appears to be difficult. Her breath is offensive. Her tongue is furred. Under a bridge of the right upper jaw there is ulceration and sepcis (sic) round some crowned teeth. The right tonsil is enlarged almost to the mi-line (sic). It is scarred with recent tonsillitis and extremely unhealthy looking. The left tonsil is enlarged but not to the same extent. There is cheesy pus in several crypts. The patient has rapid and somewhat irregular action of the heart, but no added sounds. She has no other physical signs of disease, but appears to be run down.¹⁷⁰

Nurse Clarke was admitted to the Queen Alexandra’s Military Hospital, Millbank for an operation to remove her tonsils five days later and was then returned to Vincent’s Square four days after that. On June 5th she left St Vincent’s for a month’s leave and on July 12th was declared ‘fit for duty’ and sent back to No. 13 General Hospital in Boulogne on July 17th. She was on duty till August 12th but because she was ‘not looking well’ was examined by a Medical Officer, who sent her to No. 14 General Hospital, Wimereux, with the recommendation she return to England.¹⁷¹ Nurse Clark’s records add,

¹⁶⁸ NA PIN 26/20003 Mary Frances Bealin.

¹⁶⁹ NA PIN 26/20033 Ethel G. Clark.

¹⁷⁰ *Ibid.*

¹⁷¹ *Ibid.*

The patient states that the ventilation of Ward in which she was working was very bad. She also now states that on April 1st she lifted a patient and thinks she may have strained her heart as she has not felt well since. [...] On returning to duty at Boulogne in July felt extremely shaky and could hardly control her hands, after about a week this diminished and she was able with difficulty to perform her duties which were arduous on account of the advance. In subsequently being examined she was found to have a very rapid pulse, tremor of the hands, a systolic murmur at apex.¹⁷²

On August 24th she is reported as 'feeling better' but 'gets attacks of palpitation for no apparent cause. She is sleeping well. Is taking Eastons Syrup t.d.s.'¹⁷³ On the 29th she was reported as 'better - but suffers from flatulence and indigestion - Eastons stopped and ordered an alkal mixt. To get up'.¹⁷⁴ On September 4th her records read, 'Stop mixture. To have Acid and Hydrochl dil zii. Tr. Nuc vom mins 30. Syrup aurant z iv. t.d.s. p.c.'¹⁷⁵ Finally, and of specific interest, on September 18th she was reported as having been seen by 'Sir James Mackenzie, who confirms the condition (DAH) and recommends 1 - 1 ½ years' rest in Canada.'¹⁷⁶

Lewis's understanding and description of DAH was an interesting one as far as the cases of nurses are concerned. It became one that allowed for the inclusion of nurses into the history of war neurosis more readily than shell shock did. The notion of it being 'chiefly a soldier's malady', and 'purely an army term', has some resonance with the shell shock story, but while some nurses were referred to as shell-shocked, far more were diagnosed with DAH. It is

¹⁷² *Ibid.*

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*

¹⁷⁵ *Ibid.*

¹⁷⁶ *Ibid.*

difficult to ignore that fact that, at least from a popular point of view, shell shock remained the favoured term for those who had suffered for the experience that was believed to be the result of trench or front line warfare. DAH, on the other hand, offered a more suitable alternative to describe those who had been exposed to the worst of the war's experiences but without being in a trench, and therefore could be readily applied to many of the nurses complaints. Nevertheless, and regardless of whether nurses were diagnosed with 'shell shock' or with DAH, their symptoms required them to be removed from duty and/or to receive treatment. Where that treatment took place and what form it took is the concern of the next section of this chapter.

Practical Arrangements for the Care of Sick Nurses

Lyn Macdonald has stated 'no one could spare time to look after sick nurses' and in the case of Gladys Stanford, for instance, 'she went home to Cranbourne in Dorset (to see) the family doctor'¹⁷⁷ This section seeks to explore whether this was the case for the majority of nurses and if not, whether there existed a treatment network for nurses, similar to that set up for soldiers. Significant understanding of various forms of treatment and of the hospitals where this took place has been gained from studies looking in to the network of treatment centres set up for soldiers that stretched from the battle zones through to the hospitals on the home front.¹⁷⁸ Little, however, is known of what was set up for

¹⁷⁷ Lyn Macdonald. *Roses of No-Man's land...* p. 169.

¹⁷⁸ For physical wound treatment and management see for instance the work of Claire E. J. Herrick. 'Of War and Wounds, and Jeffery Reznick. 'Rest, Recovery, and Rehabilitation. For studies relating to the physically disabled of war see Donnelly, J.K. *Treatment and Care of Disabled Soldiers in Two World Wars*; Deborah Cohen. *The War Come Home*, and Ian R.

the women who fell sick whilst serving alongside the Allied Forces. This section will address the question as to what network of treatment centres was available for sick nurses. It will subsequently focus on the methods of treatment and of the ways in which sick nurses were managed and cared for by medical authorities.

As mentioned above, several studies exist which detail the treatment and care that was set up for physically wounded soldiers. However, in terms of the care and treatment of the psychologically wounded soldier, historian Peter Leese, offers the most comprehensive study to date, and has argued that an outline of the treatment networks for soldiers 'provides a framework within which to analyse how doctors tried to understand and cure shell shock'.¹⁷⁹ In the absence of a clearly defined network of treatment centres for nurses it seems prudent to look at the framework as highlighted by Leese in an attempt to make some comparisons.

The system set up by the Royal Army Medical Corps (RAMC) was that initial treatment for the wounded was at a Regimental Aid Post (RAP) in attendance by a Regimental Medical Officer (RMO). These posts were situated very close to the fighting. From there the wounded would be carried some five hundred to two thousand yards to an Advanced Dressing Station (ADS) where they would then be transported to Casualty Clearing Stations (CCS) and then

Whitehead, 'Medical Officers and the Army during the First World War.' (Unpublished Ph.D., Leeds, 1993)

¹⁷⁹ Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War.* p. 69.

on to Stationary or Base Hospitals and evacuation to the UK if necessary.¹⁸⁰ By the end of the first year of the war there were hospitals at Le Havre, Etretat, Rouen, Boulogne, Wimereaux, Versailles, Le Treport, Dieppe, and Abbeville.¹⁸¹

In terms of treatment for psychological casualties, in the first few months of the war, male psychological casualties were evacuated back to the UK and delivered to hospitals on a makeshift basis to wherever there were free beds. These were usually in asylums or general hospitals. As the numbers of psychological casualties increased it became clear there was need to establish a specialist treatment centre. As a consequence, in 1914, 'D' Block Netley was converted in to a 'reception and clearing centre'.¹⁸² By the end of the year Moss Side State Institute was acquired by the War Office, and then, in 1915 the National Hospital for Paralysed and Epileptic at Queen's Square, London was opened. 1915 saw further centres established with the 4th London Territorial General Hospital, the Middlesex County Asylum was taken over and renamed Springfield War Hospital. In 1916 several asylums were taken over and converted in to specialist centres for the treatment of war neuroses. In France, the main centres were at Havre, Boulogne, Rouen and Etaples. The majority of these centres were for the ranks, while officers tended to have their own separate treatment centres, including the Special Hospital at Palace Green in London and later Craiglockhart near Edinburgh.¹⁸³

¹⁸⁰ Nick Bosanquet. 'Health Systems in Khaki: Chapter 33 of Hugh Cecil and Peter H Liddle (Eds) *Facing Armageddon. The First World War Experienced*. p. 455.

¹⁸¹ Elizabeth Haldane. *The British Nurse*. p. 191.

¹⁸² Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War*. p. 69.

¹⁸³ *Ibid.*

The intimation of anything similar being set up for nurses is, at best, dubious. Since the number of nursing staff in France, during 1915 alone, as mentioned in chapter two, had increased from 1,000 to 2,869, and which included 709 VAD members,¹⁸⁴ the need for some provision, should any of them fall ill, became a consideration, as early as 1914, but only, it would appear, at the behest of a charitable few.

Amongst all the preparations for the care of the wounded and sick in the war there is no special provision for invalided nurses. [...] We recognise the vital importance of ensuring for nurses who 'fall out by the way' every obtainable attention and comfort.¹⁸⁵

For example, the Duke of Portland and Lord Plymouth had recently opened a hostel for nurses at number 1 Tavistock Place. It was to have been called the Red Cross and St. John Hostel for Nurses, but Queen Mary expressed a wish that it should bear her name.¹⁸⁶ 'Queen Mary's Hostel' as it was subsequently known, purported to be

Unlike any other hostel, for it will serve as a clearing house for nurses going to and from the front or to hospitals in different parts of the country.¹⁸⁷

While not a convalescent home it nevertheless demonstrates that any provision for nurses, in terms of rest, was only provided through charitable and philanthropic sources.

¹⁸⁴ Elizabeth Haldane. *The British Nurse*. p. 191.

¹⁸⁵ *The Nursing Mirror*. Vol XIX, No. 494. (September 12th 1914). p. 439.

¹⁸⁶ 'Queen Mary's Hostel. A House of Welcome for War Nurses'. *The Times* (July 17th 1915).

¹⁸⁷ *Ibid.*

The trend for provision to be left to benevolent individuals continued in to 1916. Private institutions were set up in England, which essentially offered rest and holiday facilities. For instance

Lady Desborough's house at Taplow, and Mr Moseley's at Hadley Wood, are examples of the hospitality, which is constantly available for nurses from overseas. In France the Duchess of Argyll's villa at Hardelot is used as a rest house for nurses from the hospitals of France, and Mrs George Warre's villa at Mentone serves a similar purpose. The nurses in Egypt are well supplied with rest houses and clubs, partly supported by British funds and partly provided by local British hospitality.¹⁸⁸

Although two years into the war, such facilities continued to recognise the need for rest and recuperation for nurses and were, arguably, a move forward from the 'hostel' type accommodation a year earlier.

Ostensibly, the founding of a 'treatment network' for nurses was, by and large, considered less of a priority for nurses than for soldiers, considering the disparity of numbers, but the establishment of centres and convalescent homes designated to the treatment and care of sick nurses was left, ultimately, to the nurses themselves, particularly high-ranking nurses. For instance, S E Oram, Late Matron In Chief to the Egyptian Expeditionary Forces, (EEF) wrote

Adequate arrangements had also to be made for the nursing of sick nurses. In Alexandria a small hospital attached to a school was secured and in Cairo the Matron of the Citadel Hospital made arrangements. Later on a Convalescent Home was opened at El Arian in addition to one at Alexandria. (The need evident because) [...] Twenty-two nurses died from sickness or accident and eight were drowned within sight of land.¹⁸⁹

¹⁸⁸ 'The Care of War Nurses. Rest and Holiday Homes.' *The Times*. (March 28th 1916).

¹⁸⁹ British Red Cross Society. Women at Work Collection. 'Account of Nursing in Egypt and Palestine. 1915 - 1919'. Document reference: BRCS 25.1/9.

Conversely, but keen to be seen to be offering its support for the provisions made for the welfare of sick nurses, *The Times* of March 1916, reported a more positive view on the facilities available, claiming

The secret of the small percentage of nurses who breakdown from the strain of war work is the great care taken of them and the excellent opportunities they have for rest when off duty... Sick wards for nurses are provided at the headquarters at Boulogne, but the more serious cases - usually mental breakdowns, nervous cases, and chest troubles - are sent back to England.¹⁹⁰

This somewhat sanguine view of the provision for nurses, or rather, the limited need for it, intimates at the conservative perspective of this newspaper. Firstly, it is questionable as to whether, even in 1916, there was a 'small percentage' of nurses breaking down from their war work. Evidence from this thesis would suggest otherwise. Additionally, the idea of sending sick nurses back to England to recuperate suggests they were dispensable when in fact, evidence in this chapter alone suggests this not to be the case, as many who tried to take to their quarters for rest when they were ill were often required to 'get out of bed' as they were the only nurses on duty.

The provision and facilities for nurses who fell sick were, at best, an ad hoc arrangement. The first place for a sick nurse to retire to, if possible, was her own sleeping quarters. For instance, nurse Winifred Kenyon was instructed to 'stay in bed the next day',¹⁹¹ following her illness, whilst Alice Welsh, even after a bout of influenza, had to 'keep *getting up* as she was the only nurse on

¹⁹⁰ *The Times*. (28th March 1916) p. 10.

¹⁹¹ Diary of Nurse Winifred Kenyon. Imperial War Museum Department of Documents.

duty'.¹⁹² In this respect this thesis concurs with the view put forward by Peter Leese, who states, 'The British experience of medical treatment, is that much was 'improvised'.¹⁹³ This is further confirmed by the arrangements made for Nurse Joanna Anderson who was admitted to No. 14 General Hospital in France on 18th May 1918 following her history, which included, 'becoming unusually distraught in manner, depressed and refused to go on duty'.¹⁹⁴ She was eventually diagnosed with 'Confusional Insanity' and sent home where she was required to be nursed constantly by two nurses, and similarly for Nurse Lilian Atkins, who served in Germany as acting sister with No. 47 General Hospital, Army of the Rhine. She was also sent home after a diagnosis of Hysterical Neurasthenia, but her mother who was aged over seventy years was left responsible for her care.¹⁹⁵

It is unlikely, however, that any provision for nurses would have been set up on the same scale as it was for soldiers, but there is some indication of a limited set of facilities for nurses. If their own sleeping quarters were not suitable for recuperation and it became necessary to seek medical advice, doctors, who could be spared, would visit. If their condition required treatment and the subsequent removal to hospital then it was likely they would be sent to one of a few 'convalescent homes' for nurses, or, one of the existing hospitals that was part of the same network for soldiers that were located in France or Flanders, or in locations corresponding to the area of fighting. For instance,

¹⁹² NA PIN 26/20274. Alice Welsh. (My emphasis)

¹⁹³ Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War.* p. 73.

¹⁹⁴ NA PIN 26/19989 Joanna Anderson.

¹⁹⁵ NA PIN 26/19994. Lilian Atkins.

following a bout of malaria in September 1918, Nurse Mary Jane Lally was first admitted to No. 43 General Hospital, in Salonika, for fourteen days, and after a bout of influenza was admitted to the No. 57 (Western) General Hospital in December 1919 suffering from 'Debility'. She was subsequently discharged to England two days later, where on arrival in England she was admitted to Netley Hospital.¹⁹⁶ Nurse Lally's treatment would suggest that there was some provision in each of the hospitals that were set up in the network that was initially for soldiers, at least in the form of small wards or annexes to the male wards. Furthermore, she was finally admitted to Netley, which was the large hospital on Southampton water.

There is evidence of dedicated hospitals that were set up abroad for the care of nurses and these were generally known as Sick Sister's Hospitals. Two such centres were the Sick Sister's Hospital at Villitano in Le Touquet and the Sick Sister's Hospital attached to No. 8 General Hospital at Rouen. If it was deemed necessary to evacuate a nurse back to England then it was to St Vincent's Square Hospital in London. Nurse Collins, cited earlier in chapter two, was sent to St Vincent's Square Hospital from a hospital at Wimereux after suffering from a 'nervous breakdown' following the bombing of an ambulance train she was serving on.¹⁹⁷ Similarly, Nurse Henrietta Frances Curtis was first admitted to Kimnel Park Military Hospital for appendicitis, then to Queen

¹⁹⁶ NA PIN 26/20143 Mary Jane Lally.

¹⁹⁷ NA PIN 26/20038. A Collins.

Alexandra's Military Hospital, Millbank in London, before also being transferred to St Vincent's Square in 1917.¹⁹⁸

As far as practical arrangements for sick nurses, whether for physical or psychological illnesses, it can be concluded that the provision was largely unplanned and improvised and not on the same scale as that provided for soldiers. The system for sick nurses, at least in the early days of the war, appeared to exist because the nurses themselves took care to provide it or it was the result of the benevolence of charitable individuals. Later, in response to need, a more clearly defined system began to emerge, and case notes refer to nurses being sent to existing hospitals that were part of the network set up for soldiers, with separate wards or annexes being hastily converted for nurses. Later there is reference to 'Sick Sister's Hospitals', suggesting the need became greater, or more specialised. However, treatment centres, or hospitals, that were set up for nurses were clearly, and to some extent, logically, not on the same scale of those that were set up for soldiers given the disparity of numbers.

Finally, further evidence that little was created in the First World War for the care of sick nurses comes from a letter to *The Times* from 1942. Following a visit to a military hospital, E. Anning Forster highlighted an element of surprise at finding a ward

Full of girls from the forces and nurses, all suffering from nervous war strain in varying forms. I wondered what faced the girls who are going to be utterly disabled. I was told one Queen

¹⁹⁸ NA PIN 26/20048. Henrietta Frances Curtis.

Alexandra nurse ...was already an inmate of a council institution. She has no parents and no money. I suggest that a hospital in beautiful surroundings, on the line of the Star and Garter, be immediately established by the Government where girls broken by their war experiences can live in peace and security.¹⁹⁹

Expressing concern for the lack of any established hospital for nurses during the Second World War suggests that no foundations could be built upon from the 1914-1918 conflict, i.e., no lessons were learnt. Similarly, it equally confirms the plight of nurses who served in both of these wars of whom many suffered from psychological breakdown as a result of their war experiences.

Medical Care, Doctors and the Management of Nurses.

It is important to consider the philosophy and approach taken by the attending doctor(s) in the treatment of war neuroses for this tended to vary and depended primarily on the type of disorder, the period of the war in which it was treated and, arguably, the personality and theoretical leanings of the doctor. These factors are also important when considering how nurses were cared for and treated.

In 1914 the RAMC needed to increase its number of medical officers and recruited from the civilian medical profession but with one major amendment to the doctor's ethical code; that the needs of the State took precedence over the needs of the individual. The 'function of the Army doctor, to maintain the mental and physical well being of the men, so that they might be

¹⁹⁹ 'Nurses and War Strain'. Letter to the editor of the *Times*. January 14th, 1942.

fit to face death or injury,²⁰⁰ was bound to give rise to a moral dilemma. The 'vast majority of doctors treating psychological casualties were non-specialist RAMC medics or civilians in uniform',²⁰¹ and their objective was

To dampen the perceived threat to morale and to treat the patient just enough to return him to duty.²⁰²

Adapting to the requirements and vagaries of military medicine meant many civilian doctors were largely unprepared, and the fact was that 'both the Regulars and their civilian colleagues had much to learn.'²⁰³ Shell shock and the war neuroses posed further problems for Medical Officers, as understanding about the psychological impact of war was very limited, at least in the early years of the war. A three-month training programme was set up at Maghull Hospital in Merseyside, which 'turned out sixty-five Medical Officers, versed in modern psychiatric principles, but not until the last two years of the war. The remainder of the Army's psychiatric service was recruited from neurological hospitals, mental hospitals and from a group of insufficiently trained volunteers.'²⁰⁴

Historian Ian Whitehead has claimed that this inexperience meant many lacked the confidence to make firm diagnoses when it came to mental collapse, preferring not to attach the stigma of 'mental' to the individual.²⁰⁵ In general there was a use of blanket phrases on the part of these inexperienced doctors,

²⁰⁰ Ian Whitehead. 'The British Medical Officer on the Western Front'. p. 166.

²⁰¹ Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War*. p. 73.

²⁰² *Ibid.*

²⁰³ *Ibid.* p. 165.

²⁰⁴ *Ibid.* p. 173.

²⁰⁵ Ian Whitehead. 'The British Medical Officer on the Western Front'. p. 173. Cited earlier in this chapter, page 100, and contextual objections raised accordingly.

who demonstrated a degree of vacillation such as 'Not Yet Diagnosed - Nervous' (NYD-N) and 'Shell shock - Wound' in the description of symptoms. It was, therefore, not unusual for diagnoses to change in the course of long-term treatment. Leese maintains that

Doctors were occasionally reluctant to treat cases that they saw as entirely psychological, although they showed every concern for those who had been buried or suffered trauma as a result of gas attacks. There are many cases attributed to pre-war origin, which reflects Army recruitment policy as well as the empirical training and predilection of the British medical profession. The overwhelming impression is that doctors were barely able to cope with the various mental cases that they encountered. Often they responded intelligently and with some concern for the fate of the men placed in their care.²⁰⁶

For Leese, the claim is that in order to understand how doctors approached their shell shock patients it is necessary to re-examine the most widely used model of shell shock treatment, that which makes a sharp distinction between disciplinary and psycho-analytic methods,²⁰⁷ the former being the preferred method for ranks and the latter for officers. This section will also examine these methods of treatment in order to challenge the idea that these were not the only or dominant treatment methods and also to assess how nurses were treated and cared for. The purpose for this line of questioning is because nurses were given 'officer' status and so the assumption would be that they were treated as such.

Ideas regarding treatment for war neurosis in the First World War have been held to be based on class and therefore different for officers and for the

²⁰⁶ Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War*. p.97.

²⁰⁷ *Ibid.*

ranks. For instance, treatment for officers was that of rest and predominantly psychoanalysis, or the 'talking cure'. For the ranks it was essentially disciplinary and even 'punitive'. Historians Eric Leed and Elaine Showalter have both expounded and elaborated on these two methods of treatment. Leed has spoken of the 'quick cure' or 'Queen's Square' method which was reputed to consist largely of high-pressure 'persuasion' techniques where faradisation, or electrical treatment was applied, of whom the leading contemporary exponent of this disciplinary form of treatment was Dr. Lewis Yealland.²⁰⁸ Yet both Leed and Showalter can be criticised for their focus on these methods as they were based on uncorroborated research. Additionally their views have been seized upon by fictional writers, including Pat Barker, who in her 'Regeneration' trilogy instils in the popular mind that these were the *only* two forms of treatment, and that the 'Queen's Square' method was the preferred form of treatment for the lower ranks. Showalter claims treatment was 'essentially coercive' since it needed to restore the masculine identity that had been shattered at the front. For Showalter, treatment methods were 'disciplinary',²⁰⁹ and her assumptions have been based almost entirely on the 'Queen's Square' method where its pioneers, E.D. Adrian and L. R. Yealland, worked, and their treatment was characterised by 'electric shock' or faradisation. Whereas both she and Leed have suggested this was nothing less than torture.²¹⁰

Historian, Laurinda Stryker has re-examined Adrian and Yealland's methods and has placed them in context, claiming faradisation was essentially

²⁰⁸ Lewis Yealland. *Hysterical Disorders of Warfare*. (London: Macmillan, 1918)

²⁰⁹ Elaine Showalter. *The Female Malady*. p. 191 and 178.

²¹⁰ Eric Leed. *No Man's Land*. p. 165.

'suggestion' rather than 'persuasion' or punishment, adding that further analysis reveals that such practices were never widespread.²¹¹ For example, Adrian and Yealland themselves declared it to be, 'a little plain speaking accompanied by a strong faradic current' where soldiers were informed the treatment would cure them and correct their ideas of negativity about their disease.²¹² As such it was 'designed to overcome the resigned acceptance of symptoms by forcing the patient to recognise that his disability was functional, that he could move an affected limb or, under sufficient provocation, was able to speak.'²¹³ Stryker adds that essentially their practices were in the best interests of the patient, and

Shell shock theorists did not feel any compunction to correct soldier's values through their methods of treatment, rather their duty, as they saw it, was to remove the obstacles to fulfilment of duty, which took the form of psychological blocks, variously defined. Treatment did not teach them to do what was right; it only enabled them to once more to do what they already knew to be right.²¹⁴

Additionally, Leese claims the actual case notes from Queen's Square suggest only a third of cases were treated with some form of 'non-punitive faradisation technique'²¹⁵ and only then as a last resort. More generally

Queen Square employed skilled specialists whose methods were empirical and pragmatic, and that a variety of resourceful techniques were tried in the treatment of war-related cases. [...] Standard methods included a milk diet, bromide and massage, which together with rest was a sufficient cure for some patients.²¹⁶

²¹¹ Laurinda Stryker. *Mental Cases* p.162.

²¹² Adrian, E. D., and Yealland, L. 'The Treatment of some Common War Neuroses'. *The Lancet*. Vol. 1. (1917) p. 868.

²¹³ Laurinda Stryker, *Mental Cases* p. 162.

²¹⁴ *Ibid.* p. 163.

²¹⁵ *Ibid.* p. 76.

²¹⁶ *Ibid.* p. 80.

As far as officers were concerned the preferred method of treatment apparently took the form of the 'rest cure', where they were reputedly offered rest and rehabilitation, interspersed by sessions of psycho-analysis. At Maghull, run by R.G. Rows, another form of treatment was being tried. Analytical therapy was formulated from the work of a group of specialist and academic doctors known as the 'Integrated School of Psychology', which included W.H.R. Rivers, William Brown, C.S. Myers and William McDougal. Rivers summed up the view of this group of doctors.

The source of these mental disorders was not the emotional battlefield of childhood sexuality (the theory initially laid down by Freud) but the physical battlefield of the Western Front. The repression of fear and the desire for self-preservation were sufficient explanation for 'almost every case'.²¹⁷

However, the doctors trained at Maghull were few in number and all the evidence points to either hostility or indifference towards this method of treatment.²¹⁸

It appears, however, that despite being classed as 'officer' status, the attitude to the treatment of nurses was based on the same empirical and pragmatic approach as was afforded the ranks. This is not to suggest that nurses were treated with any less accord, but does, in fact, challenge the notion that treatment was primarily based on class. The cases of nurses examined in the course of research for this thesis suggest they were treated according to need, to the severity of the illness and with the best care and resources

²¹⁷ Rivers. Cited by Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War*. p. 83.

²¹⁸ Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War*. p. 83. For views of this treatment approach see Martin Stone. 'ShellShock and the Psychologists' pp. 242 - 271, and also Harold Merskey. 'Shell Shock' pp. 245 - 267.

available, as was the case for soldiers, as argued by Leese. This could be said to be true in the case of Helena Hartigan, a Sister with the QAIMNS was diagnosed with 'Polyarticular Arthritis'. 'Before admission to hospital and while still performing her duties (she) had extended treatments for the pains in the affected joints...'²¹⁹ She underwent various forms of treatment including those described as 'Medicinal, Thermal, Electrical and Orthopaedic'.²²⁰

Treatment afforded nurses appeared to be comprehensive. Great care was taken to record test results, and every doctor conducted what appeared to be a thorough examination according to medical records contained in the case notes. For example, the patient's account of their illness was recorded first. I.e., patient complains of... followed by a physical examination, which included record of heart, chest sounds, pulse, BP (Blood Pressure), neurological symptoms, e.g., knee jerks, sight (R (right), N (normal) 6/6 + 0.75 L (left) 6/6 to 0.75 = 6/6).²²¹

This method of recording has been analysed by medical historian Kathryn Montgomery Hunter. She claims 'medicine is fundamentally narrative'.²²² The patient's account of their illness is 'far from being the only narrative' and the 'physician's own discourse' adds to the overall account thus making it a 'story'.²²³ Accordingly, when a patient presents with a malady, 'in the brief moment between the patient's telling the story and the physician's making

²¹⁹ NA PIN 26/20098 Helena Hartigan.

²²⁰ *Ibid.*

²²¹ NA PIN 26/20096 Hilda Eleanor Harris.

²²² Kathryn Montgomery Hunter. *Doctor's Stories*. p. 5.

²²³ *Ibid.*

a hypothetical diagnosis, the physician locates its chronological ordering of the details of illness in a narrative taxonomy of similar cases.²²⁴ Generally

The account of illness that the physician is putting together is not the patient's story, although it depends upon and in part reconstructs it. Instead, it is the beginning of the medical story, a narrative that will be tested against the physical findings and amplified and refined by the physician's physical examination and the results of tests. It will be recorded in the patient's chart... the physician's main concern is to translate the subjective experience of illness into the recognisable discourse of medicine and to record its details, code like, in the patient's medical record.²²⁵

The cases of nurses examined for this thesis suggest they too were subjected to a thorough physical examination in the course of exploring their condition, regardless of whether their presentation intimated at physical or psychological origin. Nurse Eleanor Maude Bellringer, a Sister at the Ashurst War Hospital in Littlemore, Oxford, stated she had 'had a nervous breakdown and had to take to bed'.²²⁶ On complaining of 'pains in the knees and hips', her examination reads

Pulse 92. Heart and lungs - normal. No tremors. KJ (Knee Jerks) slightly increased. Pupils normal. Some tendency to exophthalmus. No Romberg. No ankle clonus. Movements of knees full and free. No swelling but distinct creaking. Only night sister through winter of 1919 and day sister afterwards.²²⁷

²²⁴ *Ibid.*

²²⁵ *Ibid.* p. 53.

²²⁶ NA PIN 26/20007. Eleanor Maude Bellringer.

²²⁷ *Ibid.*

Examinations of this type were common. Amy Byng was examined following complaints of 'Frontal headaches - frequent and severe'²²⁸ Her records state,

Physique and Nutrition fair. Tremulous facial muscles. Tongue pale and slightly furred. Teeth - many deficient. Hands - minimal tremor. No inco-ordination. No Romberg. No nystagmus. Sensation normal. Pupils - N. K.J. brisk and apprehensive. P. 84. H.S.N. A.B.N. Lungs- slight old pleuritic rub left base. Mentality - egocentric and emotional - apprehensive. Unable to work until now.

Disability:- Neurasthenia - aggravated by Military Service - Nursing overstrain and delayed diagnosis of organic disease.²²⁹

Nurse Donovan presented complaining with 'neuralgia - worse in changeable weather and when worried. Insomnia, nightmares.'²³⁰ Her examination records

GC (General Condition) - fair. Tongue clean and moist - double denture. H - NAD (Heart - No Abnormality Detected) No hernia. No varix or flat feet. Rapid P. (Pulse) 100. Lungs clear. Thyroid enlarged - equal both sides, soft (sic) moves easily with swallowing. Slight proptosis of eyes. No von graefe.²³¹ CNS (Central Nervous System) K.Jerks - brisk. Pupils and all other reflexes nil abnormal. No signs of organ's lesion. Has some pain and tenderness R. Sciatic nerve. Mentally - anxious and apprehensive. Very emotional - depressed. Case of Neurasthenia - of emotional type, moderate severe.²³²

²²⁸ NA PIN 26/20023 Amy Byng. (Romberg - a finding on examination suggesting either a sensory disorder affecting those nerves that transmit information to the brain about the position of the limbs and joints and the tension in the muscles or a failure of the brain. [M. Romberg 1795 - 1873,] German Neurologist). (Nystagmus - rapid involuntary movement of the eyes that may be from side to side, up or down, or rotatory.)

²²⁹ *Ibid.*

²³⁰ NA PIN 26/20053. L. Donovan.

²³¹ *Ibid.* (proptosis - forward displacement of an organ, especially the eye)

²³² *Ibid.*

For Sister M.J. Carter, who claims to have contracted Cerebro-Spinal Meningitis when nursing in a VAD hospital in 1919, her examinations were extensive. Invalided on account of 'Hemiplegia - attributable 100%' ²³³ her records detail,

Paralysis of right side. No hand grip - Pupils equal and react to light. R. K. J. diminished. Has severe spinal pain and occipital headaches. 38 Organic Nervous Disease (post cerebro-spinal) Can now walk ¼ mile with assistance. Cranial nerves normal - except paresis L. ext. Rectus.

R. arm slight movement at shoulder only. Jerks all +. Wasting of forearm and hand muscles.

L. Leg. Movements hip and knee practically normal.

Ankle inversion only. Slight toe movements.

K.J. present L. more than R.

Optic Discs normal. 100%. ²³⁴

Such examinations indicate a degree of care and attention on the part of the medical officers conducting the examinations and also confirm Leese's view that treatment was empirical and pragmatic.

In addition, Leese has stated that class and status did have *some* influence on treatment, but this is more evident in the 'care' taken. From the medical notes he has ascertained that doctors appeared to have

More time and specialist knowledge to give to each individual case; second, communication between hospitals, especially in continuous cases notes, was much more efficient; and third, treatment was better by virtue of rank and status. Even case notes differed according to seniority of rank. In non-officer patients the quality of case sheets ranged from a scribbled record on name and rank or scanty notes of symptoms and date

²³³ NA PIN 26/20026. M. J. Carter.

²³⁴ *Ibid.*

of discharge, to extensive battlefield histories and character eye-witness reports.²³⁵

For Leese, the class influence means treatment for officers was altogether more sophisticated and this can be also be seen in the case of nurses. With their 'officer' status it would appear they were afforded the same devotion in terms of care and attention from doctors. The nurses' medical notes depict a high degree of detail, from the first point of contact through to discharge. Each set of case notes are constructed to show the events leading up to the first presentation of the illness. Nurses' medical histories were given the same care and attention and 'weight in the identification and appraisal of symptoms by shell shock doctors, particularly the extent and severity of exposure to active warfare, and the stage of illness at which the patient was diagnosed, treated and returned to service.'²³⁶

The nurses' cases similarly include such attention to detail, uniformity of recording, and with evidence of continuity between hospitals and evidence of this can be seen in the two cases of Nurse Hunter and Nurse Hollow. [See following pages.] Nurse Hunter's medical case notes, are lengthy, follow a specific format, showing a degree of care and attention to detail, whilst being hand-written. Nurse Hollow's are considerably long documents and the care and attention to recording is evident in the careful typewritten account of her condition, which includes laboratory reports.

²³⁵ Peter Leese. *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War.* p.113.

²³⁶ *Ibid.* p.113.

BEST COPY

AVAILABLE

Poor text in the original
thesis.

Some text bound close to
the spine.

Some images distorted

NA PIN 26120120 J HUNTER

CONFIDENTIAL.		OFFICER'S RECORD CARD.		M. P. X 13	
REGION YORKS		SERIAL NUMBER 0/131			
NAME HUNTER J		Rank Staff horse	Unit G.A.M. NSIR	Year of Birth 1886	
Total Service in Years & Months 1 1/2 yrs.	Total Service in War with Germany and her Allies 1 1/2 yrs.	Theatres of War in which the Officer served in War with Germany and her Allies. England.		Date of Discharge Nov 16 1917	
Invaliding Disability		Date of Origin 14/11/17	Cause of Disability Strain of horsing	Degree of Disablement 100%	
Other Disabilities. Melancholia with Delusions					
<p align="center">MEDICAL REPORTS.</p> <p align="center">Surgical Appliances supplied and Dates of operations especially important.</p> <p>Woundwell SM SP. 14/2/18</p> <p>Began with pains in Back Feb 1917 carried on duty till Oct 1917. Then found to have Scural curvature with necrosis of 5th & 6th L.V. & an abscess. Second X Ray plate in Feb 1918 shows abscess increased in size & disease of bones well marked. More pain fluctuation near R Scapular. unfitted for duty</p>					
Date of Board..		<p align="center">AWARD</p> <p align="center">100</p>			

Subsequent Examination Place and Date	MEDICAL REPORTS. To include Treatment received, Progress, Present State, and Degree of Disabament	AWARD.
Colchester 25.3.19.	In Maryland. Sent since 4/6/18. Much improved not able to sit up in bed. Local pain tenderness much diminished as also spinal curvature. She has no pulmonary or cardiac symptoms & remains for further treatment 100%.	
London York	Visited in her own home. Now no sign of cancer except slight curvature over 5 th & 6 th D.V. No curvature and pain now suffering from Delusional insanity which commenced while at Sanatorium N.S. & P.R. Normal no Romberg no hypoglossus H.S.N. Bowels & menses normal spoke of suicide when first at home but has not done so recently. Sleep well. Delusion in regard to having committed some sin or crime brought ruin on self & family. 100%.	\$ 100 to 24/70
London Don Vis 22.12.20.	(Said) 402 Cooper 100% 100% Status slightly improved since last visit. Tachycardia nervousness. Lungs in bed. Headaches felt if something is going to happen as if she had done something wrong. No sleeplessness occasional dreams which awake her with a start. Except for some tenderness over	\$ 100 to 2.5/70
	(31035) Wt. 15443/2719. 50m. 8/19. G. P. & S. (55680) Wt. 50670/3419. 50m. 12/19. G. P. & S.	

Continuation Place and Date	MEDICAL REPORTS.	M. P. X & A. AWARD.
London Don Vis 22.12.20.	HUNTER. J. F. Nurse 1/21. 5 th & 6 th D.V. Medically there is now no apparent evidence of spinal cause. Gro. Exam. extremely pale anaemic. Has anxious depression. Answer questions rationally memory fairly good. No interest in any amusement. Fear of being in company although when amongst her friends feels better. Fine tremor eyelids face. Hands tongue K.T. normal. No Romberg not able to walk far gets tired. Attacks of extreme depression accompanied with intense headaches during attacks which last a day. Has trembling attacks 198. Menstrual period - regular somewhat excessive and get irritable at these periods. Mother states at times very irritable. Worries considerably about being unable to work. Heart & lungs normal. She is not fit to be left alone. Has improved since last visit and should continue to do improve. Treated by own Doctor Dr. Thompson of Col.	
	100%.	to W. J. Jones D.C. N.S. Maudslayi Area

NA PIN 26120120 J HUNTER

Continuation	Place and Date	MEDICAL REPORTS.	AWARD.
Edson 8/2/21. 3093/21.		<p>Hamble Sept. 9. X-rayed (x-ray photographs & report enclosed) minute condition improving. Pain & tenderness in back. Application made for spinal jacket. Patient's condition improving markedly. Increased amount of food & tenderness over dorsal vert. sensible to gentle pressure present of pain in back.</p>	
plus 7/4/21		<p>Condition on progress. Status improved since last found but so nervous. Still easily frightened able to move with her friends. Did not use the garden. Not able to walk any distance. Menstrual periods scanty. Much weaker than from other sleep better. Resound soon attacks "headache. Pain "breathing attacks". Pale & anemic nervous, irritable. Nervous food condition good. Fine humor of back pain cyclic & irregular. Depressed Still very phlegmatic. In the morning. Pain 100. H.M. Spectral 5 inches. Depressed. Appari & Appari - Pain & pressure on spine near 5th dorsal vertebra</p>	

H. Gen./1100
 M. S. 5.

Constipation.
 Place and Date
 24/12/21
 (cont)

Doctor
 Name HUNTER J. Serial No. 9131
 Patient a third cancer free on
 2nd op. X Ray report dated
 8/2/1921. - There is definite evidence of
 disease which is I think pretty well
 healed but in an active condition - -
 - The bones other than the ones on
 the hand much more opaque in the
 report.
 1. 100% 2. 30% the 100%
 C. W. Lane
 Dr. Hunter

Down.
 Slow
 1.12.21.

(A) Consciousness, feeling as if
 something was going to happen. She
 states that the nervous condition has
 somewhat improved. Prior to going to
 bed felt much better in this respect.
 (B) Still has occasional delusions
 & in continual state of mental worry.
 She says she has done some wrong to
 herself, thus, she is now able to mix
 with people without the feeling of dread
 that she had. P. 90. One tomorrow, and
 face, eyelids, H.N. Appear heat 5. Space
 internal changes normal. She looks
 depressed, anxious
 The C.A. to pain & tenderness in back.

MEDICAL REPORTS.

Continuation
Place and
Date

Name HUNTER, J. Nurse Serial No. 101
 Ale-kind-anaesthesia on left side up to level of the 10th
 dorsal segment. Sensation. Paresthesia absent left leg.
 Paries both legs most marked left knee jerks present
 both sides. Ankle jerks diminished. There is no
 evidence of spinal abscess in abdomen. On examining
 the back there is a well marked angular deformity
 involving apparently the 6th to the 9th dorsal vertebrae,
 with marked tenderness over the upper dorsal and
 cervical spines. We have made an X-ray examination
 of the area. Although there is no absolute paralysis
 there are marked signs of root symptoms and cord
 compression. We are of opinion that this is a case of
 Tubercular Osteitis of some of the Dorsal Vertebrae. We
 consider the disease to be still active and therefore
 not favorable. The only treatment to be recommended
 is rest in bed absolute and total under sanatorium
 conditions with a plaster brace.

(Signed) Dr. H. E. Patterson Physician Surgeon
 (Signed) Dr. W. E. Patterson Physician Surgeon
 Have it concluded to 4 weeks period 19.4.23 to 13.6.23
 (Signed) W. E. Patterson D.C.H.S. (Treatment)
 Have it discontinued for 8 weeks period 14.6.23 to 9.9.23
 (Signed) W. E. Patterson D.C.H.S. (Treatment)

Compared to bed requires post
 catheter 19. 1.23.
 (Signed) Dr. H. E. Patterson

MEDICAL REPORTS.

Continuation
Place and
Date

Left leg:- No loss of voluntary power. No
 wasting of muscles. K.T.S normal. No
 of this leg she states causes severe pain in
 back.
 Right leg. Voluntary power normal. K.T.S normal.
 Arms. All movements normal. Grip with
 left hand apparently slightly reduced.
 Spine. Lies in bed on her back and can only
 roll over with help. There is marked tenderness
 over spine between the 2nd & 9th Dorsal
 Vertebrae - marked prominence of 6th Dorsal
 spine. The tenderness is not nearly so marked
 when attention is distracted and there is
 only rigidity of spine at 5th & 6th Dorsal Vertebrae
 The case is a most difficult one to diagnose
 correctly. In my opinion there is Spinal
 Caries of 6th Dorsal Vertebrae. I am unable
 to state whether this condition is most
 very active or not. I do not consider the
 Anesthesia to be due to involvement of
 Spinal Cord, but in my opinion is functional.
 Sister Hunter in my opinion should be
 admitted to hospital for X-ray examination of
 spine and for treatment. She is unable to
 be moved except by ambulance.
 (Signed) J. S. Buchanan.

NA PIN 26120110 HOLLOW

T/HMJ:

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MEDICAL CASE SHEET.

No. in Admission and Discharge Book.	Regimental No.	Rank.	Surname.	Christian Name.
		S.N.	HOLLOW	Miss M.E.
	Unit.		Age.	Service.
	2162.	Q.A.Reserve.	28	26/12.
Year.				
1918.				
Station and Date.	Disease Malaria & Dysentery.			
Wharncliffe War Hospital, Sheffield. Vincent Sq:	DECEASED			
Jan. 8th.	The patient joined the service Nov. 1st 1915 and served at			
	Fargo Military Hospital, Salisbury till May 3rd 1916 went to			
	Basra, Mesopotamia and came off duty sick there Sept. 6th 1916			
	at 3rd British General Hospital, Basra suffering from a gastric			
	ulcer, was then transferred to St. Georges Hospital, Bombay			
	where she afterwards suffered with Malaria with rigors, was			
	sent to Poona in October 1916 was boarded there Nov. 10th 16.			
	and recommended 6 mths. leave out of India to date from day of			
	sailing, Nov. 29th arrived at this Hospital Dec. 22nd 1916,			
	having one attack of Malaria on transit.			
	She was boarded at this Hospital Jan. 5th 1917 and given 6 wks			
	sick leave.			
	The patient went for duty at Wharncliffe War Hospital, Sheffield			
	on Feb. 22nd last and had one attack of Malaria there in April			
	last then had three weeks leave.			
	She says she has had intermittent Pyrexia but kept on duty			
	whilst at Sheffield, she had had no illness till she went to			
	Mesopotamia.			
	She last came off duty sick Nov. 18th suffering from rheumatism			
	in head, back and joints and says her temperature ranged between			
	99 and 101 for about a fortnight. At that time she could not			
	move and perspired profusely.			
	She got better but as soon as she exerted herself			
	up and back and headache returned.			
	Patient says she was to have gone away on Dec. 27th			
	Dec. was taken ill again, as soon as able to travel			

Station and Date.	
	treatment and Board. Blood tests were taken at Sheffield.
	On admission. Patient gives a history of frequent attacks of pyrexia since returning to duty; she states that blood examinations have been made but that no malarial parasites have been found - she has been treated with Quinine.
	She is pale and rather thin and says that at Christmas time she had acute rheumatic pain in her joints and that her right ankle is still painful.
	Spleen is enlarged but barely palpable, right ankle tender but not swollen - to be kept under observation and to have calomel gr 2 Rhi Rhu to night.
April 22nd.	Since above date patient has continued to suffer from intermittent attacks of pyrexia, clinically typically malarial in character, but in connection with which parasites have never been found. These attacks appear to coincide with her menstrual periods. Quinine in various doses (See Chart) has been given throughout and she has been thoroughly cinchonised; without bringing the attacks to an end. She has been treated at the same time with Liq. Arsenicalis - & Ferri et Quinine Cit. Her general condition is improving, she is to be brought before a Medical Board to-morrow for office purposes at the request of the D.D.M.S. Northern Command.
25th.	Return of Pyrexia headaches etc. Patient has been having gr. V. only of Quinine twice daily with Opier ^{Opier} as she had complained of diminished vision recently.
April 30th.	Rigor with return of Pyrexia, sweating etc. yesterday - Quinine increased to grs. XV daily.
May 6th.	Similar attacks - T. brown coated - has vomited on several occasions especially when taking milk - complains of gastric pain tenderness to right of epigastrium, no enlargement of liver detected.
	Condition about same - seen by Sir James Fowler who considered

T/HMJ.

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MEDICAL CASE SHEET.

No. in Admission and Discharge Book.	Regimental No.	Rank.	Surname.	Christian Name.
2162.		S.N.	HOLLOW	Miss M.E.
Year. 1918.	Unit.		Age.	Service.
	Q.A. Reserve.		28	26/12.
Station and Date.	Disease <u>Malaria & Dysentery</u>			
	the condition chiefly gastric and the condition might be discontinued.			
May 12th.	Patients condition not improved - T. very brown coated - vomits after milk - very thirsty - no rigors but gets profuse sweats - epigastric tenderness as before - a slight icteric tinge over body - all milk stopped. To have chicken broth. Brands extract and a little champagne.			
13th.	No improvement - continues to get rigor, high T. with profuse perspirations. Tongue brown coated, lips dry, and tenderness over sight - epigastrium H towards lower left hypochondrium, complains of pain in right groin where is a slightly enlarged gland, no enlargement of liver detected - whole condition suggest septic absorption from some focus not localised - no tenderness on percussing spine - but right flank appears to be somewhat resistant. States that when her appendix was removed 6 years ago, it was congested etc., but no pus. The wound had to be reopened 3 days later when a small collection of pus was found about the gall bladder.			
May 14th.	Slightly better this morning p.s. as noted but T. normal.			
15th.	Seen and examined by Sir James Fowler who agrees that the case suggests septic absorption, another film to be examined for Malaria and a leucocyte count made. Patient has been inclined to constipation throughout - motions after calomel etc. dark bilious. Urine examination throws no light on the case.			
May 15th.	Sister telephoned last night that Patient informed her that afternoon that there was swelling tenderness right vulva had not liked to mention it before.			
16th.	Fairly good night. Tongue not so brown or so coated - same			

The first and last entries will be signed, and transfers from one Medical Officer to another, attested by the

Station and Date.	
	tenderness right hypochondrium, right vulva swollen and tender one or two superficial pus specks general condition not bad. Passed very little urine last few days.
	Seen by Capt. Hughes who agrees with general view of case, and that there is no special indication to search for pus at present. Rectal examination negative. It appears that the Sister in Charge was informed of the vulva condition 2 days ago.
May 17th.	Considerable quantity about oz. of pus discharged from vulva abscess last night - T. subnormal this morning, general condition satisfactory - epigastric tenderness still present.
18th.	Is getting T. again but no rigors or marked sweats - vulva abscess reported quite dry, no discharge, complains of throat one or two glands left tonsil purulent. Ordered Tr. Ferri Perchl mins and Quin Sulph gr.v. t.d.s.
20th.	Pulse good and general condition satisfactory - T. red and dry, Pharynx congested - slept after last nights raid - motions continue loose - albumen reported present in Urine.
21st.	Examination of stool sent on above date was reported as containing Entamoeba Histolytica. Emetine treatment started and since that date steadily improved and is now convalescent and getting up - and to-day has been out for a drive.
July 4th.	Since above note has gradually improved, and is able to go out a little each day. She gets a little rise of temperature occasionally if she tries to do too much, at her own urgent request to be boarded to-morrow.
Laboratory Report.	
R.A.I.M.N.S.R. Hospital. 9.1.18.	Disease. Rheumatism.
	Please carry out an examination of the accompanying specimen of URINE with special regard to Spr. W. Albumen estimate casts
5.1.18.	Report:- S.G. - 1022.

contd.

NA PIN 26/20110 ME HOLLOW

T/HMJ.

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MEDICAL CASE SHEET.

No. in Admission and Discharge Book.	Regimental No.	Rank.	Surname.	Christian Name.
2162		S.N.	HOLLOW	Miss M.E.
Year.	Unit.		Age.	Service.
1918.	Q.A. Reserve.		28	26/12

Station and Date.	Disease
-------------------	---------

Laboratory Report contd:-

Report:-

Acid.

Albumen .025.

No sugar.

Turbid.

Amorph Urates.

DECEASED

Laboratory Report.

Vincent Square

14.1.18. Please carry out an examination of the accompanying specimen of BLOOD with special regard to Malaria & Diff: Count.

14.1.18. Report:- No malaria parasites found.

P - 61%

L - 10%

S - 23%

H - 5%

T - 1%

A.I.M.N.S.
Hosp:

Laboratory Report.

12.2.18. Disease. Malaria.

Please carry out an examination of the accompanying specimen of BLOOD with special regard to Malaria - Diff: Count.

12.2.18. Report:- P - 79%

L - 9%

S - 9%

Hy. - 3%

No malaria parasite found.

P.T.O.

Station and Date.	
Vincent Square.	Laboratory Report.
7.3.18.	Please carry out an examination of the accompanying specimen of BLOOD with special regard to Malaria Parasites & Diff:Count.
9.3.18.	Report:- No Malaria Parasite found.
	P - 65%
	S - 17%
	L - 14%
	H - 3%
	E - 1%
Q.A.I.M.S. Hospital.	Laboratory Report
4.4.18.	Disease. Malaria.
	Please carry out an examination of the accompanying specimen of BLOOD. with special regard to Malaria Parasites & Diff:Count
4.4.18.	Report:- P - 69%
	S - 22%
	L - 9%
	No Malaria Parasite found.
Q.A.I.M.N.S. Hospital.	Laboratory Report.
16.4.18.	Disease. Malaria.
	Please carry out an examination of the accompanying specimen of BLOOD. with special regard to Malaria Parasites -Diff:Count
16.4.18.	Report:- P - 69%
	S - 21%
	L - 7%
	H - 3%
	No Malaria Parasite found.
	Laboratory Report.
12.5.18.	Disease.Malaria ?
	Please carry out an examination of the accompanying specimen of URINE. with special regard to Sp. Gr.Albumen Bile etc.complete
13.5.18.	Report:- S.G. - 1010.

T/EMJ.

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MEDICAL CASE SHEET.

in Admission and Discharge Book. 2162 Year. 1918.	Regimental No.	Rank.	Surname.	Christian Name.
		S.N.	HOLLOW	Miss M.E.
	Unit.		Age.	Service.
	Q.A. Reserve	28	26/12.	
Station and Date.	Disease			
Laboratory Report contd:-				
Report:- Acid.				
Clear.				
Trace Albumen.				
No Sugar.				
Many epithelial cells.				
Vincent Sq:	Laboratory Report.			
16.5.18.	Disease. Malaria.			
16.5.18.	Report:- W.B.C. - 12,800.			
	P. - 83%			
	S. - 14%			
	L. - 3%			
Vincent Sq:	Laboratory Report.			
17.5.18.	Please carry out an examination of the accompanying specimen			
	of URINE with special regard to Complete.			
19.5.18.	Report:- S.G. - 1025.			
	Acid.			
	Turbid.			
	Albumen present.			
	No Sugar.			
	Oxalates and Urates.			
Q.A.I.M.N.S.	Laboratory Report.			
20.5.18.	Disease ?			
	Please carry out an examination of the accompanying specimen			
	of STOOL. with special regard to Pathogenic organism ?			
	Report:- Entamoeba histolytica present.			
	No typhoid - dysentery group found.			

P.T.O.

* The first and last entries will be signed, and transfers from one Medical Officer to another, attested by their signatures.

Station and Date.	
Q.A.I.M.N.S.	Laboratory Report.
21.5.18.	Disease. ?
	Please carry out an examination of the accompanying specimen of URINE (Catheter) with special regard to Albumen - estimate Pus casts.
23.5.18.	Report:- S.G - 1024.
	Acid.
	Clear.
	Albumen-7%
	Nil microscopically.
Q.A.I.M.N.S.	Laboratory Report.
29.5.18.	Disease. Dysentery.
	Please carry out an examination of the accompanying specimen of STOOL with special regard to Amoeba Histolytica ?
30.5.18.	Report:- No E. Histolytica found.
	Laboratory Report.
Q.A.I.M.N.S.	
31.5.18.	Disease. Dysentery.
	Please carry out an examination of the accompanying specimen of STOOL. with special regard to Entamoeba Histolytica.
2.6.18.	Report:- No E. Histolytica found.
	Laboratory Report.
Vincent Sq.	
3.6.18.	Disease. Dysentery.
	Please carry out an examination of the accompanying specimen of STOOL. with special regard to Membrane.
4.6.18.	Report:- No Membrane found.
Hosp:Ship.	Copy of Medical Transfer Slip.
Egypt.	
29.11.16.	Admitted.
	Disease. Gastric Ulcer.

contd:-

NA PIN 26/20110 M.E HOLLOW

T/HMJ.

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MEDICAL CASE SHEET.

No. in Admission and Discharge Book.	Regimental No.	Rank.	Surname.	Christian Name.
		S.N.	HOLLOW	Miss M.E.
	2162.	Unit.	Age.	Service.
Year.	Q.A. Reserve.	28	26/12.	
1918.				
Station and Date.	Disease .			
	Medical Transfer Slip contd:-			
	9.12.16. Malarial Fever.			
	Has had to exercise great care in dietary & has o/o insomnia.			
	21.12.16. Temp. raised in night. Down this morning.			
	Mesopotamia G. Ulcer 6 Sept.			
	Malaria 6 weeks.			
	later Parasites ?.			
	Convalescent from G. Ulcer.			
	Malaria — 4 or 5 days.			
	Had a rigor at Suez. about 14 days ago. Stop Quinine.			
	Slight anaemic - no spleen.			
	Salonica early July.			
22.12.16.	Transferred to Southampton.			
	Copy of Notes attached.			
	Miss Hollow after taking (2.0/clock) dose of new medicine, got			
	up & collapsed on the floor, was put back to bed, remained			
	collapsed for a few minutes, had palpitation & was very			
	unwell. Still complains of dizziness & not being able to see.			
	(Sgd.) E.M. Rambal.			
	Sister.			
	28.12.17.			
	To the O.C. Wharncliffe War Hospital.			
	Sir.			
	Re Staff Nurse Hollow.			
	The above Nurse has been sick under my charge for over 5 weeks.			
	She had previously suffered, she tells me, from severe Malaria			
	when in the Tropics.			

DECEASED

* The first and last entries will be signed, and transfers from one Medical Officer to another, attested by their signatures.
(A.1014) W3031/P/1296 3.450m 7/18 Drafton Mill, Forms I. 1237/14 (E. 3420)

NA PIN 26/20110 M.E. HOLLOW

Station
and Date.

-10-

In this illness she has had prolonged irregular pyrexia & severe pain in various parts of the trunk & limbs. I have been unable to find any malarial parasites & cultures from the blood & dejecta have given negative results.

I am inclined to think that her present illness is the result of her previous malaria & I think it would be well for her to go to the Hospital for Sick Nurses, Vincent Square if this can be arranged.

I have the honour to be Sir.

Your obedient Servant

M.M.Bond.

(Sgd.) A.I. Naish.

Major R.A.M.C.

Matron Q.A.I.M.N.S.

From: The O.C.

Wharnccliffe War Hospital, Sheffield.

To: The Medical Officer i/c.

Sick Sisters' Hospital, Q.A.I.M.N.S.R.

71, Vincent Square, London S.W.

Dear Sir,

Staff Nurse Hollow Q.A.I.M.N.S.R.

I enclose herewith a certificate which I have received from Major Naish, regarding the above-named Lady, who has been ill for five weeks.

Will you kindly inform me whether you can accept Miss Hollow at your Hospital, and what procedure is necessary.

Miss Hollow is not fit to travel just at present, but it is thought that a change from this rather cold climate to London will be advisable.

Yours faithfully

Sgd. (William

Sheffield.

Lt.Colonel R.A.M.C.

28.12.17.

contd:-

NA PIN 26/20110 M.E HOLLOW

T/HMJ.

-11-

Army Form I. 1237.

Form
I. 1237
14

MEDICAL CASE SHEET.

No. in Admission and Discharge Book. 2162.	Regimental No.	Rank.	Surname.	Christian Name.
		S.N.	HOLLOW	Miss M.E.
Year. 1918.	Unit.		Age.	Service.
	Q.A.Reserve.		28	26/12.
Station and Date.	Disease			
	Wharnccliffe War Hospital			
	<div style="border: 1px solid black; padding: 2px; display: inline-block;">DECEASED</div> 18.			
	Dear Maj. Charlesworth.			
	<p>Staff Nurse Hollow will have reached you yesterday from this Hospital & I am sending this note on her condition whilst here. The Phys. signs & symptoms have been mainly negative. She has complained of severe pain in limbs & trunk, but I have failed to find any definite phys. signs & have not found any malarial parasites in films taken when the temp. was highest. Cultures from the blood in Citrate Broth were sterile also.</p> <p>I believe she was under your care for a short time on her return from the Tropics but I have had no documentary evidence as to her condition while abroad.</p> <p>Yours sincerely.</p> <p>Sgd. A.I. Naish.</p> <p>Maj. R.A.M.C. M.O.i/c.</p>			

* The first and last entries will be signed, and transfers from one Medical Officer to another, attested by their signatures.

W3091/P/1296 3,450m 7/18 Dayton Mill Forms I. 1237/14 (E. 3420)

Conclusions

The comments made in the opening lines of this chapter from nurses clearly indicate an erosion of their identity and a descent into neurosis or 'hell' for these women. In much the same way that men suffered hardships and deprivations, the women did too, even though they were not in the trenches. It has been shown that women were exposed to air raids, bombings, gun shot wounds and 'burials' under mounds of earth or collapsed buildings. Women saw the horrors through the mangled bodies they tried to mend and nurse. They heard the noises of the air raids, the bombs, and the screams and the moans of the wounded they could not hope to treat satisfactorily, least of all, cure. The physical and psychological shock of nursing men with dreadful and sometimes fatal injuries would naturally have had a profound impact on many of the nurses, and this combined with performing their duties often under dangerous conditions, will all have contributed to a nurse's ability to cope. They too, knew what it was like to be frightened for their lives, but throughout had to remain in control because they were there to care, to alleviate and support the wounded and dying. The pressure they endured to remain in control could only have compounded the ultimate 'breakdown' in some women.

To suggest that women suffered from war neuroses, and in particular from shell shock, challenges long held ideas about these types of conditions being the preserve of men, or soldiers of the First World War. Yet it is clear that women did indeed suffer the consequences of serving in this war and went on to display all the symptoms and disorders redolent of war neurosis. Whether it can be satisfactorily argued that they suffered from what was commonly known

as 'shell shock' will remain controversial. However, this chapter has shown that although the term was recognised and used by everyone to denote the psychological breakdown in those who saw service on or near the fighting, the medical authorities nevertheless dismissed it. Instead they preferred, and favoured, terms more familiar to them for conditions they had recognised and treated before the war, and which for them satisfactorily explained what they were seeing. The problem, for many, was the sheer volume of numbers, of which nearly all were men, because nearly all those who served during the war, *were* men. In short, one reason why so few women have been recognised as shell-shocked was because they did not serve in the same numbers. Furthermore, it could also be argued that the reason there were so few cases of women diagnosed as shell-shocked, was because there were so few men actually diagnosed with it either, at least in medical terms. However, the popular label of shell shock was used by various agencies, such as government officials, and by relatives and peers, to describe the breakdown of women.

Shell shock was initially a very appropriate term that fitted well with the bio-medical approach endorsed by a section of the medical fraternity at the beginning of the war. Concerns over its aetiology prompted others to question its origins. Meanwhile, a large body of doctors were similarly realising that what they were witnessing was nothing new and began revising and using terms more familiar to them and which had been in evidence before the war. Hence, in order to quell the rising panic, the medical authorities and the army actively discouraged the term shell shock. By adopting the use of more familiar terms, the medical authorities managed some semblance of control. Moreover, they

were operating within the sphere of the military and so adapted their knowledge and theories accordingly. Many cases of what they held to be neurasthenia, formerly the neurosis of everyday living, now became a result of the stress and strains of warfare, and became a war neurosis.

Although the term 'shell shock' quickly caught the popular imagination, the existence, nature and character of the disorder was widely contested by the military and medical authorities. Arguably it was the scale of the problem, the desire to find an acceptable condition for the male ego of 1914-18 formed by Victorian ideas, along with the moral panic, which attributed this misunderstood emotional reaction to a permanent mental illness, which made Shell Shock the problem it was in the First World War. On the one hand there was considerable anxiety amongst the military authorities, who were presented with what appeared to be a new phenomenon of rather startling proportions, recognition of which would very possibly lead to a flood of cases of those who wanted to get away from the front. On the other hand, the medical authorities were willing to accept the existence of some type of disorder and thereby started offering varying accounts of its character and aetiology. They concluded that what they were seeing was 'nothing new' and consequently reverted to more familiar diagnostic categories.

As the medical authorities revised and amended their understanding, many theorised as to the causes and reasons for breakdown and highlighted that close proximity to explosives was not a reliable explanation. The theories they arrived at allowed for the symptoms and subsequent breakdown witnessed

in nurses to be included. Arguably, nurses were prone to seeing equally as many horrific sights and sounds and regularly suffered from exhaustion. Furthermore, they endured the constant stress and burden of remaining in control as carers, and all these factors were cited by doctors as precursors to breakdown.

Qualified nurses and probationers alike, received only minimal training in preparation for their war service, and whether they served at home or abroad, the conditions they faced placed considerable strain upon them; conditions that ranged from long hours and lack of resources, leaving them frequently exhausted and living in unhygienic surroundings. Both of these factors left many prone to infections and illness, which was reputed to be a precursor of breakdown in both soldiers and nurses.

When women did experience the traumas and horrors of being at the front line area, their psychological conditions often manifested in the same way as the men's. Physiologically, trauma and stress manifests its symptoms through the vehicle that is the human body. It does not favour one sex or the other and hence the symptoms for both men and women could be identical. Often unable to find the range, and appropriateness, of language to communicate its stress verbally the body resorts to communication via bodily distress and which often formulates as symptoms of illness. The recognisable symptoms of sleeplessness, forgetfulness, tremor and shaking, nightmares, lethargy was common for both men and women. The medical records reflect this and demonstrate the symptoms did not favour one gender or the other.

Of particular interest was the disorder known as Disordered Action of the Heart, or DAH. Despite being described as a 'Soldier's Malady' it was nevertheless ascribed to women in equal numbers. It represents a fascinating picture as it was similarly dogged by the same history and controversy as 'shell shock'. It raised sufficient concern and consternation amongst military authorities to prompt yet another report and the employment of medical experts. DAH essentially stood as the diagnosis for those who had received and encountered the horrors of warfare without being in a trench. It accounted for the breakdown from extreme conditions, from physical illnesses, and from the stress and strain of warfare. Yet crucially it was acclaimed, and quite strongly, as a 'soldier's malady', even though a significant proportion of nurses were labelled as such. Disordered Action of the Heart became a more 'respectable' diagnosis for women at war. It was one that women were not averse to 'borrowing' from the men because if the premise that shell shock was a disorder of men because it meant they had served near the fighting then they could not use it. DAH on the other hand held no such connotations. In attempting to explain the high incidence of DAH amongst nurses it is argued that the term DAH became the accepted discourse for nurses through which a set of symptoms was communicated by the body to indicate distress. Notwithstanding the view amongst medical authorities that shell shock 'did not exist', it is the opinion of this thesis that DAH became the condition for a non-combatant, and for a woman who served alongside the military. In an attempt to be seen to be in distress and to be seen to be part of the military structure, nurses adopted this medico-military mode of expression for the conditions they experienced. The discourse adopted for military in terms of psychological injury and trauma

was a social and cultural phenomenon and although the symptoms were those that had been seen in peacetime, those same sets of symptoms, or syndromes, took on new titles and labels in wartime. The women saw them-selves as part of the military and appeared to adopt the required discourses to convey their distress.

The treatment and management networks for women were very limited but not absent. This was largely because a treatment network for nurses was 'not a priority' and the evidence suggests that no one had appeared to give it much thought. Most homes and hospitals were essentially 'ad hoc' arrangements but not because of any bias. Arguably this was because of a lack of expectation of a serious need and so was therefore not planned, although as the need arose, provision was made.

As regards distinctions of treatment and care because of gender, it is difficult to see any evidence for this. Nurses were classified as officers and received treatment according to the capabilities and knowledge of the doctors who attended them. Any suggestion of partiality in the management and treatment of women who were general (or qualified) nurses, and those who were VADs is not borne out by the research for this chapter. Much has been made by some historians of the different types of treatment for soldiers - specifically the difference for officers and that for ranks. Much of it has been perpetuated by myth and supported by a small section of historians and literary writers. Analysis of records would suggest that treatment was given fairly and genuinely in order to alleviate the man's, or the woman's suffering. However,

doctors were a heterogeneous group, some of whom wanted to secure the best interests of the patient standing before them. Others saw it as an opportunity to further their own development and hence career. Either way, all were faced with the moral and ethical dilemma that being a military doctor encapsulated, of treating the patient with the express purpose of returning him to face further injury or even death. In this respect, the treatment of nurses was perhaps no different.

The approach to the medical care and treatment of nurses who fell sick, either physically or psychologically, as a result of their war experience, by doctors and medical authorities suggests one that was borne out of a concern for the welfare of the individual. Whether this was because of empiricism and the doctor's self aggrandisement and pursuit of career prospects is difficult to tell. The pragmatic nature with which doctors set about examinations and subsequent treatment is indicative of the context of the circumstances they found themselves in. Nurses were needed to treat soldiers and there were few qualified nurse and therefore indispensable. Every effort that was practical under the circumstances of war appears to have been devoted to ensuring the full recovery of the nurses. When it was seen that a nurse was not 'fit' mentally or physically to do her duty, she was sent home. In this respect the amendment to the doctor's ethical code under the conditions of war along with the needs of the State were adhered to; nurses needed to be healthy so they could nurse the soldiers back to fitness for injury or death.

CHAPTER FOUR

The Aftermath: Repatriation, Rehabilitation and Recompense

My troubles, I am sorry to say, began from then onwards. England seemed quite unprepared for anything so unorthodox as myself¹

For the soldiers who returned home after service in the Great War the problems, in terms of rehabilitation and recovery, could be significant. These problems could include and were compounded by social, political, medical, moral and economic factors. The sheer magnitude of numbers of returning soldiers meant that, ultimately, the whole of society would be drawn into helping him face those problems. The war ended in 1918 but the concern of rehabilitating hundreds of thousands of war-disabled men had been raised before then. In 1916 *The Lancet* stated that, 'the problem of converting the fighting man who has been crippled by this war by sea or by land into a useful citizen again is one of appalling magnitude'.² One of the major concerns in the rehabilitation of ex-servicemen was in the provision of financial compensation through a 'war disability pension', and the assessment of that disability was through a medical board set up by the newly created Ministry of Pensions. Once again, the main focus of the studies in this area has been on male veterans.³ This chapter, however, is concerned with the rehabilitation of homecoming *female* veterans, specifically the many nurses and female

¹ Pat Beauchamp. *Fanny Went to War*. (London: Routledge, 1940) p. 190. Chapter entitled 'Home, Sweet Home'.

² 'The Future of the War Cripple.' *The Lancet*. (7th October 1916) p. 649.

³ Stephen Ward (Ed). *The War Generation*; Andrew P. Latcham. 'Journey's End'; Deborah Cohen. *The War Come Home*.

voluntary aid detachments who served during this war. Firstly, it seeks to examine the process by which they became eligible for a war pension and then to assess whether their path in the road to recovery was as troubled as that for the male veteran.

Much criticism has been levelled at the way in which the provision of pensions was awarded to disabled ex-servicemen during and after the 1914 - 18 war. All the combatant nations provided for their ex-servicemen in the form of a pensions system but in Britain the system was particularly complicated. By law, the 'responsibility for the financial compensation and physical rehabilitation of disabled veterans lay with the state, [but the] actual delivery of these services was channelled through both voluntary and state agencies.'⁴ The government in Britain found considerable problems in dealing with such large numbers of men and establishing an effective administrative framework proved both complicated and protracted. The system, that culminated in the creation of the 'Ministry of Pensions' was set up in response to the needs of ex-servicemen from the First World War, and was an attempt to centralise and co-ordinate provision for all ex-servicemen. By 1930, 1.6 million of the six million men who served in the British Armed Forces during this war, had been awarded pensions or gratuities for physical or psychological injuries incurred during the conflict.⁵

There has been some interest on the part of historians to explore the creation of war pensions and the predominant and general view has been one

⁴ Helen Bettinson. 'Lost Souls in the House of Restoration' p. 5.

⁵ *Ibid.* p. 1

of the ex-serviceman being 'betrayed' by the government because recruitment promises of a 'land fit for heroes' were dashed by a stringent inter-war fiscal policy. In short, studies have tended to fall within two broad categories. The first, supported by Stephen Ward's, *The War Generation*, Andrew Latcham's, 'Journey's End: Ex-Servicemen and the State during and after the Great War' and Deborah Cohen's *The War Come Home*,⁶ have predominantly argued that the Ministry of Pensions was an unbending monolith, whose policies and practices were heavily bureaucratic and which ultimately 'betrayed' the ex-serviceman. This was based on the general feeling from claimants, that provision of pensions and the pension system existed only and purely for the administrators. Indeed, Andrew Latcham claims

The structure of the Ministry was such that the entitlement criteria [...] helped to perpetuate and foster an adversarial relationship between claimants and pensioners [due to an] omnipresent political concern for economy.⁷

A more recent, and alternative view is that from Helen Bettinson. Her thesis 'Lost Souls in the House of Restoration? British Ex-Servicemen and War Disability Pensions, 1914 - 1930', has contested the 'betrayal' view by suggesting the Ministry was subject to all manner of problems primarily because of the scale of the task it was set up to solve and, moreover, the pensioner was not always the 'lost soul' left to the mercy of the pension system.⁸ Bettinson's premise is that the pensioner was not the passive 'lost

⁶ Stephen Ward (Ed). *The War Generation*; Andrew P. Latcham. 'Journey's End'; Deborah Cohen. *The War Come Home*.

⁷ Andrew P. Latcham. 'Journey's End' p. 381.

⁸ Helen Bettinson. 'Lost Souls in the House of Restoration'. p. 3 - 4.

soul' and he did not 'seek disablement, but once 'damaged they used their disabilities to get what they thought they deserved'.⁹ Moreover, many 'quietly accepted the procedures and decisions of the authorities; others negotiated, manipulated, or cheated.'¹⁰ Furthermore, the problem of mass rehabilitation, she argues, would be seen as an 'opportunity, by some, [and that] politicians, doctors, charity workers, civil servants and individuals from all ranks in society were drawn into the plight of the war disabled'.¹¹

Participation in, or control over, this work meant not only a share in the money that it inevitably attracted from both public and private sources, but also the prospect of promoting one's own values and enhancing one's own status.¹²

To date these studies have focused predominantly on the ex-serviceman, but the context and framework employed to examine the provision of pensions for soldiers proves to be a useful analytical tool in which to examine the provision for disabled nurses. Ultimately their plight in the evolution of the pensions system is related to, and implanted within, the system that existed and developed for men. Given the traditional responses to women who served in this war it is permissible to assume that when they did make a claim for a pension that the response from the pension authorities might be inconsistent and somewhat less than sympathetic, if indeed they were included in the pension system at all. Yet this chapter will highlight how concerned certain parties were and how they took up the issue of compensation for nurses as

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² *Ibid.* p. 3.

early as 1915. In order to do this, this chapter focuses, firstly and primarily, on the evolution of the pension system per se, for only by understanding something of this complex and bureaucratic process can some insight be gained as to how nurses were included and provided for. It will assess whether women were particularly discriminated against. It will suggest that if the attitude and response of the authorities was indeed less than favourable towards these women, then this was, in part, and, as Bettinson argues, due to the multiplicity of problems inherent within the 'system'.

The Evolution of War Disability Pensions and the Place of Nurse Claimants

Legally the responsibility for financial compensation and physical rehabilitation of disabled veterans lay with the state. Although the system, as it existed then, was executed through a series of Royal Warrants and War Pensions Acts that had been in existence prior to the outbreak of the First World War, until men were guaranteed a statutory right to a pension in 1919, they had no law-binding claim on the state.¹³ Until 1919 provision for disabled ex-servicemen was the responsibility of individual Service departments. At the beginning of the war, no less than four official bodies shared responsibility for the disabled: The War Office, the Chelsea Commissioners, the Admiralty Commissioners [for naval pensions], and the Royal Patriotic Fund Corporation.¹⁴ The two main agencies

¹³ Prior to war pensions being made a Statutory Right on August 19th, 1919 the claim for a pension was considered a 'matter of grace'. Briefly, in 1914 a Cabinet Committee drew up a scale of pensions and separation allowances. Finding these inadequate the House of Commons instructed a Select Committee to make further recommendation and their proposals were adopted and embodied in the Royal Warrants of May 1915 and November 1915. The scales had been further improved in the Royal Warrants of 1917, 1918, 1919, and 1920. See Wilkinson Sherren. '*The Rights of the Ex-Service Man and Woman*'. (London: L.J. Gooding, 1921) pp. 9 - 11.

¹⁴ Deborah Cohen. *The War Come Home*. p. 20.

for soldiers and sailors were through the Commissioners of the Chelsea Hospital and the Greenwich Hospital respectively. Yet, in essence, provision was predominantly discretionary and varied according to length of service and disciplinary record etc. While actual provision of monetary compensation was through these voluntary and state agencies, since there were no guarantees, the financial prospects for ex-servicemen were uncertain at best. Soldiers were frequently expected to rely on other charitable organisations such as the Red Cross for financial and other support. Furthermore, medical provision was restricted to that which was provided through the national insurance scheme.

For nurses, the issue of compensation was being considered as early as 1915, but by individuals who were expressing concern for the 'sacrifices' being made by them. For example, Sir Everard Hambro, Chairman of the War Nurse's Relief Fund, made an appeal on behalf of the nurses 'who have suffered, or may suffer, from attendance upon the sick and wounded during the war' in *The Times* of 27th March 1915.¹⁵ In response, Queen Alexandra sent a cheque for £100.0s.0d., together with an autographed letter expressing her sympathy and interest in the work of the fund. The reaction from the public was equally immediate and generous. The morning after the appeal was made further donations, including some from the Order of St. John of Jerusalem and the British Red Cross Society, totalled over £5,000. *The Times*, keen to be seen to be supporting the benefactors of the nurses' plight, published the names of the individuals who made significant donations. For instance, 'the most recent

¹⁵ Letter to *The Times* (Mar 27th 1915) from Elizabeth Haldane. War Nurses' Relief Fund. Queen Alexandra's Practical Help.

donors are the London City and Midland Bank and the Royal Exchange Assurance, £105.0s.0d each; Miss Edith Dempster and Sir John Ellerman, £100.0s.0d each; and Lord Boyne £50.0s.0d.' It added 'the object of the fund is to help those who have suffered mentally, physically, or pecuniarily [sic] from the consequences of attendance upon the sick and wounded during the war.'¹⁶

However, the response from Elizabeth Haldane, was mixed:

On the one hand, it is a fund which is greatly needed; on the other, it brings us face to face with the question, are our nurses to be paid a pittance, and, after risking their lives in their country's service, made the recipients of what is after all a charity? They are a highly patriotic body of women who are ready to give their services almost gratuitously even for work abroad which involves serious risks to health and life. ...Ought the public to permit of their sacrificing themselves on the altar of patriotism even if they recognize their debt by founding a fund to assist them later on? We seem just lately to have wakened up to the value of the splendid work done by our trained nurses because their numbers are limited and the demands made upon them at this time of stress are unlimited. Let us see that our gratitude, which is very real, is expressed in a proper way.¹⁷

Ethel Gordon Fenwick, President of the National Council of Trained Nurses of Great Britain and Ireland was similarly anxious to avoid nurses being compensated through charitable means and campaigned to see pensions provided on an equal basis with the soldier. In response to Elizabeth Haldane's letter, Fenwick felt that although many nurses would welcome the letter, they would nevertheless find it 'extremely distasteful to be held up in the public press in *forma pauperis*'.¹⁸ She added

¹⁶ *The Times* (23rd April 1915) p. 10.

¹⁷ Letter to *The Times* (Mar 27th 1915) from Elizabeth Haldane. War Nurses' Relief Fund.

¹⁸ Ethel Gordon Fenwick. *The Times*. (29th March 1915) p. 9.

The aim of the organisers of the various relief funds, from the Queens Fund downwards, has been to preserve the self respect of those assisted by providing them with work, for which payment is made on the ordinary scale, and to avoid giving relief in the form of charity. In the case of nurses the bad precedent has been established by expecting them to work for half the ordinary fees of a private nurse; that is, when they cannot be induced to give their services free. Nurses are a singularly uncalculating class, and only too willing to throw themselves into the breach at this crisis without considering their own future. It is therefore the more incumbent upon the committee which employs them, at a reduced rate, to make provision for them when incapacitated, because they have sacrificed themselves, in Miss Haldane's words, on the altar of patriotism. As the soldier has a right to a pension when incapacitated, so provision should be made, under similar circumstances, for the nurse who serves him, as a right, not as a charity, until she is again fit for active work.¹⁹

So while there was no statutory provision of pensions for nurses at this time, or, indeed for soldiers, nurses had to rely solely on charitable donations. Soldiers, on the other hand, not only had recourse through their official bodies, but there was some provision through the Royal Warrants of May and November of 1915.²⁰ It can be argued that there was some discrimination in this, but equally, account must be taken of the date. At this early stage in the war the scale of the problem was not, perhaps, fully realised, and the numbers of disabled nurses were few. The fact remains however, that a concerned few were considering the plight of the nurse.

While certain individuals showed concern of the disabled nurse, the ex-serviceman's plight was becoming enough of a concern to prompt two

¹⁹ *Ibid.*

²⁰ In the 'autumn of 1914 a Cabinet Committee drew up a new scale of pensions and separation allowances' and following a Select Committee appointed under Mr. Lloyd George, the proposals were adopted and embodied in the Royal Warrants of May 21st 1915 and November 26th 1915. Wilkinson Sherren. *The Rights of the Ex-Service Man and Woman*. p. 9.

parliamentary reports, which were published in 1915. A Select Committee,²¹ concerned itself with financial matters, along with the Murray Committee,²² which looked at medical treatment and employment of discharged soldiers and sailors. This prompted Asquith's Coalition government to pass the Naval and Military War Pensions Act in November 1915 and which, in effect, brought in to existence a 'Statutory [War Pensions] Committee to co-ordinate supplementary payments separate from, and in addition to, the main pension awarding authorities at Chelsea and Greenwich.'²³ Pressure from the press, and from parliament, ensued for the establishment of a centralised authority to administer pensions from the Service Departments and, as a result, a Cabinet Committee was formed in 1916.

Under the later coalition government headed by Lloyd George, the Ministry of Pensions was created in 1916 and placed the central role and responsibility for the care and welfare of the disabled soldier and sailor more firmly on the State. Subsequent changes, in the form of decentralisation, were to see the formation of a network of Regional and Area Offices,²⁴ incorporating over 1,200 Local War Pensions Committees (LWPC), albeit with limited funding.²⁵ However, Bettinson claims, just when

²¹ *Ibid.*

²² *Report of the Committee on the Provision of Employment for Sailors and Soldiers Disabled in the War.* Parliamentary Papers 1914 - 16 [Cd 7915] xi, 37. p. 41. The Committee included W.H. Beveridge, Major General Crutchley (Chelsea Hospital) and Labour MPs John Hodge and Arthur Henderson. Chaired by Sir George Murray (Parliamentary Secretary to the Treasury 1903 - 1911).

²³ Helen Bettinson. 'Lost Souls in the House of Restoration...' p. 23.

²⁴ 'For the purposes of simplifying administration, the united Kingdom is divided into 11 Pensions Regions.' Wilkinson Sherren. *The Rights of the Ex-Service Man and Woman.* p. 9.

²⁵ 'Between 1916 and 1919, 100,000 volunteers sat on, or worked with, these committees.' Deborah Cohen. *The War Come Home.* p. 22.

Consensus within the state had been achieved, and accommodation with the medical profession, local war pensions committees, and the voluntary sector, seemed possible, 'difficult' pensioners intruded to complicate state plans and test policy makers ingenuity.²⁶

In this, Bettinson argues that the male veteran became, at this point, a 'convenient object, rather than an essential subject' of the pension's system.²⁷

The pre-war system, recognised as needing much reform, therefore presented itself with a challenge and was required to make 'pensions conform to the needs and expectations of the pensioner, rather than vice versa'.²⁸

Each sick or wounded man made two journeys - one real, one metaphorical. As he was physically processed from battlefield back to civil life, his body moved through a series of assumptions that were not only alien to him but alien to one another. For the pensions agencies he was a blank canvas onto which a variety of competing Edwardian and interwar ideologies were painted. Stereotypical pensioners were fashioned to meet the demands of different interest groups: the 'rehabilitated worker' became the priority of the state; the 'moral hero' the focus of charitable concern; the functionally or anatomically 'impaired body' the gaze of the medical profession.²⁹

Thus, not only did the sheer volume of numbers present as a problem for the Ministry of Pensions, but the varied needs of these individuals compounded the difficulties even further. Such concerns were not lost on ministers. Reflecting upon his duties as first secretary to the Ministry of Pensions, Boscawen stated, 'the whole question of disablement pensions was in a chaotic state, and the gravest dissatisfaction existed in the country.'³⁰ Similarly describing his first month in office, John Hodge, second minister of pensions, commented, 'very

²⁶ Helen Bettinson. 'Lost Souls in the House of Restoration...' p. 17.

²⁷ *Ibid.* p. 6.

²⁸ *Ibid.*

²⁹ *Ibid.*

³⁰ Arthur Griffiths Boscawen. *Memories*. (London: 1925) p. 196.

quickly I made the discovery that the administration of pensions was in a terrible mess'.³¹

Efficient running of such a large organisation was, therefore, to prove very difficult, compounded by the ever increasing and extreme demand upon its services. In order to streamline its workload the Ministry devolved a large part of its responsibility to the Local War Pension Committees, for these Committees had been given the 'function of acting as his normal agents in all matters in which either a pensioner or a claimant to pension needed local handling and assistance.'³² The Ministry therefore 'relied for the great bulk of the work upon the hundred thousand voluntary workers who sat on the committees or who worked with them'.³³ Notwithstanding, the Ministry of Pensions had, by 1917, seen 'about half a million' claimants.³⁴ Demobilisation, 'involving wholesale discharges from the Forces, amounting at times to 50,000 and 60,000 men a day, threw a very heavy and, for the most part, unfamiliar work upon the Committees'.³⁵ However, while the employees and volunteers who sat on these Committees were expected to comply and behave in accordance with the department's ever-changing rules and regulations,

³¹ John Hodge. *Workman's Cottage to Windsor Castle*. (London: 1931) p. 204.

³² The Ministry of Pensions. *The Report of the Departmental Committee of Inquiry into the Machinery of Administration of the Ministry of Pensions*. (London: HMSO, nd) p.12.

³³ *Ibid.*

³⁴ *Ibid.* By '1921 there were nearly three and half millions of men, women and children receiving war pensions or allowances'. 'The actual numbers are:- a) 2,477,800 disabled officers and men of the Army, the Air Force and auxilliary services, and their dependents. b) 60,550 disabled officers and men of the Navy, auxilliary services, Mercantile marine, etc., and their dependents. c) 917,850 widows and orphan children and dependents of deceased officers and men killed or dying after discharge, following upon their war service. d) 1,475 nurses of the recognised war organisations disabled by service, and the dependents of nurses deceased in consequence of war service.' p. 3.

³⁵ *Ibid.* p.12.

compounded by the increasing need for greater economic restrictions, their decision-making powers were limited. All this would add to the problems of administration and organisation, and more opportunities for inefficiency and ill feeling were created.

However, the Royal Warrant of 1917 was seen as an important landmark for ex-servicemen for it encompassed two main elements: compensation and rehabilitation. Compensation was based on three things: a payment for injury; a payment for the degree of loss of working capacity; and a payment for the loss of amenities of life. Whereas previously earnings had been taken into account, the Royal Warrant of 1917 made changes in that it was based on individual defects, meaning payment was made irrespective of earnings or whether the pensioner returned to work. A scale was drawn up and flat rate payments were made according to this scale.³⁶ A total disability assessment of one hundred per cent was awarded for total loss of sight, or loss of two limbs, total paralysis, very severe facial disfigurement or lunacy. A fifty per cent assessment corresponded to the loss of one eye or amputation of one leg below the knee. The loss of two fingers of either hand brought the lowest pensionable assessment of twenty per cent. Disabilities calculated at less than twenty per cent were ineligible for a pension but claimants were awarded gratuities.

³⁶ Helen Bettinson. 'Lost Souls in the House of Restoration...' p. 42. See also Appendix of this thesis, Item No. 1. p. 238.

As regards rehabilitation, it was considered vital by the Ministry of Pensions, to establish eligibility through the definition of 'unfitness' according to Article 1 of the Warrant of 1917. Accordingly, eligibility was given on the grounds of 'such unfitness or impairment being certified as either attributable to or aggravated by military service in the present war and not being due to serious negligence or misconduct on the part of the discharged man'.³⁷ This, clause, however, became extremely controversial, causing much dissent and debate, and meant many men, who had entered the services and had become coincidentally ill, or who had been wounded or injured in a manner inconsistent with the phrase 'military service', were not entitled to pensions. In agreement to this, Boscawen commented, 'very nearly as much depends on the interpretation and administration of the warrant as on the terms of the warrant itself'.³⁸

The main objection to this clause was that all men taken in to the army would be classed as fit, and therefore those subsequently discharged as unfit should be entitled to a pension. In other words, fit for service, fit for pension. The number of men discharged and whose unfitness had been found by a Medical Board to be neither attributable nor aggravated by military service was estimated, in March 1917, as between 60,000 and 100,000.³⁹ However, such

³⁷ Wilkinson Sherren. *The Rights of the Ex-Service Man and Woman*. p.62.

³⁸ Arthur Griffiths Boscawen. *Inter-Allied Conference on the After-Care of Disabled Men*. (1918) p. 22.

³⁹ Cited by Helen Bettinson. 'Lost Souls in the House of Restoration...'. p. 48. Bettinson adds that Medical Boards were 'notorious for their errors, but in addition the national manpower shortages had obliged the War Office to take men into service of a lower physical standard than originally anticipated. Some, perfectly able to hold down employment in civil life, had broken down under the rigors of training or service life.' p. 48.

was the public's outcry and opposition regarding the policy of 'aggravated ailments' the government was forced to concede. Deborah Cohen confirms

Servicemen discharged because of pre-war illnesses were denied pensions. Despite evidence to the contrary, Chelsea's medical boards nearly always dismissed certain categories of disease, primary among them tuberculosis and rheumatism, as pre-existing conditions... In June 1916, largely in response to the public outcry, a Royal Warrant introduced a new category for illnesses "aggravated" by military service, which were to be compensated by an award equal to four-fifths of the pension normally granted for the condition.⁴⁰

Other changes to the Warrant of 1917 included the right to appeal⁴¹ and disablement rates in general were increased, but importantly, this Warrant was the first to make concessions for nurses. Albeit minor, 'gratuities' for nurses came in to effect on April 1st 1917, through the Special Grants Committee, which allowed for 'certain grants and allowances...[to be] made in special cases to war disabled nurses and their dependents.'⁴² Accordingly

⁴⁰ Deborah Cohen. *The War Come Home*. p. 25. The Royal Warrant of 1917 amended this further and full awards were granted. An example of the public outcry was the demonstration staged on 16th May 1919 in Hyde Park by disabled veterans and their supporters, which ultimately turned violent. *The Times* joined the growing band of supporters, claiming in an article, the 'pensions muddle grows worse instead of better. 'The Pensions Muddle'. *The Times*, 15th July 1919.

⁴¹ 'Mindful of the fact that the system might develop errors of judgement to the disadvantage of ex-service men, the Government set up Statutory Appeals Tribunals and Medical Appeal Boards. The former hear appeals against refusal of pension by the Ministry of Pensions. The latter deal with appeals against the degree of disablement assessed by the Medical Board.' Wilkinson Sherren. *The Rights of the Ex-Serviceman and Woman*. p. 38. See examples of Appeal forms in Appendix, Items No. 6 and 7.

⁴² *The Times*. (2nd March, 1920) p. 13. Other payments to nurses included those, '...below rank of principal matron equalled a lieutenant and received £40. 0s. 0d for the first year's war service and with increments of £1.0s.0d or 10 shillings per month, for each subsequent year according to whether they served at home or overseas. Principal Matrons were classed as Captains and received £45.0s.0d, and matrons-in-chief as Lieutenant Colonels. Likewise, the temporary nurses, QAIMNS (reserve), and members of the TFNS were to receive a more generous gratuity than was previously provided; staff nurses received £20.0s.0d for the first year, Sisters received £30.0s.0d and Matrons, £40.0s.0d, with all receiving 10 shillings per month increments for each subsequent year, irrespective of whether the service was at home or overseas. Furthermore, a gratuity was given to VADs and assistant nurses who were employed with the War Office. They received £10.0s.0d for the first year with increments similar to members of the TFNS.' *The Times*, (10th May 1919). p 9.

A supplementary or special allowance may be granted to a nurse where, in consequence of serious disablement arising from service during the war, she is unable to maintain herself in her pre-war standard of comfort, but the supplementary or special allowance, together with any State pension which may be awarded, shall not exceed £90.0s.0d per year.⁴³

Arguably, even though the Warrant of 1917 was held as an important landmark in the provision of pensions, and indeed made several amendments to existing payments and practices, the provision for nurses was apparently felt to be minimal by contemporaries. Indeed, government ministers were suggesting the female veteran's cause to be of less concern. Questions such as why nurses and female auxiliaries, who served their country and were injured or disabled as a result, were not afforded the same treatment and financial compensation as soldiers, was raised. Mr. P. A. Harris asked the then Pensions Minister, Sir A Griffith-Boscawen,

Is the hon. and gallant Gentleman aware there are many women who have been overseas and have suffered from being under fire who have received no pension? Does he consider it right that women should be in a worse position than men when they volunteer for services overseas?⁴⁴

Adding, if

Members of the Women's Army Auxiliary Corps, the Women's Royal Navy Corps, and the Women's Auxiliary Flying Corps who are incapacitated because of service overseas either through shell shock or other causes are entitled to pensions; and, if not, whether he will consider making representations to the Treasury to include them in the Royal Warrant? [for] there are many women who have been overseas and have suffered from being under fire who have received no pension? Does he consider it

⁴³ *Ibid.* See also *the War Pensions Gazette*. No 36 (April, 1920) p. 482. 'Grants To Nurses'.

⁴⁴ *Hansard*. (17th October 1918) pp. 277-8.

right that women should be in a worse position than men when they volunteer for services overseas?⁴⁵

In reply, Boscawen stated:

Members of these auxiliary services do not come within the Warrants administered by the Ministry of Pensions. They are, I understand, entitled to compensation under the Injuries in War Act, for which they prefer their claims against their respective department. [...] I do not think it at all right, but they have their remedy now through their respective Departments.⁴⁶

Ultimately, it was not until the Royal Warrant of 1920 that nurses were included fully in to the pension system. The 'Royal Warrant for the Retired Pay of Officers (Army) Disabled, and for the Pensions of the Families and Relatives of Officers Deceased, and for the Pensions of Nurses Disabled and of the Relatives of Nurses Deceased, in Consequence of the Great War',⁴⁷ was to take effect from 1st April 1920.⁴⁸

This Our Warrant shall apply to all officers and their relatives whose claims to retired pay, pensions or grants of the nature dealt with therein arise in respect of service during the war, *and to members of Our Nursing Services hereinafter specified and their relatives whose claims similarly arise*, and it shall, be subject to the provisions of the Fifth Schedule hereto, have effect from 1st April, 1920.⁴⁹

The late inclusion into the pension system would indeed suggest a degree of discrimination on the part of disabled nurses. Despite their plight

⁴⁵ *Ibid.*

⁴⁶ *Ibid.* It is interesting to note in this exchange that women were not only being considered in the argument for compensation formally through the Royal Warrant but also being recognised as becoming incapacitated as a result of 'service overseas either through shell shock or other causes' and 'have suffered from being under fire'. Authorities were therefore not ignorant of the experiences of women who served 'overseas'.

⁴⁷ Wilkinson Sherren. *The Rights of the Ex-Service Man and Woman*. p. 81.

⁴⁸ *Ibid.* (See Appendix, Item No. 2. pp. 239)

⁴⁹ *Ibid.* (My emphasis)

being taken up as early as 1915 by benevolent individuals and charitable organisations, and later, in 1918, through parliamentary debate, it was to be as late as 1920 before they were officially recognised in terms of eligibility. However, inclusion meant being drawn in to a complicated administrative system and subjected to its arbitrary and, to a large extent, peculiar methods. Making a claim, completing the application form, proving eligibility and providing evidence to substantiate the claim would prove difficult for all claimants, and the result as Bettinson has argued in the case of soldier claimants, was that they could be both victims in this system and, negotiators, who arguably would manipulate the system to suit their needs.

Evidence for the fact that nurse claimants were also victims and negotiators in the pension system comes in the following two documents. [See following pages]. The response from Nurse Grace Hughes in the completion of form M.P.O. 13 (Revised) shows she would have benefited from some assistance, and indeed such was the complicated nature of the claim forms that it became necessary for the Ministry to institute, in January 1919, an 'Officer's Friend', to support claimants through the process and whose role it was, 'to assist officers and their relatives in regard to their claims and to explain the regulations to them'. (Ex-Service Men's Associations in each region were responsible for 'nominating a certain number of men to act as friends' for other ranks).⁵⁰ Nurse Ethel Girling Clark appeared more accomplished in her written replies.

⁵⁰ The Ministry of Pensions. *The Report of the Departmental Committee of Inquiry into the Machinery of Administration of the Ministry of Pensions*. p. 128.

Furthermore, the process was, arguably, to prove far more difficult for nurses for other reasons. On leaving the services the completion of 'Army Form Z. 22. Statement as to Disability' was required.⁵¹ This form essentially served as a disclaimer and proving disability after completing it might ultimately prove problematic. In the case of Nurses' Hughes and Clark, their responses to Question 8 of M.P.O. 33, 'Did you on demobilisation claim to be disabled on A.F.Z. 22?' differed and suggests that processing nurses through demobilisation was not a standardised procedure. As a further complication, nurses would have to fight for compensation retrospectively given that their eligibility was not made a Statutory right until 1920, although the application criteria specified that entitlement had to be made 'within seven years after the date of discharge or within seven years after August 31, 1921, whichever date is earlier'.⁵² Additionally, the gathering of evidence in the form of medical records from the time that the nurse first fell sick, was discharged, or retired, could take time. While the time frame of 'seven years' may initially sound sufficient, the securing of evidence could, at best, take many months, or at worst, could go on for years. However, since medicine had a specific role to play in the decision to award, or not award, a pension, it is to the function and practices of the Medical Board and its doctors that this chapter will now turn in an attempt to discover if nurses were accorded the same, or different, approaches to assessment.

⁵¹ For example of Army Form Z 22. Statement as to Disability. (A.F.Z 22) See Appendix Item No. 3. NA PIN 26/ 20027 Florence Cattell. p. 240.

⁵² Wilkinson Sherren. *The Rights of the Ex-Service Man and Woman*. p. 11.

NA PIN 26120119 G HUGHES

M.P.O. 13 (Revised).

Telephone: Victoria 8740.

Telegraphic Address:

"Warpension, Parl., London."

Reply should be addressed to—
The Director-General of Awards,
and the following number quoted:

SECRETARY**MINISTRY OF PENSIONS,****OFFICERS BRANCH,**

2, SANCTUARY BUILDINGS,

GREAT SMITH ST.,

WESTMINSTER,

LONDON, S.W.1.

Oct 19th 1925

SIR,

With reference to your claim to a grant from this Department, I am directed to request you to be good enough to reply to the questions printed below. Possession of this complete statement on a single document will much facilitate the consideration of your claim.

To succeed in your claim, it will, of course, be necessary for you to show, to the satisfaction of this Department, that the disability on account of which your claim is made is attributable to or aggravated by your service in the Great War.

I am, Sir,

Your obedient Servant,

Ernest Herbert William Sanger
Director-General of Awards

Secretary.

QUESTIONS.	ANSWERS.
1. Full name (in block letters).	Surname: HUGHES Christian Names: GRACE
2. Rank and Regiment (or Corps or Ship) and Unit.	2. ATT N SR
3. Date of birth.	1877
4. Date of Commission.	DECEMBER 1916
5. Date of retirement, or relinquishment or resignation of commission, or demobilisation, and the cause. State date of Gazette Notice, if known.	1918. RESIGNATION

NA PIN 26/20119 G HUGHES

2

QUESTIONS

ANSWERS.

6. Did you ever serve at any time before your last commission, either before or during the Great War, in the Imperial Navy, Army, or Air Force, or in the Indian Army, or a Colonial or Protectorate Force?

If so, please state —

(a) Former Unit

(b) Regt. Nos.

(c) Dates of Enlistment or date of Commission.

(d) Dates of Discharge.

(e) Causes of Discharge.

British Red Cross Hospital

Leeds, Wills &

(a) Sillitoe

(b)

Royal Arsenal Woolwich

(c)

(d)

(e)

(f)

(g)

(h)

(i)

(j)

(k)

(l)

(m)

(n)

(o)

(p)

(q)

(r)

(s)

(t)

(u)

(v)

(w)

(x)

(y)

(z)

(aa)

(ab)

(ac)

(ad)

(ae)

(af)

(ag)

(ah)

(ai)

(aj)

(ak)

(al)

(am)

(an)

(ao)

(ap)

(aq)

(ar)

(as)

(at)

(au)

(av)

(aw)

(ax)

(ay)

(az)

(ba)

(bb)

(bc)

(bd)

(be)

(bf)

(bg)

(bh)

(bi)

(bj)

(bk)

(bl)

7. Nature of disabilities in respect of which your claim is made.

Loss of sight R

Loss of smell

Loss of Sleep

Loss of strength

Loss of memory

Loss of use

of right side

Pain in left

Breast

Vomiting

Constipation

No Menstruation

Loss of grip in

my right hand

breaking eye

glass on eye

fainting daily

State definitely in respect of each separate disability whether you claim that it was attributable to or aggravated by service in consequence of the Great War.

Date of Origin.

Place of Origin.

If you suffered from the disability, or one like it, prior to joining the Army, give details and dates.

Yes. Air Raids

1918.

Head.

No.

Yes.

1918.

Head.

Breast.

No.

Yes.

1918.

Stomach.

No.

Yes.

1918.

Back of Neck.

No.

After reporting all these symptoms I was treated for insanity.

8. Did you on demobilisation claim to be disabled on A.F.Z.22?

No. I was told I was to resign.

9. Have you ever previously applied (otherwise than as in 8) for retired pay or other compensation on account of the disability for which you are now making a claim?

Yes. At the War Office.

If so, to whom and with what result?

2. A.I.M.N.S.R. PERSONALLY

Any relevant documents in your possession should be attached.

NO.

NOT RECEIVED GRATUITY.

NADIN 26120119 G HUGHES

QUESTIONS	ANSWERS
10. In what countries did you serve during the Great War, and for what periods, and in what capacity?	ENGLAND STAFF NURSE
11. In what hospitals were you treated during your war service? Give approximate dates of admission and discharge, and nature of disabilities.	QUEEN MARY WHALLEY Beginning of December, 1918. Sleepless. Constant vomiting. Pain in head & spine. Loss of use of R hand. Sisters Hospital, Vincent Square.
12. If you received treatment during your war service other than in-patient hospital treatment, state: (i) Who treated you. (ii) Where you were treated. (iii) Approximate dates of treatment. (iv) Nature of disabilities.	MEDICAL Officer. 2 Marys. Whalley Sick Quarters. Vincent Square Sick Sisters December, 1918. Loss of memory Sleepless. Vomiting Home.
13. Give particulars of any retired pay, wound—or injury—pension (or gratuity), or other pension or temporary allowance, now in payment or previously received (including any from Indian or Colonial Funds). State whether the award (if any) was for service or disability, and, if possible, quote the authority.	No.
14. Prior to your Great War service— (a) Your occupation. (b) Name and address of Employers or Firms.	Royal Arsenal, Woolwich, 1 year. Sister in Charge. Col. G. Pugh R.M.G. The Arsenal. Discharged No Employer.
Since your Great War service— (a) Your occupation. (b) Name and address of Employers or Firms.	I have failed to get occupation Owing to ill health & 3 Operations
15. Were you insured under the National Insurance Acts? If so, give name and address of Approved Society.	Yes. 15, Beekingham Street Strand Mr. Dick.
16. Name and address of Doctor or Doctors who attended you— (a) Before your Great War service. (b) Since your Great War service. It is important that the names of all Doctors who have attended you should be given and if possible, certificates from these Doctors should be attached (specimen forms of certificate herewith). (The Ministry of Pensions cannot accept liability for any expense incurred on this account.)	(a) None. I was strong & well, always ready to help others. House Surgeon U.C.H. Queen St. London W.C. Mr. Wignall, District Surgeon U.C.H. Operated Dr. M. Keubler Bedford Square. Mr. H. Franklyn, Surgeon. Dorsetshire Operations
* It is particularly desirable that a certificate be submitted from the doctor who first attended you for the disability on account of which you now claim.	T WAS TREATED WITH INJUSTICE ON ACCOUNT OF MY HEALTH

NAPIN 26/20119 G HUGHES

QUESTIONS.

ANSWERS.

17. If the disability in respect of which you are claiming is the result of an accident, the following questions should be answered:

(1) The exact circumstances, time, date, and place of the accident.

(2) Whether you were engaged on military duty, at the time, the nature of such duty, and the authority under which you were carrying it out.

(3) The date and place of any Court of Enquiry that may have been held.

(4) The rank, initials and name of your Commanding Officer at the time.

(5) The names of any eye-witnesses or officers personally acquainted with the circumstances. In quoting the names of officers, initials and regiments should be given, and if possible, their present addresses.

(6) The name of the Hospital where you were first treated for the injury, giving dates of admission and discharge. If not treated in Hospital, the rank, name and initials of the Medical Officer who attended you.

18. Are you undergoing a course of treatment?

If so, state name and address of Hospital or Institution;

or, if not being treated at an institution, the address of your Medical Attendant.

19. What is your permanent address?

20. Any other information or evidence in reference to your claim.

1918. September. It began and aggravated until I was well. I lost my reason for 2. ARRY Hospital. WHALLEY Staff Nurse. MATRON. Sister Sick Quarters. WHALLEY.

Col. ROBINSON RANK WHALLEY.

Home Sister the M.O. I don't know her name.

Whalley 2. ARRY. L.A. N.K. Vincent Square London.

Yes. Resting Body + Mind.

Hughes Grace. 107 Gower Street.

I was discharged from Sick Quarters, as not normal & treated with contempt 1918.

My life was then made unhappy by the Motion

Signature of Officer.

My condition had been in care 1918. My Brain would be normal in now.

Present

Address

2. Alexandra Hotel

Forkstone

Kent

Date 22/10/25

Signature compared with letter in support of my claim 27/10/25

NAPIN 26120033 E CLARK

M.P.O. 13 (Revised).

Tel. Victoria 8740.
 Tele. Address:
 Pension, Parl., London."
 Rep. should be addressed to
 The Director-General of Awards,
 and the following number quoted:

MINISTRY OF PENSIONS,
 OFFICERS BRANCH,
 2, SANCTUARY BUILDINGS,
 GREAT SMITH ST.,
 WESTMINSTER,
 LONDON, S.W.1.

MINISTRY
 OF
 PENSIONS
 11 JUN 1926

Nurses 44059 O'Leas.

Feb. 11 1926

SIR,

With reference to your claim to a grant from this Department, I am directed to request you to be good enough to reply to the questions printed below. Possession of this complete statement on a single document will much facilitate the consideration of your claim.

To succeed in your claim, it will, of course, be necessary for you to show, to the satisfaction of this Department, that the disability on account of which your claim is made is attributable to or aggravated by your service in the Great War.

I am, Sir,

Your obedient Servant,

William Sanger

Director-General of Awards.

QUESTIONS.	ANSWERS.
1. Full name (in block letters).	Surname. Christian Names. Clark. Ethel, Cirling
2. Rank and Regiment (or Corps or Ship) and Unit.	(1st) # 5978 London/190 N.Y.A.D. (2nd) Victoria Central N.D. #34
3. Date of birth.	Oct. 14. 1885.
4. Date of Commission.	(1st) October 4. 1915. 2nd March 14. 1918.
5. Date of retirement, or relinquishment or resignation of commission, or demobilisation, and the cause. State date of Gazette Notice, if known.	1st. Demobilization Sept. 19, 1916. "Unfit for further service." 2nd. Demobilization - Jan 30 th 1920 (N.Y.A.D. France) P.T.O. 2nd. Demobilization - July 31, 1919 (N.Y.A.D.)

NAPIN 26/20033 E CLARK

2

QUESTIONS.	ANSWERS.
<p>6. Did you ever serve at any time before your last commission, either before or during the Great War, in the Imperial Navy, Army, or Air Force, or in the Indian Army, or a Colonial or Protectorate Force?</p> <p>If so, please state:—</p> <p>(a) Former Units.</p> <p>(b) Regtl. Nos.</p> <p>(c) Dates of Enlistment or date of Commission.</p> <p>(d) Dates of Discharge.</p> <p>(e) Causes of Discharge.</p>	<p>(a) London /190. V. A. D.</p> <p>(b) # 5978.</p> <p>(c) Oct. 4th. 1915</p> <p>(d) Sept. 19th. 1916.</p> <p>(e) Sickness. Diagnosis Uncertain. Heart affection due to poisoned system from infection while on duty. per. (Sin. Jas. Mackenzie)</p>

7. Nature of disabilities in respect of which your claim is made.

Disability.	State definitely in respect of each separate disability whether you claim that it was attributable to or aggravated by service in consequence of the Great War.	Date of Origin.	Place of Origin.	If you suffered from the disability, or one like it, prior to joining the Army, give details and dates.
1. Operation for Call Stones.	Yes. I think my illness was the outcome of war service, especially the length of time before recovery, and need of special treatment for Thyroid Gland, Heart etc.	Feb. 24th 1925.	Victoria	No.
2.				Had never been attended by a doctor excepting for vaccination and sprained ankle.
3.				
4.				

8. Did you on demobilisation claim to be disabled on A.F.Z.22?

I do not understand this question. No.

9. Have you ever previously applied (otherwise than as in 8) for retired pay or other compensation on account of the disability for which you are now making a claim?

No.

If so, to whom and with what result?

Any relevant documents in your possession should be attached.

NA PIN 26/20033 E CLARK

3

QUESTIONS.	ANSWERS.
10. In what countries did you serve during the Great War, and for what periods, and in what capacity?	Nursing Y.A.D. England..... 3 months. France..... 11 " England..... 13 " France as C.S.V.A.D. 5 mos. Germany " R.A.O.C. attch. Army of Rhine 6 m.
11. In what hospitals were you treated during your war service? Give approximate dates of admission and discharge, and nature of disabilities.	1. Lady Clifford's convalescent Home. Hardelet, F. 2. Chateau Mauricien - - - Wimereux - - France 3. Q.A.I.M.N.S. Hospital - - 71 Vincent St. London. 4. Operation on throat. - - - Milbank Military. Addmis. 1. Sept. 10, 1916. (2) Sept 11, 1916. (3) Sept 19, 1916.
12. If you received treatment during your war service other than in-patient hospital treatment, state (i) Who treated you. - - - (ii) Where you were treated. - - - (iii) Approximate dates of treatment. (iv) Nature of disabilities.	After return to Victoria, B.C. Can. Dr. O. M. Jones. Victoria Dec. 1st 1916 - - - Dec 27, 1917. Treatment for heart strain.
13. Give particulars of any retired pay, wound—or injury—pension (or gratuity), or other pension or temporary allowance, now in payment or previously received (including any from Indian or Colonial Funds). State whether the award (if any) was for service or disability, and, if possible, quote the authority.	Gratuity received: File no. 03253.E 122 days. @ \$3.00 - - - \$ 366. Imperial Grat. Payable. £ 15.10. or \$ 75. Can. Gratuity - - - 28/5/22 - - - 145. " " 28/6/22 - - - 90. " " 28/7/22 - - - 55. \$ 366.00
14. Prior to your Great War service— (a) Your occupation. (b) Name and address of Employers or Firms. Since your Great War service— (a) Your occupation. (b) Name and address of Employers or Firms.	Teacher. Vancouver City School Board. Charge of Orphanage. - - Cyprus. (L. M. Fund for care of Armenians) Teacher. - - - Victoria, City Schools.
15. Were you insured under the National Insurance Acts? If so, give name and address of Approved Society.	No.
16. Name and address of Doctor or Doctors who attended you— (a) Before your Great War service. (b) Since your Great War service. It is important that the names of all Doctors who have attended you should be given and if possible, certificates from these Doctors should be attached (specimen forms of certificate herewith).* (The Ministry of Pensions cannot accept liability for any expense incurred on this account.)	(a) Vaccinated by Dr. Hudson. (b) Dr. Hermann Robertson. Victoria B.C.

* It is particularly desirable that a certificate be submitted from the doctor who first attended you for the disability on account of which you now claim.

The Ministry and the Role of the Medical Board Doctor

The role of medicine within the Pensions system was both pivotal to, and the foundation of, the pension's structure. It operated as the gatekeeper and the medical examination was the way in which claimants were admitted, or refused, entry to the scheme and secondly, it formed the basis of treatment, the way in which pensioners were rehabilitated. Lord Charnwood had stated that, 'the vital problems of the Ministry are obviously medical ones; the remainder are merely matters of administration, such as are common to all government departments.'⁵³ Medical examiners therefore viewed themselves as central and as occupying seats at the heart of the system. Furthermore, 'free' medical provision for disabled ex-servicemen was considered as an investment for the future:

For upon all states rests this prime obligation - viz. that the ideal life of their members shall, as far as possible, be realized, and any loss or diminution in individual efficiency obviated or provided against. Translated into practice this implies that every effort must be made to furnish the crippled soldier with opportunities of realizing the innate faculties with which he is endowed, or of developing those residual capacities, which haply remain to him. We are faced with a colossal National Debt, and if only for economic reasons restoration to functional integrity of the victims of war is not only desirable but imperative.⁵⁴

Medical centres were, therefore, to become an integral part of the Ministry of Pensions administrative machine.

⁵³ *Recalled to Life*. 3 (April 1918) p. 321. Cited in Helen Bettinson. 'Lost Souls in the House of Restoration...', p. 208.

⁵⁴ L.J. I. Llewellyn and A Bassett Jones. *Pensions and the Principles of their Evaluation*. (1919). p. 47.

However, one view of the medical invaliding boards that decided pensions was that they were notoriously harsh and tended to look on the claimants who came before them as 'shirkers, intent upon a life at the expense of the public purse'.⁵⁵ This view came about, predominantly, as the result of Sir John Collie and histories of the medical section of the war disability pensions system are often considered incomplete without reference to Collie.

Sir John Collie was President of the Special Medical Board for Neurasthenia and Allied Disorders, a section of the Ministry of Pensions that came into being in 1917. He later became Director of Neurasthenic Institutions with the Ministry of Pensions, and finally in 1918, became Director of Medical Services. The task of the Special Medical Board was to examine all discharged soldiers and then periodically re-examine those who were in receipt of a temporary pension.

Historian Peter Leese has argued that examining Collie's background reveals why he was chosen for the Job. As medical examiner for the London County Council before the war Collie wrote and lectured on his chosen subject, the border between medicine and the law, in publications such as 'Obsession and Fraud. Studies in Diseased Personality', and *Malingering and Feigning Sickness*.⁵⁶ Therefore, Collie explored 'precisely those areas which became important in shellshock treatment and pensions policy during and after the war', for he had developed a reputation for being 'healthily sceptical of anyone who

⁵⁵ Deborah Cohen. *The War Come Home*. p. 19.

⁵⁶ Collie, J. 'Obsession and Fraud. Studies in Diseased Personality.' (Lecture.) *The Times*. (27th January 1915); and Collie, J. *Malingering an Feigning Illness*. (London: E. Arnold, 1913)

claimed to be ill, and an interest in 'functional nerve disease'.⁵⁷ His approach to the treatment of neurasthenics was evident.

I have always believed that hard work and continuous work is the only way to be really happy, and that in one form or another is the only salvation for those suffering from functional nervous disease.⁵⁸

Collie is accused of remaining ignorant of developments in medical science even after the war. Shell shock, he continued to believe, was the result of physical concussion or of microscopic shell fragments; while neurasthenia and related mental disorders were the result of personal inadequacy,⁵⁹ but he was ultimately employed because his philosophy regarding war pensions and war pensioners fitted with the government's rigorous inter-war fiscal policies. His attitude, while being in 'sharp contrast to that of many academic doctors and psychologists who were working with war neurotics', was predominantly because his policies would ultimately save the Ministry valuable money.⁶⁰ Furthermore, he was to put in place reforms that would inevitably shape the experiences of ex-servicemen, and what initially deemed to be guidelines were drastically changed into intensely rigid policies under civil servant Sir John Collie.

It has been argued that the views of John Collie were to infiltrate the practices of the doctors who sat on the medical boards or that the regular and

⁵⁷ Peter Leese. 'A Social and Cultural History of Shellshock'. p. 301.

⁵⁸ Collie, J. 'Obsession and Fraud'.

⁵⁹ Peter Leese. 'A Social and Cultural History of Shellshock'. p. 308.

⁶⁰ *Ibid.* p. 301.

frequent examinations of the claimants were in place to demonstrate how far the 'system' was prepared to go in ensuring monies were only paid to the 'deserving'.⁶¹ Yet, the idea that symptoms were exaggerated for the purpose of securing a pension prompted at least one doctor to examine the notion of 'pensionitis'. He argued that it emerged reputedly from a state of mind, which the French called *La Psychose de Revendication* and the Germans *die Rentengier*, but arguably, it was not

Just a simple desire to obtain a pension but more a sense of irreparable injury at the hand of society, for which the fullest compensation can never suffice.⁶²

He added that it 'occurs most often in those who broke down early and shows itself in phrases such as 'I was an A1 man when I joined the army and look at me now, and I know I shall never get any better',⁶³ or that 'he is afraid for the future or even finds his present troubles hindering his recovery'.⁶⁴ As a consequence, Culpin felt clinicians should '...consider the relation of the pension to the maintenance of the symptoms'.⁶⁵ Culpin also raised the issue as to the difficulties of forming an adequate assessment and the need to train those who were to sit on medical boards. Millais Culpin claimed, reliable assessment

Calls for special knowledge and understanding. [...] I am aware of the great difficulty of forming a correct judgement, at a single interview, of a man's symptoms, temperament and attitude towards reality. The untrained observer often brings to bear upon the subject a breezy dogmatism which is rarely justified, and he tends to fall into several errors: to accept a functional disease as organic, to overlook that tendency of the psychoneurotic, even before a pension board, which makes him stress his bodily and

⁶¹ Peter Leese. 'A Social and Cultural History of Shellshock' p. 308.

⁶² Millais Culpin. 'The Problem of the Neurasthenic Pensioner'. *British Journal of Medical Psychology*. 1, (1920 - 1) p. 325.

⁶³ *Ibid.*

⁶⁴ *Ibid.*

⁶⁵ *Ibid.* p. 324.

say nothing about his mental troubles, and finally to regard anxiety symptoms as something that can properly be ignored.⁶⁶

Nurses' cases were equally subject to the scrutiny of the Medical Boards. Yet whether this was the consequence of the philosophy fostered by John Collie and the need for fiscal stringency, or, ostensibly, the conflicting views of the different panel of doctors who sat on different Boards, is questionable. For instance, Ann Eliza Audsley's case may suggest that every effort was made on the part of the Board to avoid payment, but it also suggests that over a period of time different doctors held opposing views. Ann Eliza Audsley suffered a 'Fractured femur. - Attributable'.⁶⁷ The pension process for her commenced in June 1920 and continued over a two year period with questions being asked by subsequent, and intermittent, Medical Boards, as to whether the accident that caused the fracture, namely 'slipping on the floor whilst coming off duty from St Luke's War Hospital'⁶⁸ was, in fact, part of her military service, [because] at the time, she was not classed as a civilian nurse? Throughout the course of her Medical Boards the 'degree of disablement' correspondingly fluctuated between thirty per cent and sixty per cent, depending on the view of the authorities to this question. The claim was finally settled at forty-five per cent in June 1921, which was made permanent.⁶⁹

⁶⁶ Millais Culpin. 'The Problem of the Neurasthenic Pensioner.' p. 319.

⁶⁷ NA PIN 26/19995. Ann Eliza Audsley.

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

Pension awards might be arrived at because of harsh decisions based on fiscal stringency, or, might be the result of differing views of different doctors who sat on each board. [It was rare for claimants to see the same doctor at each subsequent board]. However, the following two cases, discussed in previous chapters, certainly reflect a degree of ambiguity and inconsistency between cases and demonstrate how the issue of the terms 'aggravated' and 'attributable' became a vital part of the discourse of these boards. Nurse Elizabeth Whyham, suffered multiple gunshot wounds as a result of her service at Etaples in 1918. She was also injured as a result of being 'pinned down and crushed by an iron beam' and suffered 'nervous symptoms due to shock'.⁷⁰ Sister Isabella Webster, received a bomb wound to the right leg after being 'struck by a piece of shell in an air raid'.⁷¹ However, whilst these two cases clearly highlight how some women were exposed to the stresses and horrors of warfare, the equality with which they received pensions is questionable. Nurse Whyham, although initially referred to as having received multiple gun shot wounds (GSW) and which was stated as 'attributable' to her war service, saw her records altered to reflect a diagnosis to one of neurasthenia. In itself this was not uncommon, yet her award varied between one of twenty per cent and thirty per cent over an eight year period between 1919 and 1927, finally settling at twenty per cent in 1927 when the award was made permanent. Nurse Webster, on the other hand, was only awarded a gratuity of £15.0s.0d. Despite numerous letters of complaint requesting a reassessment it appears she was unsuccessful.

⁷⁰ NA PIN 26/20277. Elizabeth Whyham.

⁷¹ NA PIN 26/20273. Isabella Webster.

These cases might also be compared to that of Nurse Edith Emma Burdge, who joined for duty in 1915. She served on the hospital ship HMHS Salter and was in France between 1915 and 1916 and again in 1919. In 1919 she complained of 'frontal headaches, tremors in the morning and after excitement, stiffness in the knees'.⁷² Her records also note she was 'elicited, [...] sleeps badly, night tremors, anaemic and debilitated, all of which was declared 'attributable to Military Service - ordinary nursing duties',⁷³ but that she experienced no further migraine attacks since returning from France. She was diagnosed with 'Nervous Debility' at each of her Medical Boards from 1919 to 1921 and then with 'Neurasthenia' in 1922. Nurse Burdge received a pension awarded first at twenty and then at thirty per cent. This amounted to £45.0s.0d per year, increasing annually with inflation and continued until her death in 1963. There is no record of any initial or significant incident in nurse Burdge's case notes, whereas, nurses Webster and Whyham⁷⁴ had suffered injuries that incapacitated them to the point they were unable to resume gainful employment after the war. Nurse Burdge, on the other hand, who had once been a midwife, resumed work as a nurse with the Red Cross after demobilisation. The rationale for awarding a pension at twenty per cent and a gratuity at £15.0s.0d to two relatively similar cases given the severity of their wounds compared with that of another who was not injured and went on to resume her work as a nurse after demobilisation is evidence of the Ministry's inconsistencies.

⁷² NA PIN 26/20020. Edith Emma Burdge.

⁷³ *Ibid.*

⁷⁴ NA PIN 26/20277. Elizabeth Whyham, and NA PIN 26/20273. Isabella Webster.

It is important to mention the relationship between doctors and the state, which was a complex and shifting one at this time. The place of medicine and its practitioners, existing as it did at the heart of the pensions system, was taken as read by most contemporaries in the assessing and repairing of veterans. However, doctors were divided amongst themselves as to whether the context of this involvement should be public or private. One section was arguing for the state provision of medicine whilst others were pursuing the private and professional nature of doctoring in order to ensure its elite status. To this end some doctors, arguably, saw the war as an opportunity to develop their career and status and took the opportunity to highlight the dangers of how a state medical service would result in the rights and privileges of the medical profession being eroded. Conversely, others saw it not only as a great opportunity for the profession but also for the nation. Doctors were paid for their presence and service on Local War Pension Committees and also for each man seen. However, whilst the hardliners had succeeded in procuring their aims of ensuring status through payment per visit, those who had favoured state medicine also saw their aims aspired to through the establishment of the Medical Services Branch, which recognised the place of medicine within the pensions system.⁷⁵

Ultimately, however, they were united in according themselves and their eminent role, for the good of their patients, the nation and themselves. Huge resources were poured in to the pensions system that peaked in the 1920s

⁷⁵ Helen Bettinson. 'Lost Souls in the House of Restoration'. See Chapter 6. 'Doctors : Mediating Pensions'.

when the vast majority of men were processed. However, the harsh economic climate was to undercut the doctors' case and the state's disrespect for the doctors' material and clinical expertise was to be revealed. It was then clear just how little power the doctors really had in terms of negotiating their own salaries, influencing departmental policy or, importantly, their own pension cases. In terms of status and income, of professional and political outlook, the medical profession was no match for its state employers. The advice of specialists was first commissioned but then over-ridden or even ignored as the Ministry saw fit.

How doctors' opinions were sought but later ignored is evident in the case of Nurse Brown who served with the QAIMNS(r) for almost four years, on a hospital ship. She was invalided out with a diagnosis of 'Exhaustion Psychosis'.⁷⁶ In the process of applying for a pension award a letter to the Ministry of Pensions dated June 27th 1921, directed through Major Dumaresque (Officer's friend), stated

Miss Brown, who was a trained nurse, joined the nursing service in 1914 and served in Gallipoli, Mesopotamia, France and India. She was demobilised in April 1919 and did not claim a disability. She was later employed at the military hospital Tooting, where she had a nervous breakdown. She has broken down again, and is in the Bloomfield Private Asylum, 'Dunnybrook'. From the enclosed medical certificate it will be seen that she is suffering from an attack of acute mania, which Dr Bewley attributes to her military service.⁷⁷

Dr. Bewley, in support, had written

Miss Isma Brown is suffering from an attack of acute mania, due in my opinion, to the strain of her war service as a nurse - I knew her for years before the war and she never showed the slightest

⁷⁶ NA PIN 26/20016. Miss I. Brown.

⁷⁷ *Ibid.*

tendency to any such malady[...]. She is under my care at Bloomfield Private Asylum, Dublin⁷⁸

R. G. Rows, an eminent doctor, who treated many shellshock cases, also saw Miss. Brown and wrote to the Ministry of Pensions Board in August 1921 on her behalf.

The illness commenced with sleeplessness, restlessness, and anxiety and gradually became more and more severe. She was sometimes depressed and sometimes excited and lost control of herself. Improvement followed and she left the hospital to stay with a sister in Liverpool, after having been in for three months.⁷⁹

Despite numerous letters and comments in support of this lady, the reply from the Ministry of Pensions was that the pension was refused 'on grounds that condition neither attributable to nor aggravated by her military service.'⁸⁰ Such was the intransigence of the Ministry's authorities.

The heterogeneity of doctors that operated within each of the Regional Centres invariably influenced examinations, treatment and subsequent awards.⁸¹ Elizabeth Armstrong was to see her diagnosis change at each of her Medical Boards. Elizabeth Armstrong served as a VAD with the British Red Cross and joined the 3rd Scottish General Hospital on 15th August 1916. She

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ Within each of the Regional Medical Services, there existed, 'a) The Commissioner of Medical Services (CMS), b) The Deputy C.M.S (at Regional Headquarters), c) The Area D.C.M.S., d) The Medical Officers of Ministry Clinics, e) The Medical Referee, f) The Local Committee or Sub-Committee, all of whom advise or supervise or make arrangements for medical treatment, and - g) The Ministry Clinics, h) The Civil (Voluntary) Hospitals and Clinics, and i) The National Insurance practitioners.' The Ministry of Pensions. *The Report of the Departmental Committee of Inquiry into the Machinery of Administration of the Ministry of Pensions.* p. 32.

was later sent to Trouville in March 1918. After nine months she was discharged with 'DAH' described as 'due to overwork'.⁸² However, a Medical Board in 1920 stated her condition was the result of an 'Infection - due to Military Service'.⁸³ Up to early 1923 her pension fluctuated between thirty and fifty per cent, yet later, in the same year, her records state that her pension was awarded for 'Appendicitis and Rheumatism', which were 'aggravated by war service'.⁸⁴ The final award, which was made in 1926, was for 'Abdominal Adhesions, the result of Appendicitis' but which was similarly reputed to have been 'aggravated by war service'.⁸⁵

Nurse Julia Caroline Adam similarly saw her diagnosis alter over a period of time and with different Boards. Nurse Adam served in France for over two years and was admitted to a hospital in Rouen in June 1915 with 'pain in her ankle and left leg'.⁸⁶ This was not held to be due to military service. She reported sick again in August 1916, reputedly suffering from 'Debility and Insomnia', when she was sent back to England to St. Vincent Square for complete rest. Her records state, 'has been two years in France - cause overwork', [and] 'missing in France after being in CCS in Somme area'.⁸⁷ Her disablement award commenced in 1920 at twenty per cent on account of 'Headache, Giddiness and Debility' and continued to 1922 at this rate when she was awarded a gratuity for 'Debility only' in 1923. Following an appeal the

⁸² NA PIN 26/19991. Elizabeth Armstrong.

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ NA PIN 26/19985. Julie Caroline Adam.

⁸⁷ *Ibid.*

award was made for twenty per cent for 'Debility' that was later increased to forty per cent in 1924, and increased once again to fifty per cent, but this time for 'VDH - Aggravated'. The award remained at this amount until 1929 when it was reduced to thirty per cent but awarded 'for life'.⁸⁸

The arbitrary and haphazard way in which the Medical Boards operated could be the result of different officials sitting at different Boards, or it could be, as Helen Bettinson has argued, the result of the interaction between Ministry officials, doctors, voluntary agencies and the claimant himself [or indeed herself], with the latter not always being the 'lost soul' in the system.⁸⁹ The symptoms and diagnoses of some nurses, like soldiers, undeniably altered according to, perhaps, the varying views of the different doctors sitting on each medical board, and while many of the claimants quietly accepted these decisions and the procedures of the Medical Boards, others however, would seize the opportunity to 'negotiate, manipulate and cheat the system'.⁹⁰ Nurse Ernestine Algar's case suggests that she 'negotiated' with the Boards when she lodged an appeal after her pension was changed. She was awarded a pension for 'Nephritis' in 1920, which was stated as being 'attributable' when she suffered an attack of 'Septic Throat, [with] rigors and albuminuria' whilst at Rouen in October 1917.⁹¹ Her condition was held to be due to 'exposure and excessive strain of active service'⁹² and she was off duty for eight months. She was awarded a disablement pension commencing in 1920 at twenty per cent,

⁸⁸ *Ibid.*

⁸⁹ Helen Bettinson. 'Lost Souls in the House of Restoration'. p. 4.

⁹⁰ *Ibid.*

⁹¹ NA PIN 26/19987. Ernestine Algar.

⁹² *Ibid.*

increasing to one hundred per cent the following year. In 1922 it was reduced to forty per cent prompting Nurse Algar to lodge an appeal. The award was reinstated at eighty per cent in 1923 but with no apparent change in her condition, prompting the question who, ultimately, was in command of this decision and why?

The complex interaction between claimants and the authorities is clearly evident in the case of Lilian Atkins. Having served a total of four and half years, which included time spent in France and Germany, Nurse Lilian Atkins' invaliding disability in 1919 was given as 'Menorrhagia'.⁹³ Her records state that this 'came on whilst in Germany', accompanied by feelings of 'nervousness', with 'peculiar subjective symptoms - head bursting'.⁹⁴ Nurse Atkins underwent surgery on account of her condition being found to be the result of 'fibroids'. The cause of her disability was recorded, however, as 'Constitutional Stress - aggravated by service'.⁹⁵ She was awarded one hundred per cent disability for a period of three months in 1920. She was also recorded as suffering from neurasthenia, which was stated as being 'Attributable to Service' and she was awarded the same degree of disablement at twelve monthly periods until 1925. The Board decided in 1924 she should undergo treatment but the pension continued the same. Lilian Atkins' case, however, elicited interesting comments throughout from the Board in the following instance;

Sister's complaints and condition are exactly as described by the last five Medical Boards except that her physical condition has further improved and she is capable of doing anything. She still

⁹³ NA PIN 26/19994. Lilian Atkins.

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

remains in bed however, talks of nothing except her past ailments, eats well and expects her mother of over 70 years to wait upon her hand and foot. [...] Conversations consist entirely of the wrong treatment she has received. [...] States she is much worse as the result of psychotherapeutic treatment, which she received from Dr. Rows at Richmond Park Hospital. [...] The Board are of the opinion that if circumstances were such that it was necessary for her to make the required efforts for self preservation, she would not fail to do so. Case Severe Hysterical Neurasthenia.⁹⁶

Lilian Atkins then went on to reply to the Board, stating

I consider it a direct insult to diagnose it as hysteria. Since if it is hysteria and I know it isn't it is due to your inhuman and cruel treatment both mentally and physically and as for saying I had it before the war it is a downright lie. It is only to the mercy of God above that I have kept my sanity so far not to the doctors and homes you have placed me in. You see being a nobody and no money - my back it makes a fleet [sic] difference in these homes. I have been worn out with rheumatism and pain ever since I left Birkenhead. [...] If I had had hysteria I could not have nursed during the war with only 1 day sick for 4½ year, and another thing, I was kept in Liverpool and by Helen - for 7 months against my will. I am not making an appeal but being classed as hysterical upsets me every time as it is untrue.⁹⁷

The Board concluded that 'when writing to the nurse refer to disability as 'Psychoneurosis'.⁹⁸ Her records show that her disability pension continued at one hundred per cent, with the comment, 'payment to be continued indefinitely'.⁹⁹

Generous provision appeared to be made in the case of veterans who had suffered to the point of 'insanity' in the course of their duties, and nurses

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*

were no exception.¹⁰⁰ This is interesting given the apparent low regard for psychological disorders by Sir John Collie and whose views were to become 'policy' within the Pension system. However, nurse Joanna Anderson was awarded a pension at the rate of one hundred per cent for life as a result of her service, which was as a VAD for almost three years. She saw approximately two years at home and one year in France before being discharged in July 1918 with a diagnosis of 'Confusional Insanity'. She was admitted to the 14th General Hospital in France with a history of 'becoming depressed and unusually distraught, refusing to go on duty'. Upon admission her records stated she was 'rather nervous and resentful of being questioned, not inclined to sleep, irresponsible, incoherent, occasionally noisy and violent'.¹⁰¹ A pension was awarded at the rate of one hundred per cent to which was added a further sum of money referred to as 'Constant Attendant Allowance'. Furthermore, her records state that her disability was '100 per cent attributable to her war experience'.¹⁰²

Although medical authorities who sat on Medical Boards on behalf of the Ministry perceived themselves to be pivotal in the system, they too were faced with and subjected to common administrative problems and they were expected to record their findings with the aid of prescriptive and standardised application forms. The templates for many of these forms were originally designed and

¹⁰⁰ See the work of Peter Barham. *Forgotten Lunatics*. Barham explores the plight of 'Service Patients. 'Where insanity either was the cause of their discharge from the Service, or where, having developed since, it is accepted as either attributable to or aggravated by service, the men are, while in the Asylum, classified as, "Service Patients" having certain special privileges.' Ministry of Pensions. 'Report of the Departmental Committee of Inquiry into the Machinery of Pensions.' p.104.

¹⁰¹ NA PIN 26/19989. Joanna Anderson.

¹⁰² *Ibid.*

arguably intended for use for male officers and completing such forms for women presented the medical authorities with difficulties, largely because the terminology did not apply to both sexes and there was no room for gender specific ailments to be included. The continued, and un-amended, use of these army medical forms did not lend itself to a detailed or specific assessment of women, for questions that were originally posed to soldiers were similarly posed to nurses, with the inevitable different, or at best, variable, answers.¹⁰³ This may suggest an element of discriminatory practice on the part of military authorities, against women, but arguably it also points towards the Ministry's continuing stringent fiscal policies in that creating another separate form for nurses might not have been a prudent expense. Similarly, the notion that the use of these forms as suitable assessment pro-forma's for both men and women as an attempt at egalitarianism is equally negligible.

In summary, the idea that doctors who served on Pension Medical Boards could be discriminatory towards their female claimants is refuted. Overall, female claimants appeared to be subjected to an equitable standard of care, based on the professionalism of the attending doctor, although how, and on what basis, the Board arrived at their decision remains an interesting one. While the philosophies of Sir John Collie are reputed to have infiltrated the decision making process, there appears to have been an element of capriciousness on the part of the Board doctors with awards seemingly mean, or generous, by comparison. Furthermore the use of the terms 'attributable' and

¹⁰³ The reader's attention is directed to the wording contained in forms in the Appendix, specifically, 'Army Form A. 45. Proceedings of a Medical Board. (Officers and Nurses), also 'Pensions Appeal Tribunal. Form of Appeal by an Officer (or Nurse), where the use of the word 'Officer' is crossed through and the word 'Nurse' is usually bracketed.

'aggravated' were employed in an arbitrary nature, suggesting the concern that was raised earlier in 1917 regarding their meaning and application had not been fully understood or equitably incorporated into the process. (See this chapter, section headed 'The Place of Nurse Claimants'). The view of this chapter is that ultimately, the pension system was a continually evolving one, and was open to interpretation, and indeed exploitation, by all concerned. If and how that system either supported or complicated the rehabilitation needs of nurses is the concern of the next section.

The Ministry, Medicine and the Path to Recovery

Notwithstanding the apparent omnipresence of the Ministry with regard to decisions, the role of medicine was fundamental as regards the rehabilitation of veterans, including nurses. However, in terms of that rehabilitation, Deborah Cohen has commented that male veterans, at least, were

Precariously employed, insufficiently pensioned, [they] scraped together a living and prayed for good health. [...] Although the charitable public championed the veteran's cause, philanthropy did little more than rescue men from penury. It did not promote their return to society. [...] They were never fully rehabilitated either as workers or as citizens.¹⁰⁴

In addition, Cohen states, the veterans became 'the Great War's most conspicuous legacy, they became its living memorials'.¹⁰⁵ Likewise, Peter Leese, has suggested that 'war-neurotic ex-servicemen and psychological casualties were treated inadequately and often neglected after the war'.¹⁰⁶

¹⁰⁴ Deborah Cohen. *The War Come Home*. p. 102.

¹⁰⁵ *Ibid.*

¹⁰⁶ Peter Leese. 'A Social and Cultural History of Shellshock.' p. Abstract.

The experience of returning to civilian life after the First World War, its problems and consequences, have been explored by several historians and scholars. Whilst providing an invaluable insight to the struggles and traumas of ex-servicemen who were physically and mentally traumatised, and who faced the apparent disorganisation of demobilisation, the petty bureaucracy of the Ministry of Pensions and the broken promises of a government, the perspective is ultimately that of the male experience. For instance, Paul Fussell, Eric Leed, R.D. Richie and P.J. Leese¹⁰⁷ have all written on the psychological aftermath of the 1914 - 1918 war for the soldiers. In particular, Leese has explored the soldier's return to civilian life in some detail, using medical and pension records to examine both the social and psychological problems they encountered and how these in turn formulated policies for war-neurotic ex-servicemen. He has claimed it was his intention to explore, 'the forces that shaped the post-war lives of this group of veterans, and to examine the common elements in their experience'.¹⁰⁸

The grievances and discontents of healthy and disabled returnees were numerous, and ranged from lack of housing, to the badly handled demobilisation, the low rates of pensions and gratuities, and the failure of coordination in the handling of soldier's cases.¹⁰⁹

More importantly, Leese has also written of the difficulties on the part of ex-servicemen to reintegrate into family life and how such difficulties were further exacerbated by poorly organised and inadequate government administration

¹⁰⁷ Paul Fussell. *The Great War and Modern Memory*; Eric J. Leed. *No Man's Land: Combat and Identity in World War One*; R.D. Richie. 'One History of Shellshock'; and Peter Leese. 'A Social and Cultural History of Shellshock'.

¹⁰⁸ Peter Leese. 'A Social and Cultural History of Shellshock'. p. 288.

¹⁰⁹ *Ibid.* p. 290.

systems, stating that most, if not all, soldiers or combatants who returned from war were to encounter numerous problems.

The process of becoming a civilian again, renewing relationships, dealing with domestic problems, all of which may seem 'trivial' in comparison to the encounters of war, can be traumatic in themselves. For many returnees this might have prompted feelings of 'separateness', coupled with resentment and frustration. This is perhaps best encapsulated in the comment of Philip Gibbs who wrote in 1920:

All was not right with the spirit of the men who came back. Something was wrong. They put on civilian clothes again, looked to their mothers and wives very much like the young men who had gone to business in the peaceful days before August of '14. But they had not come back the same men. Something had altered in them. They were subject to queer moods, queer tempers, fits of profound depression alternating with a restless desire for pleasure. Many of them were easily moved to passion when they lost control of themselves. Many were bitter in their speech, violent in opinion, frightening.¹¹⁰

Demobilisation on the scale of that seen after the 1914-18 war was fraught with problems and could lead to numerous and varied personal and psychological problems. One reason for this is the very often bizarre conditions and inherent traumas of warfare and conflict being outside the realm of most people's comprehension, and which prompts thoughts of idealisation in the form of a peaceful and secure home life. Conversely, a failure to re-integrate to civilian life sometimes prompts idealisation of the front.

There is a sense in which every soldier who has seen active combat and returned home suffers from traumatisation and post-

¹¹⁰ Philip Gibbs. *Now It Can Be Told*. (New York, 1920) p. 547 - 548.

traumatic stress reaction. In any war there is a process of idealisation whereby combatants would naturally prefer to be at home living in peace and security while on active duty, but the experience of war separates participants and non-participants. Consequently, the return from the front and the transition to civilian life itself becomes a trauma, the difficulties of civilian life have often meant that in peacetime ex-combatants reversed the process and idealised the front.¹¹¹

There is minimal recognition, however, of the plight of women who suffered psychologically in the immediate aftermath of the war and of their path to rehabilitation, and of this transition period.¹¹² For example, Higgonet commented in 2002 that

Behind the moving accounts of combatants' psychological injuries lies concealed another history of wartime trauma, one that has only begun to be written... the shock experienced by combatants during the war for a long time displaced our attention from non-combatants.¹¹³

Similarly, in *The Second Battlefield*, Angela K. Smith, in focusing on women's writing and how styles and techniques were inspired and influenced by their war experiences, states the period is

Still an under-researched area in comparison with the literary representation of men's war experience...' [and] ...historically the war has been defined as an area of male dominance, perhaps because many of the most haunting representations of war experience that have survived the intervening decades are built around images of trench warfare.¹¹⁴

Moreover, in terms of using women's writing as evidence of their emotional response to their war experience, she comments that

¹¹¹ Peter Leese. 'A Social and Cultural History of Shellshock' p. 296.

¹¹² The amount of research in to the psychological effects of the First World War on women is negligible but where it exists it is particularly related to those who stayed on the home fronts. More recently Margaret Higgonet has touched on this area in 'Authenticity and Art'.

¹¹³ Margaret Higgonet. 'Authenticity and Art.' p. 92.

¹¹⁴ Angela K. Smith. *The Second Battlefield*. p. 3. She further states that the 'trench experience was one encountered by less than half the total population; consequently these texts provide an unrepresentative record of the impact of war.'

Many of the diarists who kept such conscientious records during the early years of the war had abandoned their pens before 1918. [...] The end of the war is not much celebrated in published works. There is often an ambiguity to be found in the emotional responses of the writing, a question mark hanging over what comes next.¹¹⁵

The period of transition between war and home has, however, been commented on by feminist historians in social terms, who argue that for many women, their attitude was one of disillusionment at the thought of being subsumed back in to their pre-war, and often, marginalized roles. For instance, Sharon Ouditt commented that for some women the war 'reinforced their identity as merely temporary active citizens'.¹¹⁶ Sandra Gilbert has argued that the women's 'topsy, turvy world' was turned on its head once again.¹¹⁷ These arguments centre on women's responses to Britain's post war social policies that emphasised a return to pre-war gender stereotypes and the proposed restoration of motherhood and family life. They do not recognise the more personal, deeper, psychological responses that came from witnessing and having to endure the trauma of war. Yet it becomes evident through research and reading for this thesis that this was a period experienced by both men and women alike. It was a common reaction to a divide that was created for having undergone the experience of war, a divide that separated the ex-service man and woman from their civilian counterparts, and in some cases from their families.

¹¹⁵ *Ibid.* p. 193.

¹¹⁶ Sharon Ouditt. *Fighting Forces*, p. 217.

¹¹⁷ Sandra Gilbert. *Soldier's Heart*. p. 424.

For example, May Wedderburn Cannan's response to the period in her life after the end of war in 1918, was

Now must we go again back to our world
Full of grey ghosts and voices of men dying,
And in the rain the soundings of Last Posts,
And Lovers' crying;
Back to the old, back to the empty world¹¹⁸

She added, 'what one needs most in shock and grief, is time. Losing one's world one still wanders in it, a ghost. It is for long, more real than the new world into which one knows (but does not want to know) one must presently move and live.'¹¹⁹ Her words might be described as those of a woman both traumatised by her war experiences and trying to manage the transition between leaving her life on the Western Front and returning to civilian life. Similarly, following evacuation back to England as a result of leg injuries, Pat Beauchamp, a 'FANY', wrote

My troubles, I am sorry to say, began from then onwards. England seemed quite unprepared for anything so unorthodox as myself, and the general impression borne in on me was that I was a complete nuisance. There was no recognised hospital for 'the likes of us' to go to...¹²⁰

Such experiences suggest difficulties in terms of reintegration and transition to civilian life after the war in 1918 and clearly these nurses struggled to regain their sense of 'normality'.

¹¹⁸ May Wedderburn Cannan. *Grey Ghosts and Voices*. (Warwick: Roundwood Press, 1976) p. 150.

¹¹⁹ *Ibid.*

¹²⁰ Pat Beauchamp. *Fanny Went to War*. p. 190. Chapter entitled 'Home, Sweet Home'.

The post-war sentiments and the psychological traumas experienced by Vera Brittain, who found the return to civilian life very difficult after having spent time serving as a VAD in the war of 1914 -1918, are those that have more often been referred to in regard to women. Brittain's experiences are familiar to us as a result of her autobiographical accounts, *Testament of Youth* and *Testament of Experience*,¹²¹ in which she wrote of her bitterness and unhappiness at the loss of both her fiancée and her brother to the war, but also of having suffered whilst serving as a VAD in France and in Malta, and of how, on her return, she felt totally isolated. Similar sentiments are evident in the work of May Wedderburn Cannan, Mary Borden, and Irene Rathbone, who also wrote of their experiences. Their war experiences reflect, in much the same way as Brittain's, significant psychological trauma, and as such their writing might be viewed as cathartic attempts in themselves to come to terms with their experiences and to resolve the various problems of transition back to civilian life. However, these women were an elite few, and while they were able to record and publish their war memoirs providing us with a valuable insight to the struggles they faced in the aftermath of war, their accounts are, arguably, not representative. However, the evidence held within medical records and in personal testimonies reveals some insight to the trials and tribulations of the nurses who returned home from war.

¹²¹ Vera Brittain. *Testament of Youth*. and Vera Brittain, *Testament of Experience*. (London: Gollanz Ltd, 1957)

The struggle to make the transition from war to home life resulting in the 'idealisation' of the front was one that was seen in returning nurses. Again, May Wedderburn Cannan encapsulates the difficulties faced by many.

When I got home there was a question mark against the future. [...] I had told myself that there was France left; France where we had been happy: [...] I thought of the refugees [...] making their way across the Somme Battlefields, and I thought that if I could help to repair that desolation, that would be something; but coming home on a cold March evening to a house that had suddenly grown old and sorrowful and tired, I knew that here in England were also two houses made desolate and that France could not be.¹²²

Similarly, Irene Rathbone's 'faithful and unromanticised story of women's war work',¹²³ which centred around three young women, Joan, Betty and Pamela,¹²⁴ depicts feelings of longing to be back in France. The central character 'Joan' is in London when the armistice is declared and writes to her friend Pam who is still in Rouen.

It was wonderful, in a way, being in those surging shouting crowds, but I wished - oh, how I wished - to be back with the British Army! If peace had only broken out while we were still in the Rest Camp what a time we would have had. But I mustn't think about it. It makes me too home-sick - I mean too army-sick.¹²⁵

Rathbone, demonstrates through her characters, that returning home was going to be difficult, but also that such feelings were transitory; 'the ending of the war *can* only be felt, at first, as the ending of a powerful and blessed drug'.¹²⁶ Once the initial 'shock' was over, she reflected, again through 'Joan', as to how she

¹²² May Wedderburn Cannan. *Grey Ghosts and Voices* (Kington: Roundwood, 1976) p. 147.

¹²³ Irene Rathbone. *We That Were Young*. (London: Chatto and Windus, 1932) p. vii.

¹²⁴ Elizabeth M. Delafield wrote, in the preface to Rathbone's *We That Were Young*, '(h)ere is one who has remembered. ...I am glad that Miss Rathbone has written her sober, accurate and moving account of those incredible years, seen from the angle of 1914's young womanhood...I believe that her contemporaries and mine will read it and remember.' p. viii.

¹²⁵ Irene Rathbone. *We That Were Young*. p. 408.

¹²⁶ *Ibid.*

would attempt to come to terms with these changes, and perhaps reveals how much contemporaries were cognisant of the various problems of repatriation.

With a sort of terror she envisaged her own life at home - the life to which she had looked forward for so many war years, and which now seemed to stretch bleakly before her, holding only memories. She would have to find something to do.¹²⁷

Wedderburn Cannan's comment, although resigned, also acknowledged, 'I had had no real 'training', I had no degree, and I was twenty-five'.¹²⁸

However, while Rathbone recognised that some women were resolute in their aim to overcome the feelings that came with this transition from war to home, others, she demonstrated, appeared unable or reluctant to make the change. Her character 'Joan', comments on her friend, 'Betty's', failure to 'unwind herself from the strings of war', for in the middle of January 1919 Betty went back to France to run a Y.M. hut among some troops that were awaiting demobilisation near Amiens. Wistfully Joan commented, 'to be working once more with the B.E.F. - still to be part of a machine - what content!'¹²⁹

It can be argued that Rathbone's voice, resonating through those of her fictional characters, is not one of a feminist, but that of a woman 'alienated' only because she is struggling to come to terms with a post war world that is unrecognisable to her. She is seeking acceptance from something she once knew and felt safe with, not, as is suggested by feminist historians arguments,

¹²⁷ *Ibid.* p. 425.

¹²⁸ Wedderburn Cannan. *Grey Ghosts and Voices*. p. 147.

¹²⁹ Irene Rathbone. *We That Were Young*. p. 424.

that she is an embittered and disillusioned women struggling against being marginalized once more by a male dominated society. Arguably there were many more men, but who were equally marginalized and Rathbone was aware of the changes that had taken place, changes that had not just affected, or were directed at, women, but that affected both men and women alike.

Pre-war interests had vanished almost as though they had never been; and the struggle for the Vote, which had been her special interest, no longer required to be pursued. ...But the war - officially over - still lingered on. The results of it were all around, distressing, insistent; and the men who for so many years had been heroes were now 'returned soldiers', a problem to their country, if not a bore.¹³⁰

Similarly, May Wedderburn Cannan appeared to recognise the difficulties that faced both men and women.

The battered remnants of the first seven divisions and the old Army; the bank clerks, the insurance men, the milk-roundsmen, [sic] the salesmen, the foremen and the men from the shop floor; ...the men who had survived the great push of the spring offensive of '18 were trimming the frayed ends of their shirt-cuffs, polishing their worn shoes and beginning to tramp the pavements looking for work. Not yet did they realize that there was no work, and that, if there were, it was not they who would get it. [...] "You must remember that you've lost four years" "Yes, yes, but things have changed". "Call next week, we might have something then". "It's the younger men we want".¹³¹

She, like Rathbone, sought a practical solution.

I was determined not to be dependent on father. [...] In any case I was too old. Too much had happened. I was too used to work because the work lay under my hand waiting to be done; and I did not want, above all I did not want, long hours in which to think.¹³²

¹³⁰ *Ibid.* p. 430.

¹³¹ Wedderburn Cannan. *Grey Ghosts and Voices*. p. 149.

¹³² *Ibid.* p. 147.

Historian's theories about this period of post-war disillusionment from women have suggested it is because of a longing for a return to the independence and freedom, found and realised in their wartime roles. For instance, the 'double helix' theory, put forward by Gilbert and Gubar,¹³³ would now be inverted yet again, and would ultimately see women returned to their 'pre-war' subordinated roles. However, I would argue that this view could be interpreted more simply as that of a common reaction to the demobilisation process, as both soldiers and nurses sought emotional security and safety in what they had been familiar with, which was, paradoxically, the strange intimacy that was part of being on the Western Front, and in their search for solace many, including nurses, campaigned for a 'club' of their own which demonstrated a desire to remain in contact with those they had served with. In 1920 Dowager Lady Airlie, Dame Maud McCarthy and Dame Ethel Belcher met to discuss 'a scheme for establishing a United Nurses Services Club [which was] a response to the wish expressed by nurses who worked in France to have such a club'.¹³⁴ This was not unlike many clubs and charitable organisations that were set up for male veterans such as the British legion.

For Vera Brittain, her feelings on returning home were that she found she was considerably intolerant of those around her once she returned home. She resented the Oxford students she lectured to who appeared singularly uninterested when she spoke of the traumas of war. Brittain reveals much about her experiences and perceptions of repatriation. She spoke of an

¹³³ S. Gilbert and S. Gubar. *No Man's Land*.

¹³⁴ *The Times*. (July 20th, 1920) p. 4.

Automatic existence', and of her decision to go back to Oxford, 'not because I particularly wanted to go back, for I was not conscious of wanting to do anything, but because college seemed the one thing left out of the utter wreckage of the past. [...] I could not remain blind to the hectic reactions of my generation, frantically dancing night after night in the Grafton Galleries, while pictures of the Canadian soldiers' wartime agony hung accusingly on the walls.'¹³⁵

Her resigned and fatalistic tone evident in the comment

Returning in April 1919, 'taking home with me a legacy of rough hands and swollen ankles [to the] spring of life after the winter of death [...]. A future not without its dreads and discomforts, but one in whose promise we had to believe, since it was all some of us had left to believe in'.¹³⁶

Her rhetoric might be described as both emotive and symptomatic of the traumatic experiences often associated with war veterans, further confirmed by comments such as

Not having anyone left with whom to dance, I spent most of the blank and rather frightening days between leaving Millbank and returning to Somerville in roaming about London with a demobilised and erratically jubilant Hope Milroy, and in meditating, as the differences between our war and peace-time preoccupations forced themselves upon my mind, on the problems of an unaccompanied civilian life. How would the War ultimately have affected me? I wondered, looking with dull eyes in to a singularly empty future, which seemed capable of being filled only by individual efforts that I did not feel in the least inclined to make. The immediate result of peace - the cessation of direct threats to one's personal safety - was at first almost imperceptible, just as prolonged physical pain which has turned from acuteness into an habitual dull ache can cease altogether without the victim noticing it has gone. Only gradually did I realise that the War had condemned me to live the end of my days in a world without confidence or security.¹³⁷

¹³⁵ Vera Brittain. *Testament of Youth*. pp 467 - 468.

¹³⁶ *Ibid.*

¹³⁷ *Ibid.* p. 469.

The returning veteran often found it difficult to relate to those at home. The experiences they endured and witnessed during warfare cannot be adequately conveyed in words to those who have not witnessed the same. Consequently, it was not unusual for a void, or for misunderstanding to exist between the veteran and those who stayed at home during the war. Unable to adequately 'communicate' their experiences of war, the relationship might become strained, or even hostile. The discourse contained in the case studies of nurses between their relatives and friends suggest a variety of responses. For example, this letter from a seemingly distraught husband to the Director General of Medical Services (DGMS) in 1930, regarding his wife suggests a degree of difficulty based on the void that the war had created between them, and arguably his inability to comprehend her experience and resulting condition.

I regret that I have to reopen this matter to ask you to consider (a) making Mrs. Donovan's pension permanent and (b) increasing the amount thereof. I would also be glad of any advice you can give me as to how I can cope with a difficult situation.

Mrs. Donovan's disability takes the form of an abnormal attitude of mind and it makes it impossible for me to earn a living whilst I live with her. A year ago I secured an appointment here and I think I can say I was doing well, as my employers paid my wife's fare here (£97.0s.0d) a few months ago. This, I am told, is most unusual in the case of men on their first contracts. Since Mrs. Donovan's arrival I have been unable to do my work and I am continually being involved in situations, which make my employers consider me an idiot. In fact I am given to understand that I am now regarded as unsatisfactory. I append a cutting from a letter from my brother, (Rev. M. Donovan, All Saints Vicarage, Kennington Park, SE11) from which you will see that Mrs. Donovan's most peculiar unhinged behaviour causes people to question my sanity. The whole thing seems a deadlock. For if I tell my employers that Mrs. Donovan is suffering from a War disability which places me in curious situations (& if they believe this) there is the probability that they will cease to employ a man who tells them, in effects, that he cannot be depended upon for punctuality and work.

Please have the kindness not to advise Mrs Donovan of this communication. I am not prepared to withstand the disgusting scene which would ensue should she be informed that I have written to you. Incidentally, you will see that I have the interest of Mrs. Donovan and her child at heart when you understand that, since 1921, I have paid £36 per annum for a Widow's and Orphan's Insurance and shall continue this payment as long as I can do so.¹³⁸

Nurse Donovan served twenty-one months as a VAD with the British Red Cross Society. During this time she suffered an accident when she was thrown from a car in Salonika on 14th March 1918 and sustained a fractured right 'frontal bone'. She was off work for two months and complained of 'headaches and debility'.¹³⁹ She contracted Malaria and complained of neuralgia, which was worse in 'changeable weather and when worried'.¹⁴⁰ She also suffered from 'insomnia and nightmares'.¹⁴¹ A Medical Board for Nurse Donovan in June 1920 recorded

States condition is variable since last board. 'sometimes better, sometimes worse'. Complains of, 1. easily tired, 2. twitching of the face, 3. lacks concentration, 4. mind wanders at times, 5. easily upset, 6. sleep delayed and broken by stupid dreams. Physical condition - fine tremor of hands, KJ++, Pupils N (Normal). Mouth in order, tongue clean, P (pulse) 104. Mentally - wept freely at exam, introspective, apprehensive and depressed. Disease attributable to service. Stress of service.¹⁴²

The evidence from this case suggests that Nurse Donovan's husband may have found it difficult to relate to the experiences she had encountered during her services as a VAD with the Red Cross Society, a role that took her to

¹³⁸ NA PIN 26/20053 Nurse L Donovan.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.*

¹⁴² *Ibid.*

Salonika. Arguably, the rigid gender stereotypes apparent in pre-war Edwardian society would perhaps have led Mr. Donovan to expect his wife to return to her former role. However, the element of indifference, or even hostility, seen in this case contrasts with that seen in the case of Nurse Mary Cleverly.

The case of Mary Cleverly, mentioned previously in chapter three, illustrates the extent to which friends and relatives were involved. Miss Cleverly was a certificated nurse who worked before, during and after the war for a total of 7 years. She enlisted in 1915 with the TFNS and worked 'at home' before being declared '..Fit for Active Service in a hot climate' and sent to Salonika in February 1917. She was aged 31 years old when she was demobilised in the March of 1919 having recently served in Salonika.

In 1929 a claim for a pension was made on her behalf, by her sister, on the advice of the Joint Nursing and V.A.D. Services Committee of the United Services Fund. The secretary of this committee forwarded to the Ministry of Pensions some particulars relating to this nurse.

This lady was employed at the Fifth London General Hospital, August 1915 to February 1917, and with the Mediterranean Expeditionary Force, Salonica, [sic] from February 1917 to March 1919.

She returned to work at her Training School, St. Thomas's Hospital, on demobilisation, and in February, 1920, whilst on duty, had an attack of acute mental disorder, necessitating removal to Bethlehem [sic] Hospital.

The Nurse is able at the present time to do light work, but is unable to undertake any responsible position. She is easily tired, and easily excitable. (Also) [f]rail. Suffers from slight enlargement of the Thyroid. Heart reg. 100. B.P. 180/90.

Dr. Wauchope [...] recommends that the candidate should lead a regular and sheltered life. It is stated that the breakdown in 1920, is a sequel to attacks of Malaria in Salonica, [sic] and I am to

request that this case may receive consideration by the Ministry of Pensions¹⁴³

Miss. Cleverly's former Matron at St. Thomas's writes,

After a holiday Miss. Cleverly returned in August 1919 to St. Thomas's Hospital (No. 5 London (City of London) General Hospital and worked in the ward for Limbless Officers. It would appear that she was put on light duty and there was no overstrain, but she showed increasing desire to avoid responsibility and this became much more marked during the month of February 1920. On February 23rd she reported sleeplessness, and was on the Nurses' Sick Floor. On February 25th, she was transferred to Christian Ward and on February 27th to Bethlem Hospital. The report on her transfer was "Shell Shock, Hallucinations; Delusions accompanied by considerable violence. Acute insomnia. Refusal of food. Threats of suicide."¹⁴⁴

Miss Cleverly's sister responded thus. 'I presume there is no questioning the fact that the accumulative effect of her Army Service at home and abroad caused the original physical and mental breakdown?'¹⁴⁵ adding that 'this would seem to be established as prior to mobilisation her record was proved to be that of a normally healthy person'.¹⁴⁶ Miss. Cleverly's sister further emphasised her views regarding her sister's 'diagnosis' after the submission of yet more evidence.

I presume there is sufficient medical evidence to prove the initial breakdown was caused by shell shock - due to service in the Great War?¹⁴⁷

Nurse Cleverly's case demonstrates how her relatives were prepared to accept, or at least not question, firstly the label of shell shock and secondly the

¹⁴³ NA PIN 26/ 20035 Nurse Mary Cleverly.

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*

likelihood of her having endured extreme conditions as a nurse. Nurse Cleverly's family clearly committed themselves to the battle to secure some assistance from the Ministry of Pensions. Whether this was in response to the need to secure recognition of their sister's plight or whether it was to secure some financial benefit is, of course, debatable. It remains however, that some women who returned from the war were single and would look to the help and assistance of their families, both socially and financially. For the family this responsibility may have been a burden and it may therefore have been in their interests to secure financial help. Relatives often wrote letters of support to family doctors, to the local and central government offices in charge of war pensions, and to charitable organisations; generally, anyone who would listen. Prior to the introduction of pensions for women's war service it was more accepted that families would take on the responsibility of caring for the returning women but the availability of additional funds via a pension may have prompted a different view. Rather than assume overall responsibility for their female relatives the possibility of securing additional funds through the form of a pension, meant families were able to support their female relative in pursuing an independent life. In general families appeared largely sympathetic and provided support where possible.

Likewise, many single women who returned from war did not have families for whom to turn for support and the possibility of a war pension provided a valuable means of income. Furthermore these women had achieved a level of independence through their war experiences, which many wished to retain. Being provided with an income via a war disability pension enabled this

to continue. How far symptoms were 'embellished' by some in order to secure a disability pension is questionable, but the evidence of an equal number of cases suggests that financial compensation was an inadequate substitute for good health. For instance, the long-term effects of war experience was evident in the cases of nurse Eileen King, who, mentioned previously in chapter two, was still recalling her experiences some twelve years later. She had, in November of 1917 been in an air raid when 'four bombs fell [...] killing and wounding over 100 soldiers'.¹⁴⁸

I still picture the scene in unguarded moments and at such time am always greatly upset even though twelve years have passed.¹⁴⁹

She returned home to Australia in July 1919.

In very poor health - in fact I was very sick. I saw Dr. Syme who gave me permission to visit my people in Brisbane. I remember that my appetite was poor because it has been so ever since I was wounded. I suffered with gastric trouble and occasional pain and treated myself by starvation methods, but I considered my condition to be part of the nervous effects caused by my past experiences, and did not worry a great deal. Late in 1919 I was an inmate of Caulfield Hospital.¹⁵⁰

Others, however, were to find more extreme ways of coping. Nurse Nellie Haigh enlisted with the Territorial Forces Nursing Service in January 1917. Nurse Haigh had contracted influenza in November 1918 but had also complained of being 'run down' for some months previous 'due to excessive night work'.¹⁵¹ Her records state that in 1920 she complained of 'attacks of

¹⁴⁸ NA PIN 26/20141. Eileen King.

¹⁴⁹ *Ibid.*

¹⁵⁰ *Ibid.*

¹⁵¹ NA PIN 26/20089. Nellie Haigh.

suffocating lasting about half an hour.’¹⁵² Her records describe her as being ‘very irritable, sleeps badly, dreams with a manifest content, pain in back (of) neck, was always highly strung, but more so since service. Appearance pallid and rather nervous’.¹⁵³ Miss Haigh’s symptoms continued to deteriorate and the following year was to include, ‘trembling attacks, memory improving, concentration poor, [...] has frequent fits of temper and has to seek solitude to ‘have it out’’.¹⁵⁴ In 1934 she was admitted to hospital and diagnosed with ‘Alcoholic Psychosis superimposed on Psychasthenia’ and her symptoms now included, ‘disturbance for time and place, excitable, delusions at times, no definite hallucinations. Continual yearning for alcohol.’¹⁵⁵ A summary of her condition included, ‘she was a nurse during the war and then she had several breakdowns as she found the strain too much.’¹⁵⁶ She admitted to taking ‘a little alcohol to procure sleep’.¹⁵⁷

Alcohol was not the only substance used to alleviate problems. Nurse J Hunter served as a staff nurse in the QAIMNS(r) for one and a half years and was demobilised in November 1917. The cause of her disability was given as ‘Strain of Nursing’ and ‘Melancholia with Delusions’.¹⁵⁸ Miss Hunter’s problem began with pains in her back and she was ‘unfitted for duty’. In 1919 there was ‘no curvature and no pain [...] now suffering from Delusional Insanity’. Further examinations prompted the doctor to write, ‘fine tremors of eyelids, face and

¹⁵² *Ibid.*

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid.*

¹⁵⁸ NA PIN 26/20120. J Hunter.

hands, [...] attacks of extreme depression accompanied with intense headaches'.¹⁵⁹ Five months later she was still complaining of, 'nervousness and feeling as if something was going to happen' and her symptoms continued in the same manner for several years. As late as 1939 her condition was causing some considerable concern as evident in a letter contained in her records.

With regard to the recommendation for treatment, this is a matter of some difficulty as the lady is extremely averse to being examined. The doctor visits her thrice weekly, but so far as I could ascertain no treatment of a special character is being carried out, the chief exhibition being morphia. The lady is still having a half-grain of morphia every three hours; whether this is necessary I am quite unable to say.¹⁶⁰

In summary, the role of medicine within the Ministry of Pensions was integral to the rehabilitation of both soldiers and nurses alike. Whilst one of its functions was to provide monetary compensation it was also important in the overall rehabilitation, medically and socially, of veterans, male or female. It has been made clear in this chapter, through contemporary medical opinion, that suffering incurred during war service did not always cease with the armistice as veterans seemingly struggled to come to terms with their experiences. The pension system, as it existed, required that regular medical examinations were held in order to ascertain whether an award be offered in the first instance and then, at subsequent intervals, if it should be continued. While Bettinson has argued that some claimants were far from the 'lost soul' in this system or 'house of restoration',¹⁶¹ it is the opinion of this thesis that for both nurses and soldiers alike the process that was the regular medical board could either alleviate or

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.*

¹⁶¹ Helen Bettinson. 'Lost Souls in the House of Restoration'. p. 4.

complicate their suffering, and whilst nurses, like their soldier counterparts, could see some advantages of manipulating the system, there were those who, on the other hand, had clearly suffered, also like their male counterparts, and indeed did so for many years after.

Conclusions

The chapter concludes with several findings. First, there was considerable foot dragging in relation to bringing nurses into the pensions system, for, despite concern being voiced early on in the war, through benevolent individuals, charities, voluntary agencies, and nursing organisations, pensions for nurses were not made a Statutory Right until 1st April 1920, a full two years after questions were raised in parliament. However, to argue that this was a discriminatory move against the nurses is difficult, for despite there being some provision for soldiers prior to 1914, *their* right to a pension was not made Statutory until August 19th, 1919. Questionably, the delay was ultimately due to the complex and protracted way in which the system was established.

Once the issue of compensation for nurses had shifted, from one of charity to that of formal and legal recognition of their rights through the Royal Warrant in 1920, they were then subject to all the problems and complexities of that system. Entrance to the Ministry of Pensions as a claimant would mean the beginning, for some, of a long and intriguing relationship.

The Medical Boards at the Ministry of Pensions had an integral role to play and staff saw themselves as the gatekeepers of the system. The Boards,

based on the philosophy and policies of Sir John Collie, alongside the need for government economic stringency, had a reputation for harsh decisions. Claims, based upon medical symptoms, could be awarded, or rejected, in an arbitrary, subjective and inconsistent fashion, which many accepted unquestioningly. Similarly, there were some individuals who were aware of the vagaries inherent within the Ministry of Pensions' so-called system, and these claimants, soldiers and nurses alike, would take the opportunity to negotiate and manipulate the system, through exaggeration and amplification of their symptoms. For the most part it seemed that nurses were compensated or remunerated comparatively well, but some inevitably would receive very little in relation to what they had actually suffered, or in comparison to others. Doctors too, while employed by the Ministry for their expertise, would also find themselves subjected to the system and in some cases see their decisions over-ruled.

Nurses, like soldiers, had to contend with the complicated, somewhat inept, system of demobilisation that incorporated and necessitated involvement with various different groups and agencies such as central and local government, charities and the medical profession, who all sought to 'control and benefit from the restoration of Great Britain's disabled ex-servicemen'.¹⁶² They were required to maintain, or indeed were forced to maintain, their independence and returned to work, while others were aided and supported in their return to employment. Others, however, had to rely on the support of family and friends, whose attitudes could either complicate or alleviate the transition from war to home.

¹⁶² Helen Bettinson. 'Lost Souls in the House of Restoration'?

Ultimately, it is difficult to arrive at the view that nurses were treated unfairly in their pursuit of compensation for their war experiences in the form of a pension, or were subjected to prejudices en masse as a result of their gender. Inconsistencies, insensitive decisions, were the result of problems inherent in the pensions system that affected everyone.

The period of demobilisation and the transition from life at war to life at peace is a difficult one for both men and women. This period is not particularly influenced by gender, as both the soldiers and nurses encountered similar problems. They both endured extremes and witnessed sights that were difficult to comprehend for themselves, let alone explain or share with those who had little or no understanding. They had to rebuild relationships, find work, and find ways to cope with a world that was vastly different from that leading up to 1914. Added to these problems, for many, was the concern of dealing with illness brought about by the experience of being a part of that war.

There is little doubt that many women who served alongside the BEF during the First World War experienced considerable suffering as a result of their involvement, not only during the war years as they worked as nurses and VADs, but after the war as they relived their experiences and coped with physical and psychological injuries. Their suffering may have been complicated by their gender, for once the initial transition to home had passed they then had to face the varied responses of both loved ones and external agencies and organisations in their fight to have their war experiences acknowledged and recognised. This response by some relatives was influenced by the view that

the woman's war experience was reputedly not the same as that of the men's and therefore could not have the same cause for complaint as the men. Equally, their need for re-employment was not seen to be as great as it was for men.

Nurses, like soldiers, struggled to come to terms with the illnesses they had as a consequence of their war experiences. Suffering with neurasthenia, or DAH, as well as other diagnoses that came under the rubric of war neuroses, they had need for frequent recourse to medical services. The response from a sensitive and experienced doctor could, arguably, serve to aid recovery or conversely, would prompt the extension of symptoms. The lack of expertise and experience of the conditions per se and not the fault of any particular individual or group questionably influenced the problems. The extreme coping strategies of some was representative of the inadequate knowledge on the part of all concerned as nurses went on to resort to the substances of alcohol and drugs to alleviate symptoms and distress. These nurses would be beleaguered by long periods of ill health, consumed as they were, by traumatic and invasive memories, or symptoms of enduring war neurosis. For some the physical and psychological conditions were transitory, for others the search for a recognisable 'normality' took longer, if it arrived at all.

CHAPTER FIVE

Conclusions

Within a few months of the start of the First World War, the military, the field of medicine and society in general were faced with a mysterious new phenomenon. Volunteer soldiers began presenting with bizarre, unexplained symptoms thought to be the result of front line and specifically, trench warfare. It escalated to extreme proportions within a very short space of time, giving rise to consternation significant enough to prompt questions amongst the military and the medical authorities. Occurring, as it did, within this heavily gendered society, where perceptions of strength, bravery and heroism were personified in the volunteer soldier, to see such large numbers of men 'break down' mentally and succumbing to the fear of combat was almost an abomination. In an effort to make sense of this the term 'shell shock' emerged.

The term, shell shock, very aptly described, for our Edwardian contemporaries, the symptoms and the behaviour that was being seen in soldiers, whilst at the same time preserving their masculinity. Accordingly, the trauma of fighting in the trenches where soldiers were exposed to the risks of shellfire, necessarily led to the symptoms of shock. It became a term that was to encapsulate all that was horrific about trench warfare and the horrors of the First World War per se. It therefore became a term that truly embedded itself in the public consciousness and one, which in turn, would persist throughout the twentieth century.

Furthermore, this view has existed for several decades and to date has been uncontested by historians. To suggest, therefore, that women suffered from shell shock has been a considerable challenge and one that has met with both surprise and scepticism, for such is the potency that accompanies the nuances of the word. However, ultimately this was made considerably easy by the discovery of a number of medical records that confirmed nurses and female voluntary aid detachments suffered as a result of their war experience in the form of a war neurosis, as it was also called, with the added affirmation that some of these were referred to as shell-shocked.

In an effort to understand the importance of what was being presented by the finding of these records it became necessary to re-examine the literature, not only of the traumatic neuroses of the First World War, but also of the place of women within this war. Questions had to be re-asked firstly about their geographical location and exposure to danger, for the notion continues to exist that women, even nurses, were protected from the worst horrors of the fighting. This argument of women being in a privileged and safe position has long persisted, even to the extent that in an effort to explain the content of some women's war accounts, feminist historians have promoted the idea that women 'borrowed' their experiences from the men in order to feel a part of the war. Research, however, would have concluded that this experience need not have been 'borrowed' for the nurses' experiences were as real as any soldier's.

Additionally, the terminology used to describe the 'forward' and 'rear' areas of the Western Front has been consistently ambiguous. Standing as the

metaphors for 'dangerous' and 'safe', they intimate at clearly defined boundaries, compounded by the notion that warfare during the First World War was static. Trenches, commonly thought of as places of mud, blood and vermin, have been shown to be, by revisionist historians, places that could exist outside of these horrors. Furthermore, in terms of defence, trenches offered a form of safety that was not available on open ground. Moreover, advances in technology fostered advances in weaponry and in the way the fighting was conducted, which meant the most forward areas were not always the most dangerous places to be. Trench positions did alter and this is highlighted by the fact that Casualty Clearing Stations frequently had to be moved so as to be out of the line of fire when the forward lines had to retreat.

The male and female experience cannot be directly compared but while nurses did not fight in trenches, equally men were not in the trenches all of the time. The horrors that reputedly existed in the trenches, and this is not to say they did not exist, for some locations were consistently bad, were comparable with the horrors that faced nurses as medical personnel. Nurses were subjected to and expected to deal with some of the worst sights and sounds of that the war was to create. Unimaginable wounds and injuries, left suppurating through lack of effective medical resources, were left to the inadequately trained nurses and VADs. Added to this, nurses frequently carried out their duties under extreme conditions, conditions that left them exhausted and prone to illness themselves.

Furthermore, in the course of their nursing duties, women received gun shot wounds, and wounds from shellfire and aerial bombardment, which were sufficient to lead to the types of symptoms seen as shell shock. While some of the problems arose from being injured, extreme tiredness and overwork, infection, the stress and strain of seeing and hearing the wounded and not being able to care fully for their patients, led some to suffer psychologically.

The argument that women did not suffer from shell shock is weakened when considered within the framework that contemporary medical authorities used to understand and explain the condition. Deconstructing the way in which medical contemporaries sought to understand the term means not only has it been possible to relocate the place of women within the history of war neuroses and shell shock, but difficult to appreciate why they have been omitted at all.

The framework with which contemporary medical authorities came to understand shell shock is an interesting one. By and large, it was understandable, but nevertheless, intriguing, that there were various views as to its aetiology during the early years of the war. As a condition it was not unheard of in former conflicts and ostensibly the overriding concern came not only from its sheer volume of numbers, but also from the notion that it fitted well with the bio-medical approach popular before 1914. However, the panic it was to create amongst the military, the general population, and, amongst the soldiers themselves ballooned to epidemic proportions. Control was quickly regained by doctors and medical authorities, who, in the process of seeking explanations revealed that what they were seeing was nothing new. To allay

the panic the term shell shock was frowned upon and actively discarded in favour of other, more familiar, terms, such as neurasthenia.

Surprisingly, historians have acknowledged this conceptual change without acknowledging the link to non-combatant sufferers, or indeed women. Ian Whitehead, in 'The British Medical Officer on the Western Front'¹⁶³ summarises.

Medically speaking, the term was inaccurate and extremely damaging, as it suggested a causal connection between the effects of a shell explosion and the development of neurotic symptoms, which, in the majority of cases did not exist. In fact, there was no need for a new term, because the symptoms, which emerged under the emotional stress of war were virtually identical to those already known in civil life. Once this became apparent, doctors with previous experience of treating psychiatric cases were able to correctly classify the various disorders, which comprised emotional shell shock.¹⁶⁴

Similarly, Peter Barham adds,

Shell shock became less the marker for a specific condition, or set of conditions, than for a wide-arching perspective affirming the emotional origins of mental disturbances.¹⁶⁵

Barham continues,

The problems of shell shock were not in the least unprecedented, but simply the eruption under circumstances that inevitably threw them into prominence of regular problems of 'nervous breakdown' that were entirely familiar to those who had been willing and able to recognise them.¹⁶⁶

Ted Bogacz has also stated how 'concussion from exploding shells was the earliest remarked cause of war neurosis' but

¹⁶³ Ian Whitehead. 'The British Medical Officer on the Western Front'. p. 173.

¹⁶⁴ *Ibid.*

¹⁶⁵ Peter Barham. *Forgotten Lunatics*. p. 151.

¹⁶⁶ *Ibid.*

Of far greater consequence, however, was the strain of serving in the inhuman conditions of trench warfare and the exhaustion which followed from the soldier's inability to obtain sleep in the line. The witnessing of the mutilation or annihilation of a comrade often produced cases of severe shock.¹⁶⁷

As the condition became more and more understood by contemporaries, other terms more familiar to medical authorities were favoured. Soldiers and nurses psychologically injured in the course of their war duties were labelled with the term neurasthenia, as well as other labels under the umbrella of war neurosis. In this there was recognition and validation of the conditions for women alongside their male counterparts. For medical authorities, as well as other agencies, theories and dialogues were extended to include the cases of the nurses who worked amid the fighting.

However, the term shell shock remained the preferred 'popular' terms and has similarly remained in the popular consciousness to this day. 'Shell shock helped people conjure up the long-term effects of the war service. Everyone understood the war to be traumatic, but struggled to find the appropriate language in which to express this. Shell shock became a very apt term because it denoted a violent physical injury albeit of a special kind. That injury was validated by the term, enabling many people and their families to bypass the stigma associated with terms like 'hysteria' or 'neurasthenia'

¹⁶⁷ Ted Bogacz. 'War Neurosis and Cultural Change. p. 233.

connoting a condition arising out of psychological vulnerability. Shell-shock was a vehicle at one and the same time of consolation and legitimation.¹⁶⁸

However, while the problem became, marginally, more tolerable by giving it a name that served to preserve the masculine ideal, for contemporary doctors and medical authorities the term met with derision. This was because once they explored the condition further it held no aetiological mysteries. The symptoms of this apparently new syndrome were no different to those seen in various other disorders that had existed long before the war of 1914 - 18. The argument that medical authorities, supported by the military, actively discouraged the term in an attempt to regain some semblance of order and control is accepted. However, this thesis would assert, in line with contemporary medical authorities, that, as a medical diagnosis, the term held no virtue.

Of similar particular interest was the diagnosis known as Disordered Action of the Heart. It represents a fascinating picture as it was similarly dogged by the same history and controversy as 'shell shock'. It raised sufficient concern and consternation amongst military authorities to prompt yet another inquiry and it sought the expertise of medical experts. DAH essentially stood as the diagnosis for those who had received and encountered the horrors of warfare without being in a trench. It accounted for the breakdown through extreme conditions, from physical illnesses, and from the stress and strain of warfare.

¹⁶⁸ Jay Winter. 'Shell-shock and the Cultural History'. p. 9.

Yet crucially it was acclaimed, and strongly, as a 'soldier's malady', even though a significant proportion of nurses were labelled as such.

In attempting to explain the high incidence of DAH amongst nurses it is argued that the term DAH became the accepted discourse with which some medical authorities were able to describe the plight of women. Notwithstanding the view amongst medical authorities that shell shock 'did not exist', it is the opinion of this thesis that DAH became the condition for a non-combatant, and therefore more suitable for a woman who served alongside the military. Since it was later accepted that nurses were very much a necessary part of the military structure and for some the role was to lead to psychological distress the term DAH was best suited to describe their conditions.

Once the soldier had fallen sick, it was necessary to care for and treat him with the aim of returning him to duty, and this meant returning him to face further injury or even death. This presented as a dilemma for doctors, some of whom had been recruited from civilian society. The military structure accommodated for the care and treatment of soldiers through an elaborate network, which began with Regimental Aid Posts through to Base and Stationary Hospitals that extended from the forward areas through to the home fronts.

The same, however, was not immediately present for nurses and care had to be provided for, initially, by benevolent individuals or by the nurses themselves. A network of treatment centres had established itself by the end of

the war, although arguably more by accident than design. The treatment of nurses when they fell sick occupies two extremes. On the one hand, when in the field, acceptance of sickness was 'frowned' upon, largely by the individual who fell sick, because she felt she was letting her colleagues down and was not honouring her status as a 'nurse. This arguably led to increased pressure to remain on duty whilst ill and which for some would ultimately had an adverse affect. However, this is not to suggest that the treatment they received at the hands of military and civilian doctors was secondary. For, once forced to go off duty as sick, the medical records of nurses suggests they were treated well and in some cases every care and attention was afforded them. This may in part be due to the fact nurses were given 'officer' status.

Sickness could be severe enough to warrant discharge or retirement from nursing duty. Whether discharged, retired or demobilised, nurses were slow to be subsumed in to the minefield that was to become the Ministry of Pensions. The problems of repatriation were of considerable concern for the government before the end of the war. These were to be addressed through the creation of the Ministry of Pensions. For nurses, the responsibility fell to a concerned few, and provision was made on a charitable basis initially. Inclusion in to the system set up by the Ministry of Pensions did not incorporate nurses until two years after the end of the war. The problems faced by the Ministry of Pensions were on such a grand scale and were so profound, further exacerbated by its own complicated bureaucratic and administrative framework, that to suggest that this late inclusion of nurses was evidence of preconceived bias is, perhaps, unreasonable.

However, with inclusion to the Ministry of Pensions system came inclusion into its complexities and peculiarities. Assessment of eligibility for pension from the Ministry of Pensions was through medical examination, further complicated by the need to establish whether the condition was attributable to or aggravated by war service. The Ministry would prove to be omnipresent in its decision to withhold pensions from those it felt to be 'undeserving' and because it was subject to strict inter-war economic policies. Similarly, the Ministry's Medical Boards were made up of an eclectic mix of doctors, coming as they did from civilian and military backgrounds and with different areas of expertise. Therefore decisions to award, or not to award, a pension, along with treatment could be inconsistent and arbitrary.

In the aftermath of war, wrapped up as it was with the Ministry of Pensions and its complex policies and procedures, it is easy to lose sight of the individual. Few studies exist that explore the plight of the male war veteran from the First World War, and to date, none exist which examine that plight of the First World War nurse in her effort to return to some semblance of normality. There is a sense in which everyone who returns from war is psychologically affected. The degree to which some recover more than others can be dependent on many factors, both internal and external, and peculiar to the individual concerned.

This thesis has challenged the long held assumption that shell shock is a masculine affliction. As a result of the findings produced in this thesis it is felt that women nurses should be included in the category of trauma sufferers from

the First World War since their involvement in the battle zone means their experience of war trauma is validated both conceptually and materially. The nurses who served in this war did not have to make concerted efforts to be recognised for their involvement, as argued by certain historians. Evidence for this comes in the form of comments made by their contemporaries, who clearly accepted and acknowledged their plight. Their treatment, though tardy in political and administrative terms, at the medical level shows little evidence of gender bias on the part of the medical authorities. The resistance of the popular mind of subsequent generations to conceive of women as suffering from shell shock is largely the result of the influence of cinematic and literary representations, resulting in the history of shell shock as one that has been subjected to a metaphorical dimension, and one that has excluded women. This thesis has challenged this and has attempted to redress the imbalance.

APPENDICES

1. Scale of Disability Pensions Awards. Source: Wilkinson Sherren. *The Rights of the Ex-Service Man and Woman*. (London: L. J. Gooding, 1921) pp. 12-13.
2. The Royal Warrant of 1st April 1920.
3. Army Form Z. 22. 'STATEMENT AS TO DISABILITY'. (NA PIN26/20027 Florence Cattell)
4. Army Form A. 45. 'PROCEEDINGS OF A MEDICAL BOARD. (Officers and Nurses.)' (NA PIN 26/20027 F A Cattell).
5. 'REPORT OF MEDICAL BOARD ON OFFICER OR NURSE Claiming Disability in Respect of Service in the Great War.'. M.P.O. 44. (NA PIN 26/20027 Florence Cattell).
6. 'PENSIONS APPEAL TRIBUNAL.' (NA PIN 26/20125 Annie Jerrett).
7. Pensions Appeal Tribunal (Entitlement) Form M.P.O. 79. (NA PIN 26/20125 Annie Jerrett).
8. 'Deaths of Nurses and VADs Reported on Service between 4th August 1914 and 1st April 1920.' Statistics of the Military War Effort of the British Empire during the Great War, 1914 - 1920. Published by the War Office. London: HMSO. (1922)

1. Scale of Disability Pensions Awards. Source: Wilkinson Sherren. *The Rights of the Ex-Service Man and Woman*. (London: L. J. Gooding, 1921) pp. 12-13.

Degree of Disablement	Specific Injury	Proportion corresponding to Degree of Disablement	Disablement Pensions according to rank*					
			Warrant Officer Class I	Warrant Officer Class II., or N.C. Officer, Class I.	N.C. Officer, Class II.	N.C. Officer, class III.	N.C. Officer, Class IV.	Private etc., (Class V.)
1.	Loss of two or more limbs Loss of an arm and an eye Loss of a leg and an eye Loss of both hands or of all fingers and thumbs Loss of both feet Loss of a hand and a foot Total loss of sight Total paralysis Lunacy Wounds, injuries, or disease resulting in disabled man being permanently bedridden Wounds of or injuries to internal, thoracic, or abdominal organs, involving total permanent disabling effects Wounds of or injuries to head or brain involving total permanent disabling effects, or Jacksonian epilepsy Very severe facial disfigurement Advanced cases of incurable disease	Per Cent	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.
		100	60. 0	53. 4	50. 0	46. 8	43. 4	40. 0
2.	Amputation of right arm through shoulder	90	54. 0	48. 0	45. 0	42. 0	39. 0	36. 0
3.	Amputation of leg at hip or below hip with stump not exceeding 5 inches in length measured from tip of great trochanter; of right arm below shoulder with stump not exceeding 6 inches measured from tip of acromion; or of left arm through shoulder Severe facial disfigurement Total loss of speech Lisfranc operation, both feet.	80	48. 0	42. 8	40. 0	37. 4	34. 8	32. 0
4.	Amputation of leg below hip with stump exceeding 5 inches in length, measured from tip of great trochanter, but not below middle thigh; of left arm below shoulder with stump not exceeding 6 inches measured from tip of acromion; or of right arm below shoulder with stump exceeding 6 inches measured from tip of acromion, through elbow, or below elbow with stump not exceeding 5 inches measured from tip of olecranon. Total deafness	70	42. 0	37. 4	35. 0	32. 8	30. 4	28. 0
5.	Amputation of leg below middle thigh, through knee, or below knee with stump not exceeding 4 inches; of left arm below shoulder with stump not exceeding 6 inches measured from tip of acromion, through elbow, or below elbow with stump not exceeding 5 inches measured from tip of olecranon; or of right arm below elbow with stump exceeding 5 inches measured from tip of olecranon	60	36. 0	32. 0	30. 0	28. 0	26. 0	24. 0
6.	Amputation of leg below knee with stump exceeding 4 inches; or of left arm below elbow with stump exceeding 5 inches measured from tip of olecranon.	50	30. 0	26. 8	25. 0	23. 4	21. 8	20. 0
7.	Loss of vision of one eye Loss of thumb or of four fingers of right hand Lisfranc operation, on foot	40	24. 0	21. 4	20. 0	18. 8	17. 4	16. 0
8.	Loss of all toes of both feet above knuckle	30	18. 0	16. 0	15. 0	14. 0	13. 0	12. 0
9.	Loss of thumb or of four fingers of left hand, or of three fingers of right hand Loss of two fingers of either hand Loss of all toes of one foot above knuckle Loss of all toes of both feet at or below knuckle	20	12. 0	10. 8	10. 0	9. 4	8. 8	8. 0

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2. ROYAL WARRANT for the RETIRED PAY OF OFFICERS (ARMY) DISABLED, AND FOR THE PENSIONS OF THE FAMILIES AND RELATIVES OF OFFICERS DISABLED, AND FOR THE PENSIONS OF NURSES DISABLED AND OF THE RELATIVES OF NURSES DECEASED, IN CONSEQUENCE OF THE GREAT WAR. (London: HMSO, 1920) [cmd. 811]

ROYAL WARRANT

FOR THE

RETIRED PAY OF OFFICERS (ARMY) DISABLED, AND FOR
THE PENSIONS OF THE FAMILIES AND RELATIVES
OF OFFICERS DECEASED, AND FOR THE PENSIONS
OF NURSES DISABLED AND OF THE RELATIVES
OF NURSES DECEASED, IN CONSEQUENCE OF
THE GREAT WAR.

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1920.

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ROYAL WARRANT

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FOR THE PENSIONS OF THE FAMILIES AND RELATIVES OF
OFFICERS DECEASED, AND FOR THE PENSIONS OF NURSES
DISABLED AND OF THE RELATIVES OF NURSES DECEASED,
IN CONSEQUENCE OF THE GREAT WAR.

GEORGE R.I.

WHEREAS We deem it expedient to make further provision concerning the retired pay of officers disabled, the pensions of the families and relatives of officers deceased, and the pensions of nurses disabled and of the relatives of nurses deceased, whose claims arise in respect of service during the Great War (hereinafter referred to as "the war") and to provide for their administration by Our Minister of Pensions (hereinafter styled "the Minister") in accordance with the Ministry of Pensions Act, 1916:

OUR WILL AND PLEASURE IS that as from the 1st day of April 1920, the provisions of this Our Warrant shall take effect in place of the provisions of Our Warrant of the 1st August 1917, concerning the retired pay of officers disabled and the pensions of the families and relatives of officers deceased, and the pensions of nurses disabled, in consequence of the war and that this Our Warrant shall, except in the cases stated in the Warrant of Her Majesty Queen Victoria of the 27th October 1884, and except as otherwise provided by Statute, be established and obeyed as the sole authority in the matters herein treated of, and that the Minister shall, subject to the provisions of the War Pensions (Administrative Provisions) Act, 1919, be the sole administrator and interpreter of this Our Warrant, and shall be empowered to issue such detailed Instructions in reference thereto as he may from time to time deem necessary.

This Our Warrant shall apply to all officers and their relatives whose claims to retired pay, pensions or grants of the nature dealt with therein arise in respect of service during the war, and to members of Our Nursing Services hereinafter specified and their relatives whose claims similarly arise, and it shall, subject to the provisions of the Fifth Schedule hereto, have effect from 1st April 1920. In the case of such persons whose claims to retired pay, pensions or gratuities have been dealt with or arose under previous Warrants the terms of this Our Warrant may, if more beneficial to them, and subject to the provisions of the Fifth Schedule hereto, be applied with retrospective effect from the above date.

The retired pay of an officer or the retired pay or pension of a nurse who has served as such before the date of this Our Warrant may be assessed under the terms of Our previous Warrants regulating retired pay or pensions if more favourable to him or her than this Our Warrant; and no grant to an officer or to the family or relatives of an officer, or to a nurse, shall be re-assessed to their disadvantage; and any widow, child or dependant of an officer promoted from the ranks during the war shall not be less favourably treated than if the officer had continued to serve as a soldier.

PART I.—OFFICERS DISABLED.

Retired pay
for officers
retired, &c.,
on account
of disable-
ment.

1. An officer who retires, relinquishes his commission, reverts to unemployment, or is placed in the Territorial Force Reserve, on account of medical unfitness certified as either attributable to or aggravated by military service during the war, and not being due to his serious negligence or misconduct, may, subject to Article 8, be granted the retired pay shown in columns 3 to 8 of Part I. of the First Schedule to this Our Warrant which corresponds to the degree of his disablement as certified: Provided that—

(1) If the officer (other than an officer to whom Our Warrant of the 19th December 1919 applies) holds a permanent commission in Our Regular Forces he may be granted—

Regular
officer with
permanent
commission.

(a) if he retires, the retired pay or gratuity for which he is eligible under Our Warrant of 13th September 1919, for the Pay, Half-pay and Retired Pay of officers (or, where his service does not entitle him to such retired pay, the annual sum set forth in Part II. of the First Schedule hereto), together with an addition as in column 9 of Part I. of the said Schedule, but so that the total retired pay under this paragraph is in no case less than the officer's half-pay as laid down by the said Warrant of 13th September 1919, according to his substantive rank at the time of his retirement; and

(b) if he reverts to unemployment and is already in receipt of service retired pay, whether re-assessed or not under the said Warrant of 13th September 1919, such retired pay, together with an addition as in column 9

of Part I. of the said Schedule, and, if the officer has been promoted during the war, and before being pronounced permanently unfit for general service, to a rank higher than that for which such service retired pay was awarded, a further addition corresponding to the difference between the retired pay under columns 3 to 8 of Part I. of the First Schedule hereto appropriate to the rank for which such service retired pay was awarded and the retired pay under such columns appropriate to his higher rank ;

but so that in no case shall the retired pay under this Warrant of such officer be less than the retired pay to which he would have been entitled under columns 3 to 8 of Part I. of the said Schedule.

(2) If the officer served as a soldier in Our Regular Forces and does not hold a permanent commission in those Forces he may be granted—

Temporary officer who has served as a soldier.

(a) if in receipt of a service pension, or retired pay or gratuity under Our Warrant of 3rd May 1918, that pension, retired pay, or gratuity, with an addition for his disability as in the last column of Part I. of the First Schedule hereto: provided that where his service was continuous he may be granted at any time, if more favourable to him, the permanent pension he would have received if he had continued to serve in the rank from which he was promoted and had not been pensioned when promoted to a commission ;

(b) if in receipt of a permanent pension for a disability which has been aggravated by military service as an officer during the war, and if he was eligible for a service pension when discharged for disability, such service pension with an addition as in column 9 of Part I. of the First Schedule hereto ;

(c) if not within the terms of paragraph (a) or (b) above, the permanent pension he would have received if he had continued to serve in the rank from which he was promoted, if qualified therefor by length of service, whether his service was continuous or not ;

but so that in no case shall the retired pay under this Warrant of such officer be less than the retired pay to which he is entitled under columns 3 to 8 of Part I. of the First Schedule hereto.

(3) If the officer is in receipt of a wounds pension, he may be granted only—

If in receipt of wounds pension.

(a) retired pay at the rate and under the conditions laid down in Our Warrant of the 1st December 1914 for the Pay, Appointment, Promotion, and Non-effective Pay of Our Army, with an addition (subject to conditions and limitations approved by the Minister) not exceeding 20 per cent. of such retired pay and the wounds pension ; or

(b) if he is an officer to whom proviso (1) (a) of this article applies, the retired pay or gratuity for which he is eligible under Our said Warrant of the 13th September 1919 ; or

(c) if he is an officer to whom proviso (1) (b) of this article applies, the service retired pay therein referred to ; or

(d) the difference between the wounds pension and the retired pay to which the officer would be entitled under this Our Warrant if he was not in receipt of wounds pension ;

whichever be the greatest.

(4) If the officer has lost the sight of both eyes as the result of wounds received in action he shall be granted not less than 300*l.* a year in wounds pension and retired pay taken together.

If totally blinded in action.

(5) Subject to the preceding provisos, if the officer is already in receipt of pension or retired pay as a soldier or an officer it shall be suspended so long as he is receiving a higher rate under this Our Warrant.

If already receiving pension or retired pay.

1A. If an officer on or after demobilisation, or on or after retirement, or relinquishing his commission, or transfer to or reversion to the Reserve or to unemployment, otherwise than for misconduct or in circumstances which do not, in the opinion of the Minister, justify the award, is certified to be disabled by wounds, injuries or disease attributable to or aggravated by military service during the war, such disablement not having been caused or aggravated by his serious negligence or misconduct, he may be granted retired pay or gratuity as if he had retired on account of medical unfitness under Articles 1 or 8 of this Our Warrant, with effect from the date from which his claim is established. But the benefit of proviso (1) to Article 1 shall only be granted if the officer is certified to have been permanently unfit for general service on his retirement or reversion to unemployment.

Disablement on or after retirement.

Retired pay
to be tempo-
rary at
outlet.

1B. Except in those cases where the disablement has reached its final condition, a grant of retired pay shall be temporary at the rate appropriate to the temporary disablement, and the grant shall be reviewed from time to time until a permanent assessment can be made or the grant ceases.

Education
allowances
for children
of disabled
officers.

2.—(1) In cases of pecuniary need the Minister may, at his discretion, grant to a disabled officer who is in receipt of or eligible for retired pay under this Our Warrant an education allowance not exceeding 80*l.* a year in respect of each child above the age of 8. The continuance of the allowance shall depend upon the continuance of the retired pay and on the Minister being satisfied as to the education the child is receiving.

(2) In any case in which, in the opinion of the Minister, it may become necessary to secure the proper care of a child on behalf of whom an education allowance is payable, the allowance instead of being paid to the parent may be administered under such conditions as the Minister may determine.

Alternative
retired pay.

3.—(1) An officer in receipt of retired pay under Article 1 of this Our Warrant, or of a wounds pension in lieu thereof, whose pre-war earnings (excluding any addition thereto under paragraph (b) of Article 30 (5)) exceeded 132*l.* a year and who, within one year of the date of this Our Warrant or one year after the notification to him of the first award of retired pay under Article 1, whichever is the later date, shall prove to the satisfaction of the Minister the amount of his pre-war earnings, may, at the same time or at any time thereafter, make application for alternative retired pay, and if he shows that his retired pay together with any wounds pension of which he is in receipt, and together with the average earnings of which he remains capable, are less than his proved pre-war earnings he may be granted alternative retired pay in lieu of retired pay or retired pay and wounds pension.

Alternative retired pay may be granted temporarily or permanently, and shall be of an amount which together with any wounds pension of which the officer is in receipt and together with the average earnings (if any) of which he is judged capable, shall not exceed his pre-war earnings up to 300*l.* a year plus half any pre-war earnings between 300*l.* and 600*l.*, a year: provided that—

(a) in assessing the average earnings (if any) of which an officer remains capable any decrease thereof not due to the disablement for which the officer is in receipt of retired pay or wounds pension shall be disregarded, and the refusal or neglect to undergo any course of treatment or training which in the opinion of the Minister would materially increase the officer's earning capacity may be taken into account; and

(b) where owing to physical incapacity or other cause over which the officer had no control he has been unable to prove the amount of his pre-war earnings within the time above specified the Minister may, in his discretion, extend such time.

(2) Alternative retired pay shall be payable as from the date from which the claim thereto is established.

(3) Where, in the opinion of the Minister, it may become necessary to secure the proper care of a child of an officer in receipt of alternative retired pay, the Minister may deduct from the alternative retired pay such sum as he may deem sufficient for the maintenance of such child, and may administer the same under such conditions as he may determine.

Permanent
awards to
disabled
officers.

4.—(1) When permanent retired pay has been granted, it shall not be altered on account of any change in the officer's earning capacity, whether resulting from training or other cause; neither shall it be subject to review except—

(a) when an officer whose retired pay is assessed under Article 1 of this Our Warrant claims that there has been a substantial increase in the extent of the disablement due to the original cause;

(b) when an officer whose retired pay is assessed under Article 1 of this Our Warrant, and who has duly proved his pre-war earnings as provided by Article 3 shows that it would be more advantageous to him to be assessed under that Article; or

(c) under the following subsection or under Article 30A or 30B.

Review of
retired pay.

(2) The Minister may at any time order the review of any retired pay in any case where—

(a) retired pay has, by error in interpretation or fact, been granted to a disabled officer in excess of the amount appropriate to the degree of his disablement;

- (b) the Minister has reason to believe that retired pay has been obtained by any improper means ; or
 (c) retired pay has been granted by error.

5. Half the retired pay awarded under the preceding Articles may be subject to the condition that the disabled officer shall undergo medical treatment in an institution or otherwise for any period during which it is certified that such treatment is necessary in his interests. Conditions as to undergoing treatment.

Such misconduct of the officer as shall render it necessary, in the discretion of the Minister, to discontinue treatment may be deemed to be refusal to undergo treatment.

6. In any case where it is certified that an officer should undergo any course of medical treatment in an institution or otherwise for a disability which renders him eligible for retired pay or gratuity under Articles 1 or 8 of this Our Warrant, he may be granted, for such period and subject to such conditions as the Minister may determine— Grants to disabled officers undergoing treatment.

(a) retired pay at the rate for the highest degree of disablement (subject to any necessary adjustments in respect of wounds pension, retired pay or gratuity already awarded) for the purpose of undergoing the treatment which he is certified to require and whilst deemed unable in consequence to provide for his own support and that of his family, a deduction of such an amount as the Minister may determine being made from the officer's retired pay on account of the cost of his maintenance in the institution ;

(b) if he is certified to require treatment which does not render him unable to provide for his own support and that of his family, but requires him to absent himself from his work on one or more occasions in the week, an allowance not exceeding 1*l.* a week for the time he is required to absent himself ;

(c) the necessary medical and other expenses and allowances incidental to the treatment of such disability up to such amount as the Minister may determine.

7. In addition to any retired pay awarded under the foregoing Articles, or any wounds pension in lieu thereof, there may be granted, under such conditions as the Minister may determine, to or on behalf of an officer disabled in the highest degree, an allowance not exceeding 100*l.* a year in any case where a constant attendant is necessary. Constant attendance allowance.

8. In any case where the degree of disablement is assessed at less than 20 per cent. or, in exceptional circumstances, where it is considered by the Minister more in the interests of the officer, a gratuity or temporary allowance may be granted in place of any retired pay under this Our Warrant. The grant will be subject to such conditions as the Minister may determine and its amount will not exceed 500*l.* and will depend on the nature of the disablement and other circumstances of the case. Gratuities for minor disablements.

9. An officer who retires, relinquishes his commission, reverts to unemployment, or is placed in the Territorial Force Reserve on account of medical unfitness, such unfitness being neither attributable to nor aggravated by military service, and not being due to the serious negligence or misconduct of the officer, may be granted a gratuity or temporary allowance. The grant will be subject to such conditions as the Minister may determine. In exceptional circumstances it may amount to a sum not exceeding 300*l.*, and generally it will depend on the extent to which the officer is incapacitated and on the other circumstances of the case. Where disablement not attributable to service.

PART II.—WIDOWS AND OTHER RELATIVES OF OFFICERS DECEASED.

10. Pensions and gratuities to the widows, children and relatives of deceased officers, for which provision is made in the following Articles, shall only be given as a reward of the officer's services, and no pension or gratuity shall be granted or continued to a deceased officer's widow or relative who, in the opinion of the Minister, is unworthy of a grant from public funds, and it shall be in the power of the Minister to terminate or suspend any pension that may have been granted to any such person or to provide for the administration of a pension or gratuity under such conditions as he may determine. General conditions for pensions to officers' widows and relatives.

Pensions to
officers'
widows.

11. The widow of an officer may be granted—

(1) If the officer, otherwise than through his serious negligence or misconduct—

(a) is killed in action, or suffers violent death due directly and wholly to war service, or is killed or dies of injuries sustained on flying duty or while being carried on duty in aircraft under proper authority, or dies within seven years from wounds or injuries so received, or

(b) dies from illness which is certified as directly traceable to fatigue, privation, or exposure incident to active operations in the field within seven years after having been first removed from duty on account of such illness, or

(c) dies in consequence of injuries received in the performance of military duty otherwise than under (a) within seven years after having been so injured,

and the widow is over 40 years of age, or has a child eligible for an allowance under the Article next following, a pension as in the second column of the Second Schedule hereto; but if the widow is not over 40 and has no child so eligible then a pension as in the third column of the said Schedule.

(2) If the officer, otherwise than through his serious negligence or misconduct—

(a) dies of disease attributable to or aggravated by military service other than under subsection (1) (b) of this Article within seven years after having been first removed from duty on account of such disease, or

(b) dies of injuries attributable to military service other than under subsection (1) (a) or (1) (c) of this Article, within seven years after having been first removed from duty on account of such injuries,

and the widow is over 40 years of age, or has a child eligible for allowance under the Article next following, a pension as in the fourth column of the Second Schedule hereto; but if the widow is not over 40 and has no child so eligible, then a pension as in the fifth column of the said Schedule.

Gratuities to
officers'
widows.

(3) If the officer dies in the circumstances referred to in subsection (1) (a) of this Article, a gratuity, in addition to pension, as in the sixth column of the Second Schedule hereto.

Children's
allowances
to officers'
widows.

12.—(1) The widow of an officer awarded a pension under the preceding Article may be granted a further allowance at the rate of 36*l.* a year for each child maintained by her.

This allowance may be granted or continued up to the age of 18 in the case of sons and up to the age of 21 in the case of daughters, unless the child is otherwise provided for or marries, and may be granted or further continued after such ages in the case of children who are apprentices receiving not more than nominal wages, or are being educated at a secondary school, technical institute, or university.

(2) The above allowance may also be granted or continued after the specified ages in very special cases in which it is shown (a) that the child became afflicted during the officer's lifetime with some mental or bodily infirmity rendering it dependent upon him and incapable of making adequate exertion for its own support; (b) that such incapacity dates from a period before the child reached the limit of age; and (c) that it is in distressed circumstances. The allowance may be granted or continued for such term as the Minister may decide.

(3) If the officer dies in the circumstances referred to in Article 11 (1) (a) a gratuity of one-third of the amount laid down in the sixth column of the Second Schedule hereto may be granted, in addition to children's allowance, for each child.

(4) The widow of an officer awarded a pension under Article 11 or 13 may, if in pecuniary need, be granted, at the discretion of the Minister, an education allowance not exceeding 50*l.* a year for each child above the age of 8. The continuance of the allowance shall depend on the Minister being satisfied as to the education the child is receiving.

(5) In any case in which, in the opinion of the Minister, it may become necessary to secure the proper care of a child on behalf of whom an allowance is payable, the allowance, instead of being paid to the widow, may be administered under such conditions as the Minister may determine.

13.—(1) A widow who—

(a) is over 40 years of age or has a child eligible for an allowance under the preceding Article, Alternative pension to widows.
 (b) is in receipt of a pension under Article 11 of this Our Warrant, and
 (c) makes application and shows that she was married to the officer before the commencement of the war or of his military service, whichever was the later, and that her pension under Article 11 with any children's allowances under Article 12 (1), and (2) and any pension under Article 17 in respect of the officer is, or eventually may be, less than two thirds of the alternative retired pay that might have been awarded to her husband under Article 3 had he survived and been incapable of supplementing that retired pay by earnings, may be granted, in lieu of such pension and such children's allowances and pension, an alternative pension (which shall not exceed two thirds of such alternative retired pay) up to a maximum of 300*l.* a year: provided—

(i) that application shall be made within one year of the date of this Our Warrant, or one year after notification to the widow of the award of pension under Article 11, whichever is the later;

(ii) that such widow's pension under Article 11 (together with any such children's allowances and pension) shall, if greater than the alternative pension assessed under this subsection, continue until it becomes less than the alternative pension;

(iii) that if a widow to whom an alternative pension has been granted under this subsection ceases to be eligible for a pension under this subsection, but would be eligible for a pension under subsection (2) of this Article, her alternative pension shall cease to be calculated under this subsection and shall be thenceforth calculated under that subsection; and

(iv) that the provision in Article 3 (3) of this Our Warrant to secure the proper care of a child shall apply in the case of any pension awarded under this subsection.

(2) A widow who—

(a) is not over 40 years of age and has no child eligible for an allowance under the preceding Article,

(b) is in receipt of a pension under Article 11, and

(c) makes application and shows that she was married to the officer before the commencement of the war or of his military service, whichever was the later, and that her pension under Article 11 with any pension under Article 17 in respect of the officer is, or eventually may be, less than one half of the alternative retired pay that might have been awarded to her husband under Article 3 had he survived and been incapable of supplementing that retired pay by earnings, may be granted, in lieu of such pension, an alternative pension (which shall not exceed one half of such alternative retired pay) up to a maximum of 225*l.* a year: provided—

(i) that application shall be made within one year of the date of this Our Warrant or one year after the notification to the widow of the award of pension under Article 11, whichever is the later;

(ii) that such widow's pension under Article 11 (together with any pension under Article 17) shall, if greater than the alternative pension assessed under this subsection, continue until it becomes less than the alternative pension;

(iii) that when the widow reaches the age of 40 the alternative pension may be raised from one-half of such alternative retired pay to two-thirds thereof up to a maximum of 300*l.* a year.

(3) If the officer's pre-war earnings (exclusive of the addition under Article 30 (5) (b), were less than 132*l.* a year, his pre-war earnings (inclusive of such addition) may be substituted for the alternative retired pay in the preceding subsections of this Article.

(4) Any pension under Article 17 shall be deducted from a widow's alternative pension.

14. The widow of an officer not eligible for pension under Article 11 may be granted a gratuity of not less than one and not more than three years' pay of the appointment held by the officer: provided that—

(a) the officer dies during the war, while on full pay, or, after removal from full pay, from the injury or disease for which he was removed from full pay or

Gratuity to widow where death is not attributable.

some closely connected disease and there is a continuous medical history of sickness; and

(b) the widow is disqualified only through the insufficiency of the officer's service for an ordinary pension under the terms of Article 660 of Our said Warrant of 1st December 1914.

The amount of the gratuity, within the above limits, shall be at the discretion of the Minister, and may be paid in a lump sum or in instalments as he may determine. In the event of the officer leaving motherless children, a similar grant may be made to them under such conditions as the Minister may determine.

Suspension
of pensions
to officers'
widows on
re-marriage.

15. Any pension granted to the widow of an officer under this Our Warrant shall cease on her re-marriage; but in the event of her again becoming a widow, her pension (subject to adjustment under Article 30A) may be restored, wholly or in part, if she is otherwise qualified, and if in the opinion of the Minister her pecuniary circumstances are such as to justify the restoration. Allowances for children under Article 12 may be paid after re-marriage.

Pensions to
widows of
officers on
retired pay.

16. (1) The widow of an officer who was at the time of his death (not being due to his serious negligence or misconduct) in receipt of retired pay of not less than 70L. a year, may, provided she was living with the officer at the time of his death, be granted a pension of not more than one-half of the deceased officer's retired pay and in no case at a higher rate than as in the fifth column of the Second Schedule hereto, this grant to be subject to such conditions as the Minister may determine and to cease on re-marriage.

(2) "Widow" in this Article means a widow—

(a) the circumstances of whose husband's death do not entitle her to a pension under Article 11 of this Our Warrant; and

(b) who, if her husband had died in the circumstances set forth in Article 11, would have been eligible for a pension under that Article.

(3) The motherless children of an officer whose widow would have been eligible for a pension under this Article may be granted pensions at the rates and subject to the conditions of Article 17 (1) and (2), the total of the pensions not to exceed one-half of the officer's retired pay.

(4) "Retired pay" in this Article means retired pay in consequence of disability attributable to or aggravated by military service during the war at the rate the officer was receiving or might have received under columns 3 to 8 of the First Schedule to Our Warrant of the 1st August 1917.

Motherless
children.

17.—(1) The child of an officer who has died in the circumstances set forth in Article 11 of this Our Warrant may be awarded a pension of 60L. a year where the child is or becomes motherless, or has been removed from the control of its mother. In the event of two or more children being maintained by one person in the same household, the amount will be reduced to 50L. for each child after the first.

(2) The grant, continuance and administration of the pension shall be subject to the same conditions as those set forth for children's allowances in Article 12 (1), (2) and (5).

(3) A child granted a pension under subsection (1) of this Article shall be eligible for a gratuity under the conditions of Article 12 (3), and for an education allowance under the conditions laid down in Article 12 (4).

General con-
ditions for
pensions to
officers'
relatives.

18. The following conditions shall apply to the grant or continuance of pensions to the relatives, other than widows and children, of deceased officers under Articles 19 and 21 below:—

(1) It shall be granted only if the officer dies in the circumstances set forth in Article 11 of this Our Warrant.

(2) It shall be granted or continued only if the pecuniary and other circumstances of the relative are such as, in the opinion of the Minister, to justify the award.

(3) Subject to the provisions of subsection (2) of the following Article, it shall not exceed the pension which has been or would have been awarded to the officer's widow under Article 11 (1) or (2), as the case may be, if under 40 and childless.

(4) It shall not be transferable; except that where it is granted to one of two parents, or to two or more sisters or brothers, it may be continued wholly or in part to the survivor or survivors and that where it has been granted to a

parent it may on the death of such parent be continued, wholly or in part, to a sister who is otherwise eligible for a pension in respect of the deceased officer.

(5) It shall cease on marriage or re-marriage.

19.—(1) A pension may be granted to the parent or parents of an officer of such an amount as the Minister may decide, subject to the conditions of Article 18 and such other conditions as he may determine, regard being had to pre-war dependence, if any, and to the age or infirmity of the parent or parents. Pensions to officers' parents.

(2) A pension may be granted in respect of each son who has died in the circumstances set forth in Article 11, subject to such conditions and limits as the Minister may determine.

20. A gratuity not exceeding the value of one year's pension of a widow under 40 and childless may be granted to the parent or parents jointly of an officer, at the discretion of the Minister, in special cases where the conditions for pensions laid down in the two preceding Articles are not fulfilled. Gratuities to parents.

21.—(1) A pension may be granted to the sister or brother (or sisters or brothers) of an officer, provided they were wholly or partially dependent on him for support. The pension shall be of such an amount as the Minister may decide, subject to the conditions of Article 18 and such other conditions as he may determine, and shall not be granted or continued to a brother after the age of 18, or to a sister after the age of 21, unless he or she is unfitted by age or infirmity to earn his or her living. Pensions to officers' sisters or brothers.

(2) A pension under the same conditions may be granted in respect of each brother who has died in the circumstances set forth in Article 11, subject to the limit laid down in Article 18 (3).

22. A gratuity not exceeding one-half the value of one year's pension of a widow under 40 and childless may, at the discretion of the Minister, be granted to the sisters or brothers jointly in special cases where the conditions for pensions laid down in Articles 18 and 21 are not fulfilled. Gratuities to officers' sisters or brothers.

PART III.—NURSES DISABLED OR DECEASED.

23. A member of Our Queen Alexandra's Imperial Military Nursing Service, of Our Army Nursing Service Reserve, and of Our Territorial Force Nursing Service (hereinafter referred to as a nurse) who retires on account of medical unfitness certified as either attributable to or aggravated by military service during the war and not being due to her serious negligence or misconduct, may, subject to Article 28, be granted the pension shown in the Third Schedule to this Our Warrant which corresponds to the degree of her disablement as certified: provided that a nurse who is eligible for or in receipt of retired pay under the terms of Our said Warrant of 1st December 1914, may be granted either—

(a) such retired pay together with an addition as shown in the last column of the Third Schedule to this Our Warrant, or

(b) the pension provided by columns 3 to 5 of that Schedule for her rank and degree of disablement,

whichever is more favourable.

23A. If a nurse on or after demobilisation or on or after retirement, or transfer or reversion to the Reserve, otherwise than for misconduct or in circumstances which, in the opinion of the Minister, do not justify an award, is certified to be disabled by wounds, injuries, or disease attributable to or aggravated by military service during the war, such disablement not being due to her serious negligence or misconduct, she may be granted pension or gratuity as if she had retired on account of medical unfitness under Article 23, with effect from the date from which her claim is established. But the benefits of proviso (a) to Article 23 shall only be granted if the nurse is certified to have been permanently unfit for general service on her retirement. Disablement on or after retirement.

23B. Except in those cases where the disablement has reached its final condition a pension shall be temporary, at the rate appropriate to the temporary disablement, and the grant shall be reviewed from time to time until a permanent assessment can be made or the grant ceases. Temporary awards to disabled nurses.

23C.—(1) A nurse in receipt of pension under Article 23 of this Our Warrant whose pre-war earnings (excluding any addition thereto under paragraph (b) of Article 30 (5)) exceeded 95*l.* a year and who, within one year of the date of this Our Alternative pensions to nurses.

Warrant or one year after the notification to her of the first award of pension under Article 23, whichever is the later date, shall prove to the satisfaction of the Minister the amount of her pre-war earnings, may, at the same time or at any time thereafter, make application for alternative pension, and if she shows that her pension together with the average earnings of which she remains capable, are less than her proved pre-war earnings she may be granted alternative pension in lieu of pension under Article 23.

Alternative pension may be granted temporarily or permanently and shall be of an amount which, together with the average earnings (if any) of which the nurse is judged capable, shall not exceed her pre-war earnings up to 250*l.* a year, provided that—

(a) in assessing the average earnings (if any) of which a nurse remains capable any decrease thereof not due to the disablement for which the nurse is in receipt of pension shall be disregarded, and the refusal or neglect to undergo any course of treatment or training which in the opinion of the Minister would materially increase the nurse's earning capacity may be taken into account; and

(b) where owing to physical incapacity or other cause over which the nurse had no control she has been unable to prove the amount of her pre-war earnings within the time above specified the Minister may, in his discretion, extend such time.

(2) Alternative pension shall be payable as from the date from which the claim thereto is established.

(3) In this Article "pension" shall include retired pay.

Permanent
awards to
disabled
nurses.

24.—(1) When a permanent pension has been granted it shall not be altered on account of any change in the nurse's earning capacity, whether resulting from training or other cause; neither shall it be subject to review except—

(a) when a nurse whose pension is assessed under Article 23 claims that there has been a substantial increase in the extent of the disablement due to the original cause, or

(b) under the following subsection or under Article 30A or 30B.

(2) The Minister may at any time order the review of any pension in any case where—

(a) a pension has, by error in interpretation or fact, been granted to a disabled nurse in excess of the amount appropriate to the degree of her disablement;

(b) the Minister has reason to believe that a pension has been obtained by any improper means; or

(c) a pension has been granted by error.

Conditions
as to under-
going treat-
ment.

25. Half the pension awarded under Article 23 or 23*a* may be subject to the condition that the disabled nurse shall undergo medical treatment in an institution or otherwise, for any period during which it is certified that such treatment is necessary in her interests.

Such misconduct of the nurse as shall render it necessary, in the discretion of the Minister, to discontinue treatment, may be deemed to be refusal to undergo that treatment.

Grants to
disabled
nurses under-
going treat-
ment.

26. In any case where it is certified that a nurse should undergo any course of medical treatment in an institution or otherwise for a disability which renders her eligible for pension or gratuity under Articles 23 or 23*a* of this Our Warrant, she may be granted, for such period and subject to such conditions as the Minister may determine—

(a) a pension at the rate for the highest degree of disablement (subject to any necessary adjustments in respect of retired pay, pension or gratuity already awarded) for the purpose of undergoing the treatment which she is certified to require and whilst deemed in consequence incapable of work, a deduction of such amount as the Minister may determine being made from such pension on account of the cost of her maintenance in the institution;

(b) if she is certified to require medical treatment which does not render her incapable of work, but requires her to absent herself from her work on one or more occasions in the week, an allowance not exceeding 15s. a week for the time she is required so to absent herself ;

(c) the necessary medical and other expenses and allowances incidental to the treatment of such disability up to such amount as the Minister may determine.

27. In addition to any pension awarded under the foregoing Articles there may be granted, under such conditions as the Minister may determine, to or on behalf of a nurse disabled in the highest degree, an allowance not exceeding 52l. a year in any case where a constant attendant is necessary. Constant attendance allowance.

28. In any case where the degree of disablement is assessed at less than 20 per cent., or where, in exceptional circumstances, it is considered by the Minister more in the interests of the nurse, a gratuity or temporary allowance may be granted in place of any pension under this Our Warrant. The grant will be subject to such conditions as the Minister may determine, and its amount will not exceed 300l., and will depend on the nature of the disablement and the other circumstances of the case. Minor disablement gratuities to nurses.

29. A nurse who retires on account of medical unfitness certified to be neither attributable to nor aggravated by military service may be granted a gratuity or temporary allowance. The grant will be subject to such conditions as the Minister may determine. In exceptional circumstances it may amount to a sum not exceeding 200l., and generally it will depend on the extent to which the nurse is incapacitated and on the other circumstances of the case. Where disablement not attributable to service.

29A. Pensions or gratuities may be awarded to the relatives of deceased nurses in accordance with the terms of Articles 18 to 22 of this Our Warrant so far as they may be applicable, and under such conditions as the Minister may determine. Grants to relatives of deceased nurses.

PART IV.—GENERAL PROVISIONS.

30. In this Our Warrant, unless the context otherwise requires—

Definitious.

(1) "Officer" means a commissioned officer whether holding a permanent or temporary or local commission in Our Regular or Reserve Forces or of the Territorial Force, who has served and been in receipt of military pay as such during some period of the war, but shall not include any officer of Our Indian Army, or any officer of Dominion, Colonial, or Protectorate Forces, whether raised for local or general service, unless the terms of his service have been made to include the pension rights of the Regular Army, or any officer holding a permanent commission in Our Regular Forces disabled or dying through service in India. Officer.

(2) "Widow" means the widow of an officer whose marriage took place before the receipt of the wound or injury which caused his death, or before his removal from duty on account of the contraction or aggravation of the disease which caused his death : provided that the widow of a permanent regular officer married after such date (but not later than the date of this Our Warrant) shall not forfeit pension or gratuity if he survives his marriage by at least one year or it can be shown that he was manifestly in good health at the date of his marriage. Widow.

(3) "Child" means the legitimate child of an officer born before or within nine months after demobilisation, retirement, relinquishment of his commission, or transfer to or reversion to the Reserve or to unemployment, and may include a step-child regularly maintained by him ; but shall not include a child whose mother is excluded by (2) above. Child.

(4) "Parent" includes a grandparent or other person who has been in the place of a parent to an officer, and has wholly or mainly supported him for not less than one year at some time before the commencement of the war. Parent.

(5)—(a) "Pre-war earnings" means in the case of an officer who was in employment under a contract of service the average earnings during the twelve months immediately preceding the outbreak of the war. Average earnings shall be computed generally in such manner as is best calculated to give the rate at which the officer was being remunerated, and, so far as may Pre-war earnings.

be applicable, in accordance with the provisions of the Workmen's Compensation Act, 1906: provided that where in the course of such twelve months there was a change in the officer's rate of remuneration, and such change was not of a temporary but of a reasonably permanent nature, then the average earnings shall be calculated on the officer's earnings during the period since such change in his remuneration, or since the last of such changes if there were more than one. In the case of an officer in a trade, business, or profession, the average profits of the last three years preceding the commencement of the war shall be taken, or of such lesser period as he engaged therein.

(b) In computing the average earnings or average profits of an officer an addition of 60 per cent. may be made to any such earnings or profits.

Pre-war
dependence.

(6) "Pre-war dependence" means the amount representing the annual value of the support afforded to, or of benefits conferred upon a relative by an officer for a reasonable period immediately preceding the commencement of the war or of his military service, if later, exclusive, however, of any increase thereof due to circumstances arising out of the war, in the case of entry into service or commission subsequent to the commencement of the war, and shall include the following—

(a) Amount regularly contributed by the officer if he received no material benefits in return therefor.

(b) Amount regularly contributed by the officer in excess of expenditure incurred on his account.

(c) Money value of any benefit conferred upon the relative by the officer.

Certified.

(7) "Certified" means, in respect of any medical certification, certified by a medical officer or Board of Medical Officers appointed for the purpose by the Army Council or by the Minister.

Prescribed.

(8) "Prescribed" means prescribed by Instructions issued by the Minister.

Wounds
pension.

(9) "Wounds pension" includes wounds gratuity.

Application
of Part IV.
to nurses.

(10) The provisions of this Part of this Our Warrant shall, so far as they are applicable, apply to and in respect of nurses in the same way as they apply to and in respect of officers.

Royal War-
rant of 23rd
March 1920.

(11) References in this Our Warrant to Our Warrant of the 13th September 1919 include references to Our Warrant of the 23rd March 1920, for the Appointment, &c., of officers of Our Royal Army Chaplains Department.

Readjust-
ment of
rates accord-
ing to cost
of living.

30A. The rates of retired pay, pension, and allowance specified in the Fourth Schedule hereto, and any retired pay, pensions, and allowances awarded under or by virtue of the Articles therein mentioned (hereinafter referred to as the scheduled rates), shall be deemed to be based on the cost of living for the year 1919, and shall be subject as prescribed to increase or decrease in accordance with the increased or decreased cost of living as compared with the cost of living for the year 1919, such increased or decreased cost being determined by a certificate to be furnished in January of the year 1923 and of each succeeding year for this purpose by Our Minister of Labour: provided that the scheduled rates shall not be reduced below the minimum rates set forth in the second column of the Fourth Schedule hereto, and that no re-adjustment shall take effect before the 1st day of April 1923.

There shall be no re-adjustment in the year 1923 unless the certificate of Our Minister of Labour shows a difference between the cost of living in the year 1919 and in the year 1922 of at least 5 per cent., nor shall there be any re-adjustment in any succeeding year unless the certificate of Our Minister of Labour shows that the cost of living for the previous year differs from the cost of living in the year as to which the last re-adjustment was made (or the year 1919 if there had been no re-adjustment) by at least 5 per cent. of the cost of living in the year 1919.

Cost of
living.

"Cost of living" in this Article means the general cost of living of working-class families.

Third party
compensa-
tion may be
taken into
considera-
tion.

30B. Where an officer is injured or killed in such circumstances that any retired pay, pension, allowance, or grant is payable to or in respect of him under this Our Warrant or the Preamble thereof, and where he or his widow, child, or dependant receives compensation from or on behalf of a third party, for the act, omission, or circum-

stances which caused the injury or death, any such compensation may be taken into consideration in assessing any retired pay, pension, allowance, or grant which might be awarded to or in respect of the officer, and where the compensation is received after assessment it may be taken into consideration and the assessment may be amended or cancelled accordingly.

31. The rate of retired pay or pension or gratuity granted under this Our Warrant may be determined according to the temporary, acting, or local rank held by the officer at the time he was killed, wounded, injured, or removed from duty in consequence of disablement. Temporary and acting rank.

32. Except as modified by this Our Warrant, any general conditions governing the grant, issue, and administration of retired pay to officers and of pensions to their families laid down in Our said Warrant of 1st December 1914, and in subsequent Warrants, shall remain in force and be applicable to grants made under this Our Warrant. Warrants retained in operation.

Given at Our Court at St. James's, this second day of July, 1920, in the 11th year of Our Reign.

By His Majesty's Command,
IAN MACPHERSON.

FIRST SCHEDULE.

PART I.

RETIRED PAY TO DISABLED OFFICERS (*Article 1*).

Degree of Disablement.	Percentage of Degree of Disablement.	Retired Pay on Account of Disablement.						
		Officers not holding Permanent Commissions in Regular Forces, or as otherwise provided.						Additional Retired Pay under provisions (1) and (2) to Article 1.
		Major-General.	Brigadier-General.	Colonel.	Lieutenant-Colonel.	Major.	Captain, Lieutenant,* or Second Lieutenant.	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Per Cent.	£	£	£	£	£	£	£
1	100	420	390	330	300	270	210	150
2	90	378	351	297	270	243	189	135
3	80	336	312	264	240	216	168	120
4	70	294	273	231	210	189	147	105
5	60	252	234	198	180	162	126	90
6	50	210	195	165	150	135	105	75
7	40	168	156	132	120	108	84	60
8	30	126	117	99	90	81	63	45
9	20	84	78	66	60	54	42	30

* Quartermasters, Assistant Paymasters, and Inspectors of Army Schools may be treated as Lieutenants.

PART II.

ANNUAL SUM WHICH MAY BE GRANTED WHERE OFFICER HAS COMPLETED LESS THAN 15 YEARS' SERVICE (*proviso (1) (a) to Article 1*).

Lieutenant-Colonel of 14 years' service or less	-	-	-	-	-	£ 200
Major " " " or less	-	-	-	-	-	170
Captain of " " " "	-	-	-	-	-	140
" " 13 " " "	-	-	-	-	-	130
" " 12 " " " or less	-	-	-	-	-	120
* Lieutenant or 2nd Lieutenant of 14 years' service	-	-	-	-	-	140
" " 13 " " "	-	-	-	-	-	130
" " 12 " " "	-	-	-	-	-	120
" " 11 " " "	-	-	-	-	-	110
" " 10 " " "	-	-	-	-	-	100
" " 9 " " "	-	-	-	-	-	90
" " 8 " " "	-	-	-	-	-	80
" " 7 " " " or less	-	-	-	-	-	70

SECOND SCHEDULE.

PENSIONS AND GRATUITIES TO OFFICERS' WIDOWS (*Article 11*).

Rank.	Highest Pension (<i>Article 11 (1)</i>).		Intermediate Pension (<i>Article 11 (2)</i>).		Gratuity <i>Article 11 (3)</i> .
	Widow with child eligible, &c., or over 40.	Widow without child eligible, &c., and under 40.	Widow with child eligible, &c., or over 40.	Widow without child eligible, &c., and under 40.	
(1)	(2)	(3)	(4)	(5)	(6)
	£	£	£	£	£
Field Marshal - - -	800	800	600	600	3,500
General - - -	600	600	450	450	3,000
Lieut.-General - - -	500	500	375	375	2,000
Major-General - - -	400	400	300	300	1,100
Brigadier-General - - -	320	300	260	240	900
†Colonel - - -	240	220	220	180	600
‡Lieut.-Colonel - - -	216	200	200	162	450
Major - - -	180	168	168	126	300
Captain - - -	140	120	120	90	250
*Lieutenant - - -	140	120	120	90	140
Second Lieutenant - - -	140	120	120	90	100

* Quartermasters, Assistant Paymasters, and Inspectors of Army Schools may be treated as Lieutenants.

† Colonel means a Colonel who has been employed as a substantive Colonel if a combatant officer, or in the rank of Colonel if a medical, veterinary, or departmental officer.

‡ Including a Colonel not employed as above.

THIRD SCHEDULE.

PENSIONS TO DISABLED NURSES (*Article 23*).

Degree of Disablement.	Percentage degree of Disablement.	Disablement Pension if not entitled to Service Retired Pay.			Addition to Service Retired Pay if entitled to such.
		Principal Matron or Matron in Chief.	Matron.	Staff Nurse or Sister.	
(1)	(2)	(3)	(4)	(5)	(6)
	Per cent.	£	£	£	£
1	100	210	180	150	90
2	90	189	162	135	81
3	80	168	144	120	72
4	70	147	126	105	63
5	60	126	108	90	54
6	50	105	90	75	45
7	40	84	72	60	36
8	30	63	54	45	27
9	20	42	36	30	18

FOURTH SCHEDULE.

READJUSTMENT OF RATES (*Article 30A*).

Scheduled Rates.	Minimum Rates.
Retired pay under Article 1— Under Columns 3 to 8 of Part I. of First Schedule	The corresponding rates under the Warrant of the 1st August 1917.
Under Column 9 of Part I. of First Schedule	The rates in this Warrant less 20 per cent. thereof.
Annual sum under Part II. of First Schedule	
Under proviso (3)	The retired pay in paragraph (a) without the addition, or the retired pay in paragraph (b) or (c) duly adjusted, or the difference in paragraph (d) duly adjusted.
Alternative retired pay and pensions under Articles 3, 13, and 23c	The alternative retired pay or pension calculated without the addition of the 60 per cent. under paragraph (b) of Article 30 (d).
Treatment— Additional retired pay or pension under paragraph (a) of Articles 6 or 26	The corresponding rates under the Warrant of the 1st August 1917.
Allowance under paragraph (b) of Articles 6 and 26	16s. and 12s. respectively.
Widows' pensions under Article 11	Where the rate of the widow's pension in the Second Schedule is equivalent to two-thirds of the total disablement retired pay as set forth in Columns 3-8 of Part I. of the First Schedule, the minimum rate of the widow's pension shall be two-thirds of the total disablement retired pay as set forth in Columns 3-8 of the First Schedule to the Warrant of 1st August 1917; in other cases the minimum rates shall be the rates in the Second Schedule less 20 per cent.; but in no case shall the minimum rate be less than the corresponding rate in the Warrant of 1st August 1917.
Children's Allowances under Article 12	30l.
Motherless children's pensions under Article 17	48l. and 40l. respectively.
Nurses' pensions under Article 23— Principal Matron or Matron-in-Chief	175l.
Matron	150l.
Staff Nurse or Sister	125l.
Addition to service retired pay under Column 6 of the Third Schedule	75l.
Relatives pensions and gratuities— References to widow's pensions under Articles 18 to 22	The minimum rate for the pension of a widow under 40 and without children.

FIFTH SCHEDULE.

PROVISIONS SUBJECT TO WHICH THIS WARRANT IS TO BE READ (*Preamble*).

A.—Date from which certain portions of the Warrant apply.

	Portions of the Warrant.	Date of Application.
Article 1A - - -	The words "or in circumstances which do not, in the opinion of the Minister, justify the award" -	April 1st, 1917.
Articles 2 (1) and 12 (4) -	The words "each child above the age of 8" -	September 1st, 1919.
Article 6 - - -	The whole, except paragraphs (a) and (b) -	April 1st, 1919.
" - - -	The whole, except paragraph (c) -	June 3rd, 1919.
Article 19 (2) - - -	The whole - - - - -	August 29th, 1919.
Article 23A - - -	The whole - - - - -	April 1st, 1917.
Article 28 - - -	The whole, except paragraphs (a) and (b) -	April 1st, 1919.
" - - -	The whole, except paragraph (c) -	January 15th, 1920.
Article 29A - - -	The whole - - - - -	September 16th, 1918.
Article 30 (5) - - -	The words from "provided that" down to "more than one" - - - - -	March 7th, 1919.

B.—Retrospective Application of Amendment of Article 13 of the Warrant of 1st August 1917.

As from 1st May 1918 Article 13 of the Warrant of 1st August 1917 shall be read as though "two thirds" was substituted for "one half."

3. Army Form Z. 22. 'STATEMENT AS TO DISABILITY'. (NA
PIN26/20027 Florence Cattell)

Reference:

PIN 26 20027

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Army Form Z 22

STATEMENT AS TO DISABILITY.

(This form is not applicable to Officers and Soldiers in Hospital or on leave therefrom who will be brought before a Medical Board).

On Demobilization every Officer and Soldier, whether remaining with the Colours or not, will be given an opportunity of filling in this Form. Should he not wish to put forward any claim in respect of a Disability due to Military Service he must sign the Statement hereunder to this effect, in the presence of an Officer of the Unit with which he is serving, who will witness the Signature. Whether a claim is made or not, this Form will be forwarded by the Unit Commander, in the case of every Officer, direct to the Secretary, War Office; and in the case of every Soldier, to the Record Office of his Unit.

Unit <u>249th Killingshaw Leeds</u>	If the Officer or Soldier has previously been discharged from the Army, Royal Navy or the Royal Air Force, he will state:—
Regiment or Corps <u>T & N S</u>	(a) Former Regiments or Corps with Regimental Numbers:—
Regtl. No. _____ Rank <u>Sgt</u>	
Surname <u>CATTELL</u>	
Christian Name in full <u>Florus</u>	(b) Dates of discharge <u>May 14</u>
Permanent address <u>27, High St. -</u>	(c) Causes of discharge <u>Demobilization</u>
<u>Sheffield - ex - Devon</u>	(d) Particulars of Pension or Gratuity received (if any):—
Age last birthday <u>37 yrs.</u>	
First joined for duty (Date) <u>Aug. 7th 1914</u>	(Place) <u>2nd A. G. H. Rectory, Leeds</u>
Medical Category or Grade in which joined _____	
I do not claim to be suffering from a disability due to my military service.	
Place of Examination _____	Signature of Officer or Soldier.
Date _____	Signature of Officer witnessing.

Before the claimant answers questions 1—8 the following should be read by, or to, him:—

"Your statement will be checked by Official Records. In answering question 2, any special matters which in your opinion caused or aggravated any unfitness from which you are suffering, must be clearly stated."

The claimant will answer the questions in his own words and after completing the form will sign it. The Officer will witness the signature. If the claimant cannot write, he will affix his mark, such act being witnessed.

THIS PORTION IS NOT TO BE COMPLETED IF A CLAIM IS NOT MADE.	1. (a) In what countries have you served during this war and for what periods?	<u>England: Aug. 7th 1914 — June 1915</u> <u>Hosp. Ship. Mediter. Ex. Force July 1915 to June 1916.</u> <u>Staff Nurse & Sister. England since that date.</u>
	(b) In what capacity?	
	2. If you are suffering from any disease, wound or injury, state what it is, the date upon which it started, and what in your opinion was the cause of it. (If more space is required a sheet of foolscap should be used and attached firmly to this form).	<u>Severe head-ache at irregular periods. Insomnia.</u> <u>Breathlessness on exertion.</u> <u>Following sun-stroke + dysentery July (or August) 1916.</u>
	3. Give the names of any Hospitals in which you have been treated for the above disabilities during this war.	<u>Sick Sisters' Hospital,</u> <u>19th Gen. Hospital</u> <u>Alxandra.</u>
	4. Did you suffer from the disease or injury mentioned in above answer to Question 2. or anything like it, before joining the Army? If so, give details and dates.	<u>No.</u>
	5. Give the names and addresses, (if you know them) of any Hospitals you were in or Doctors who attended you before you joined the Army.	<u>R. A. Deale, Major R.A.M.C.</u> <u>37, Park Square,</u> <u>Leeds</u>
6. Give the name of your National Health Approved Society and, if possible, your membership number.	<u>Nurses' Insurance Society,</u> <u>Buckingham St. London.</u> <u>No. 257, 1914</u>	

PTO

PIN 26 20027

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15

16

17

18

19

20

7. What is the name and address of your last employer before joining the Army?

Miss. Barrow (matron)
The Northern Hospital
Manchester

8. What was—

(a) your Industrial Group occupation before joining the Army?

(b) your trade or calling before joining the Army?

Professional Nurse.

(To be checked from A.B. 439, A.B. 64, or A.F.B. 103.)

The above statement has been read over to me, and I agree to it and have nothing to add to it.

Place of Examination

Signed

(Claimant).

Date

Signed

(Witness).

OPINION OF THE EXAMINING MEDICAL OFFICER.

(i) Clear and definite answers to the following questions are to be carefully filled in by the Examining Medical Officer, as it is essential that the Minister of Pensions should be in possession of the most reliable information to enable him to decide upon the applicant's claim to pension.

Expressions such as "may," "might," "possibly," &c., should be avoided.

(ii) The rates of pension vary according to whether the disability is (a) caused or aggravated by service in the present war; (b) due to causes not connected with the present war, viz.: (1) previous active service, (2) climatic diseases in pre-war service, (3) ordinary military service before the war. It is therefore essential when assigning the causes of a disability to differentiate between them.

(iii) When there is more than one disability the replies will distinguish between them.

9. Give Diagnosis and particulars of—

(a) Each disability claimed or discovered.

Headache & insomnia
to insomnia in 1916

(b) The present condition thereof.

Slow & gradual improvement

10. State whether each disability is—

(a) Service during the present war.

(b) Previous active service.

(c) Climate in pre-war service.

(d) Ordinary military service before the war.

(e) Serious negligence or misconduct on the part of the claimant.

Give details:—

(i) Attributable to

or (ii) Aggravated

Yes

No

No

No

No

No

No

No

No

No

11. (a) Is each disability in a final stationary condition?

(b) If not, is re-examination before the expiration of the period of twelve months specially advised?

No

Yes

12. (a) What is the degree of disablement at which in your opinion he should be assessed at present?

Degrees of disablement should be expressed in words in the following percentages: 100, 80, 70, 60, 50, 40, 30, 20, less than 20, or nil).

40%

40%

(b) In case of aggravation, what in your opinion was the degree of disablement which existed before joining the Army?

Examining Medical Officer's Signature

R. A. Veale

Rank

Major

Unit to which attached.

R. A. N. C. (7)

Place of Examination

NORTHERN COMMAND

Date

4/5/19

CARDIAC CENTRE

GENERAL

THIS PORTION IS NOT TO BE COMPLETED IF A CLAIM IS NOT MADE.

4. Army Form A. 45. 'PROCEEDINGS OF A MEDICAL BOARD. (Officers and Nurses.)' (NA PIN 26/20027 F A Cattell).

Reference:

PIN 26 20027

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Army Form A. 45.

PROCEEDINGS OF A MEDICAL BOARD.
(Officers and Nurses.)

STATION

COVENTRY

Date

23 4 20

1. Rank and Name *Sister F. A. Cattell*2. Unit *T. F. N S*3. Whether Regular, S.R.,
T.F., T.C., or R. of O.*T.F.*4. Age *38*5. Total Service *4 9/12*

6. Service during the present War ...

HOME		ABROAD	
PERIOD		PERIOD	THEATRE
<i>6th Aug. 14 to 14.11.15</i>		<i>July 15 to Oct. 15</i>	<i>Mediterranean</i>
<i>Oct. 15 to 14.11.19</i>			

7. Address (permanent)

26 High St. Stratford on Avon

STATEMENT OF CASE.

NOTES.—(a) In answering the following questions the Board will carefully discriminate between the officer's statements and evidence recorded in his medical documents.

(b) Medical certificates, radiographs, or photographs (especially in cases of gross facial deformity) should be attached.

(c) When there is more than one disability, they should be distinguished.

8. Disability

Neurasthenia - mild & improving

9. Date of origin of disability

1917

10. Place of origin of disability

Mediterranean

11. Give concisely the essential facts of the history of the disability (personal and family history, etc.).—

(NOTE.—Boards subsequent to the first should record here the progress of the case since the last medical examination.)

Of Headaches at times and insomnia, depression.
There is nothing in the family history which suggests any nervous disability.
Appetite pretty fair. B.O. constipated.
On exertion she still suffers breathlessness, but feels much steadier than she was, and recently assisted in a Diphtheria Hospital and worked from 8 AM to 8.30 PM during a period lasting 12 Twelve weeks. At the end of this period she felt rather spent.

12. Describe in detail the officer's present condition

Sister's
G.P.C. good. No anaemia.
No oral syphilis - wears upper & lower dentures satisfactory.
P.W. 117 lbs. well.
Heart: No enlargement No murmurs. P. 96 Regular
Lungs - Healthy.
C.N.S. aspect - listless and lackadaisical.
R.F. + + equally. Coarse Tremors outstretched fingers
but there is some general Tremors.
Pseudo-Rhombus - Pupils equal & reaction normal.
When not being examined and in repose she is calm
and unperturbed.
No signs of symptoms of Dysentery.

13. AMPUTATION CASES.—Has an artificial limb, temporary or permanent, been satisfactorily fitted?

N.A.

5. 'REPORT OF MEDICAL BOARD ON OFFICER OR NURSE Claiming Disability in Respect of Service in the Great War.' M.P.O. 44. (NA PIN 26/20027 Florence Cattell).

Awards Reference No.

Hussar 41398

M.P.O.44.

REPORT OF MEDICAL BOARD ON OFFICER OR NURSE CLAIMING DISABILITY IN RESPECT OF SERVICE IN THE GREAT WAR

(Held on 7/1/1924.)

Names (Surname first) CATTELL Florence Annie
 Rank Sister Unit, Regt., or Corps I F A S
 Date of relinquishment, etc. 14.5.19 Date of Claim 26.10.28 Present age 46 Born 1882
 Permanent Address and nearest Railway Station 50 The Secretary, The British
Legion Pensions Committee,
Stratford on Avon.
 Former trade or occupation.....
 Disability or disabilities (if any) in respect of which Retired Pay, &c., has previously been granted:—

Disabilities.	Nature of Award (state whether final or not).	Current Assessment.
<u>None</u>	<u>The nurse was in receipt of an award but allowed her claim to lapse</u>	

TO THE C.M.S.
D.C.M.S.BirminghamREGION.
AREA.

You are requested to be good enough to cause the above-named Officer to be examined by a Medical Board who should report overleaf.

The Officer claims compensation in respect of.....
 (See M.P.O. 18 attached)

Previous medical reports upon his case, and Form M.P.O. 638, giving particulars of military service, etc., are enclosed.

Form M.P.O. 115 is enclosed for completion at the examination.

The assessment should be made as from 26.10.28 The assessment and opinion of the Board must not be communicated to the Officer.

Any recommendation by the Board as to Treatment and Constant Attendance Allowance should be made to you separately on the forms prescribed for the purpose.

The report should be rendered through you to the Officers Branch, Ministry of Pensions, Sanctuary Buildings, 18, Gt. Smith St., Westminster, S.W.1.

SPECIAL INSTRUCTIONS

The Board's attention is drawn to
its observations at 24^a

GEORGE CHRYSTAL,

Secretary.

Date 8.12.28

Reference:

PIN 26

2002

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- Notes.—(i) Clear and definite answers are to be filled in by the Board. Expressions such as "may," "might," "probably," etc., are to be avoided.
- (ii) A report is to be made on any disability claimed and not previously compensated under the Pension Warrants. If it is found not to exist, the finding "No Disability" should be recorded at paragraph 1. If it exists, but is not considered to be connected with naval or military service, it should be as fully reported on as if it were. The words "No Disability" should never be used as equivalent to "No Disability connected with Service."
- (iii) If more than one new disability is claimed, distinguish by numerals throughout.

STATEMENT OF CASE BY THE MEDICAL BOARD.

- 1.—Are you satisfied that the Officer referred to in the Documents sent herewith is now before you?—
- 2.—Disability or disabilities (not already compensated under the Pension Warrants) now considered. State diagnosis and Code No. (To be entered AFTER THE EXAMINATION HAS BEEN COMPLETED).
- 3.—(a) State concisely the essential facts of the history of the disability claimed as recorded in the official documents, including DATE and PLACE of origin of the disability.
- (b) Add any supplementary details given by the officer himself, indicating clearly whether these are uncorroborated.

Yes

Neurasthenia

35.

2.22. Headache due to
indigestion

- 4.—Was an operation performed? If so, when and what was its nature?
- 5.—If an operation was advised and declined, was the refusal unreasonable?

OPINION OF THE MEDICAL BOARD.

- 6.—Give particulars of:—

(a) The disability giving rise to the claim.

(b) The present condition thereof, giving:— (i) Symptoms and physical signs; (ii) Effect of disability on function.

He is speaking ^{stammer} under any slight excitement always shaken, especially on excitement. Sleeps very badly. He recently has been sleeping a little better. Appetite fair to moderate. Suffer from occipital headaches. Memory is poor. No complaint regarding inclination to emaciation.

He states that although he did not qualify for a pension in 1921 he has not feeling any better but still the same carry on & that it distresses him so much having to appear at the board.

T.P.C. good. Teeth practically complete dentures. Tongue firm & he does not N. P. 128. Lungs hard. A.D. neg. he N.V. an C.V. Mentality. Very nervous & shaky. Concentration ~~and~~ efforts memory defective. Tremor (coarse) hands & head. Speech hesitant stammer, at first severe, improving later. Pension reflects exaggerated. N. P. 128. Some Rumblerism.

Finding Neurasthenia (Severe).

- (1) Present condition is identical with that from which he has suffered in service
- (2) Present condition is wholly due to service factors
- (3) Present disability is 80%. The board are strongly of the opinion that 20% is an allowance to be made for his service (precipitating factor) and 40% condition 40% should be

7.—If the claim is in respect of a wound or injury sustained in service, is the present condition solely due to that wound or injury?
 If the answer to the above is in the negative the case should be dealt with under question 9 or 10.

no

8.—In the case of other disabilities, is there a record that the officer suffered from the disability during service, or from a disability (naming it) medically identifiable with it?

yes.

9.—If there is a record of the disability during service—

- (a) Had the officer recovered from the disability before his discharge or 30th September, 1921?
- (b) If not, is it established that the present disability is continuous with that recorded in service, and that it is not a fresh attack unconnected with service—
 - (i) by direct evidence consisting entirely of medical reports and certificates covering the period since discharge or since 30th September, 1921? or
 - (ii) by a continuous history of overt symptoms of ill-health since discharge or 30th September, 1921, established by evidence partly or wholly of a non-medical character?
- (c) Where a part of the period since discharge is not covered by evidence, is it considered that the disability must have persisted throughout, and if so, for what reasons?

*No.**yes.*

10.—If there is no record of the disability during service—

Is it established that the disability existed or must have existed during service, and that the present condition is a continuation of that disability, and is not a fresh attack unconnected with service?

- (a) If so, has this been established by direct evidence consisting entirely of medical reports and certificates covering the period since discharge or 30th September, 1921? or
- (b) has this been established by a continuous history of overt symptoms of ill-health since discharge or 30th September, 1921, consisting of evidence partly or wholly of a non-medical character? or
- (c) where a part of the period since discharge is not covered by evidence, is it considered that the disability must have persisted throughout, and if so, for what reasons? or

no

- (d) in the case of the diseases specified in paragraph 2115 of the Manual—
 - (i) was there a definite manifestation of the disease within the prescribed period?
 - (ii) is the clinical or pathological evidence such that the disability then manifested would be universally recognised by medical opinion as having existed in Great War service?
 - (iii) If the answers to (i) and (ii) are in the affirmative, is there a continuous medical history to connect the present condition with the manifestation, and what is the nature of the evidence for this?

*11.—Attributability or Aggravation.

If a continuous medical history can be certified under Questions 7 to 10 above, state whether—

- (a) The disability from which the officer is now suffering is attributable to conditions which were experienced by him in, and particularly in consequence of, his service during the Great War, and which were operative to give rise to the disability; or
- (b) the disability, though not attributable to War Service, was and STILL IS aggravated by conditions which were experienced by the officer in, and particularly in consequence of, his service during the Great War, and which were operative to aggravate the disability; and
- (c) state briefly the reasons for the opinion given in answer to Questions 11 (a) and (b) and if the answer to either is in the affirmative, the nature of the conditions which caused or aggravated the disability.

Attrib:

*12.—Exceptional Cases.

If a continuous medical history cannot be certified under Questions 7 to 10, but the disability is one which for exceptional reasons the Board hold to be attributable to the conditions of the officer's War Service, or to have been aggravated thereby, state fully the Medical grounds for the opinion and the evidence on which it is based. (If space insufficient, annex another sheet.)

no

* Where the Board consider that the medical evidence for and against the claimant is not sufficiently definite, or otherwise feel doubt as to the expression of a confident opinion one way or the other on the question of entitlement, they may leave the question unanswered and instead set out in their report the pros and cons of the medical evidence.

Base estimate of the service factor in this case and they recommended that if the present to other claimant (in future social circumstances) that this document of 1921 should be made final

Reference:

PIN 26

20027

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13.—If the disability is not attributable to, nor still aggravated by, naval or military service in the Great War, was it caused or aggravated by:—

- (1) Active service in a previous war,.....
 or (2) Other naval or military service before the Great War,..... *na.*
 or (3) Post-war service (i.e. service after the 30th September, 1921),.....
 or (4) Causes other than the above?.....

14.—Is there any evidence that the disability was due to serious negligence or misconduct on the part of the officer? If so, state the nature of such evidence.

no

15.—(1) In cases where an award has previously been made in respect of another disability or disabilities, state whether the disability now reported upon is:—

- (a) An entirely separate disability,.....
 or (b) Part of or a direct sequela of the former disability,.....
 or (c) Connected with, but not a necessary consequence of, the former disability or disabilities

(2) If the answer to Question 15 (1) (c) is in the affirmative, state whether a change of diagnosis or of entitlement is involved by the additional medical evidence available.

16.—(1) (a) State the degree of disablement at which in the Board's opinion the officer should be assessed in respect of the disability now being reported on, independent of hospital or other treatment?

(b) In the case of aggravation, where there is any definite or presumptive evidence that the disability was present at the commencement of service in the Great War, what in the Board's opinion was the degree of disablement which existed at that time?

(2) If compensation has already been granted in respect of any other disability or disabilities (see page 1), what is the composite assessment for these and the disability now reported on?

(3) If the above assessments have been arrived at after discounting any "other condition" (e.g. personal habits, misconduct, etc.), the facts should be fully stated, and the method of arriving at the assessment indicated (see M.P.M.S.D. 57, Supplement 5).

*40%**Permanent*

NOTES.—(1) Degrees of disablement should be expressed in the following percentages: 100, 90, 80, 70, 60, 50, 40, 30, 20, less than 20, or Nil, and in words as well as figures.
 (2) With regard to disabilities assessed at under 20 per cent. see M.P.M.S.D. 57, Supplement No. 3 D. Whenever a 5-14 per cent., or a 15-19 per cent., Indeterminate Duration assessment is given in a case not in a final and stationary condition, an explanation should be given.

17.—Is the disability in a final and stationary condition?.....

If not:—

- (a) How long is the present average degree of disablement likely to last?
 (b) If the present degree of disablement is not likely to last 12 months, can a further assessment at a reduced rate be made with reasonable confidence to cover a period of 12 months in all? If so, the reduced percentage and the period to which it will be applicable should be indicated in the answer to Question 16 (1) (a).

Signatures:—

G. A. Hallen

Chairman.

A. Williams-Walker

Assessor.

W. J. G. G. G.

Specialist.

Place of Board.

Date.

7 Jan 1929

Reference:

PIN 26 / 20027

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Army Form Z. 22.

STATEMENT AS TO DISABILITY.

(This form is not applicable to Officers and Soldiers in Hospital or on leave therefrom who will be brought before a Medical Board).

On Demobilization every Officer and Soldier, whether remaining with the Colours or not, will be given an opportunity of filling in this Form. Should he not wish to put forward any claim in respect of a Disability due to Military Service he must sign the Statement hereunder to this effect, in the presence of an Officer of the Unit with which he is serving, who will witness the Signature. Whether a claim is made or not, this Form will be forwarded by the Unit Commander, in the case of every Officer, direct to the Secretary, War Office; and in the case of every Soldier, to the Record Office of his Unit.

Unit 249th Killingbuck Leech
 Regiment or Corps T 2 NS
 Regtl. No. _____ Rank Sgt
 Surname CATTELL
 Christian Name in full Florus
 Permanent address 27, High St.
Stratford-on-Avon
 Age last birthday 37 yrs.
 First joined (Date) Aug. 7th 1914 (Place) 2nd G. H. Reckelt's Park
 Medical Category or Grade in which joined Leeds

If the Officer or Soldier has previously been discharged from the Army, Royal Navy or the Royal Air Force, he will state:—

(a) Former Regiments or Corps with Regimental Numbers:—

(b) Dates of discharge May 14

(c) Causes of discharge Diminished

(d) Particulars of Pension or Gratuity received (if any)

TO BE CANCELLED
IF A CLAIM IS MADE

I do not claim to be suffering from a disability due to my military service.

Place of Examination

Signature of Officer or Soldier.

Date

Signature of Officer witnessing.

Before the claimant answers questions 1—8 the following should be read by, or to, him:—

"Your statement will be checked by Official Records. In answering question 2, any special matters which in your opinion caused or aggravated any unsuitness from which you are suffering, must be clearly stated."

The claimant will answer the questions in his own words and after completing the form will sign it. The Officer will witness the signature. If the claimant cannot write, he will affix his mark, such act being witnessed.

THIS PORTION IS NOT TO BE COMPLETED IF A CLAIM IS NOT MADE.

- (a) In what countries have you served during this war and for what periods?
 (b) In what capacity?
England: Aug. 7th 1914 — June 1915
Hosp. Ship. Mediter. Ex. Force July. 1915
to June 1916. till Oct 1916.
Staff nurse & Sister. Bugland since
that date.
- If you are suffering from any disease, wound or injury, state what it is, the date upon which it started, and what in your opinion was the cause of it.
 (If more space is required a sheet of foolscap should be used and attached firmly to this form).
Severe head-ache at irregular periods. Insomnia.
Breathlessness on exertion.
Following sun-stroke + dysentery
July (or August) 1916.
- Give the names of any Hospitals in which you have been treated for the above disabilities during this war.
Sick Sister's Hospital,
19th Gen. Hospital
Alexandria.
- Did you suffer from the disease or injury mentioned in above answer to Question 2, or anything like it, before joining the Army? If so, give details and dates.
No.
- Give the names and addresses, (if you know them) of any Hospitals you were in or Doctors who attended you before you joined the Army.
R. A. Deane, Major R.A.M.C.
37, Park Square,
Leeds.
- Give the name of your National Health Approved Society and, if possible, your membership number.
Nurses' Insurance Society.
Buckingham St. London.
No. not known.

P.T.O.

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15

16

17

18

19

20

7. What is the name and address of your last employer before joining the Army?

Miss Barron (matron)
The Northern Hospital
Manchester

8. What was—

(a) your Industrial Group occupation before joining the Army?

(b) your trade or calling before joining the Army?

(To be checked from A.B. 439, A.B. 64, or A.F.B. 103.)

Professional Nurse.

The above statement has been read over to me, and I agree to it and have nothing to add to it.

Place of Examination

Signed

(Claimant).

Date

Signed

(Witness).

OPINION OF THE EXAMINING MEDICAL OFFICER.

(i) Clear and definite answers to the following questions are to be carefully filled in by the Examining Medical Officer, as it is essential that the Minister of Pensions should be in possession of the most reliable information to enable him to decide upon the applicant's claim to pension.

Expressions such as "may," "might," "possibly," &c., should be avoided.

(ii) The rates of pension vary according to whether the disability is (a) caused or aggravated by service in the present war, (b) due to causes not connected with the present war, viz.: (1) previous active service, (2) climatic diseases in pre-war service, (3) ordinary military service before the war. It is therefore essential when assigning the causes of a disability to differentiate between them.

(iii) When there is more than one disability the replies will distinguish between them.

9. Give Diagnosis and particulars of—

(a) Each disability claimed or discovered.

Headache & insomnia, subsequent to stroke in 1916

(b) The present condition thereof.

Slow & gradual improvement

THIS PORTION IS NOT TO BE COMPLETED IF A CLAIM IS NOT MADE.

10. State whether each disability is—

(a) Service during the present war.

(b) Previous active service.

(c) Climate in pre-war service.

(d) Ordinary military service before the war.

(e) Serious negligence or misconduct on the part of the claimant.

Give details:—

(i) Attributable to

or (ii) Aggravated

Yes

No

No

No

No

No

No

No

No

No

11. (a) Is each disability in a final stationary condition?

(b) If not, is re-examination before the expiration of the period of twelve months specially advised?

No

Yes

12. (a) What is the degree of disablement at which in your opinion he should be assessed at present?

Degrees of disablement should be expressed in words in the following percentages: 100, 80, 70, 60, 50, 40, 30, 20, less than 20, or nil.

(b) In case of aggravation, what in your opinion was the degree of disablement which existed before joining the Army?

40%

40%

Examining Medical Officer's Signature

R. A. Veale

Rank

Major

Unit to which attached.

R.A.M.C. (7)

Place of Examination

NORTHERN COMMAND

Date

4/5/19

CARDIAC CENTRE

GENERAL

Awards Reference No. *Russell 41398*

M.P.O.44.

REPORT OF MEDICAL BOARD ON OFFICER OR NURSE CLAIMING DISABILITY, IN RESPECT OF SERVICE IN THE GREAT WAR

(Held on... *7/1/1929*).

Names (Surname first) *CATTELL Florence Annie*
 Rank *Sister* Unit, Regt., or Corps. *18th S*
 Date of relinquishment, etc. *14.5.19* Date of Claim *26.10.28* Present age *46 born 1882*
 Permanent Address and nearest Railway Station *To The Secretary, The British Legion Pensions Committee, Stratford on Avon.*
 Former trade or occupation
 Disability or disabilities (if any) in respect of which Retired Pay, &c., has previously been granted:—

Disabilities.	Nature of Award (state whether final or not).	Current Assessment.
<i>neurasthenia</i>	<i>The nurse was in receipt of an award but allowed her claim to lapse</i>	

TO THE C.M.S.
D.C.M.S.*Birmingham*REGION.
AREA.

You are requested to be good enough to cause the above-named Officer to be examined by a Medical Board who should report overleaf.

The Officer claims compensation in respect of... *Annex 24^a*
 (See M.P.O. 18 attached)

Previous medical reports upon his case, and Form M.P.O. 638, giving particulars of military service, etc., are enclosed.

Form M.P.O. 115 is enclosed for completion at the examination.

The assessment should be made as from *26.10.28* The assessment and opinion of the Board must not be communicated to the Officer.

Any recommendation by the Board as to Treatment and Constant Attendance Allowance should be made to you separately on the forms prescribed for the purpose.

The report should be rendered through you to the Officers Branch, Ministry of Pensions, Sanctuary Buildings, 18, Gt. Smith St., Westminster, S.W.1.

SPECIAL INSTRUCTIONS.

The Board's attention is drawn to the SI observations at 24^a

GEORGE CHRYSTAL,

Secretary.

Date... *8.12.28* 1928

- Notes.—(i) Clear and definite answers are to be filled in by the Board. Expressions such as "may," "might," "probably," etc., are to be avoided.
- (ii) A report is to be made on any disability claimed and not previously compensated under the Pension Warrants. If it is found not to exist, the finding "No Disability" should be recorded at paragraph 7. If it exists, but is not considered to be connected with naval or military service, it should be as fully reported on as if it were. The words "No Disability" should never be used as equivalent to "No Disability connected with Service."
- (iii) If more than one new disability is claimed, distinguish by numerals throughout.

STATEMENT OF CASE BY THE MEDICAL BOARD.

- 1.—Are you satisfied that the Officer referred to in the Documents sent herewith is now before you?—
- 2.—Disability or disabilities (not already compensated under the Pension Warrants) now considered. State diagnosis and Code No. (To be entered AFTER THE EXAMINATION HAS BEEN COMPLETED).
- 3.—(a) State concisely the essential facts of the history of the disability claimed as recorded in the official documents, including DATE and PLACE of origin of the disability.
- (b) Add any supplementary details given by the officer himself, indicating clearly whether these are uncorroborated.

Yes.

Neuroasthenia 35.

2.22. Headache due to
insult

- 4.—Was an operation performed? If so, when and what was its nature?
- 5.—If an operation was advised and declined, was the refusal unreasonable?

OPINION OF THE MEDICAL BOARD.

- 6.—Give particulars of:—

(a) The disability giving rise to the claim.

(b) The present condition thereof, giving:— (i) Symptoms and physical signs; (ii) Effect of disability on function.

He is speaking ^{stammer} under any stress or excitement. Always shaky, especially on excitement. Sleeps very badly. He recently has been sleeping a little better. Appetite fair to moderate. Suffer from occipital headaches. No complaint regarding indigestion, inclined to constipation. Memory is poor. He states that although he is not really fit for a pension in 1921 he was not feeling any better but felt that he could carry on & that it distressed her so much having to appear at the board.

S.P.C. good. Teeth practically complete dentures. Tongue firm & clean. H.C. N. P. 128. Lung. h.d. Ad. neg. h. V.V. an C.V. Mentally. Very nervous & shaky. Concentration ~~an~~ sports memory defective. Tremor (coarse) hands & head. Speech hesitant stammer, at first severe, improving later. Pension reflects exceptional. H.C. N. Some Rombergism.

Finding Neuroasthenia (Severe).

- (1) Present condition is identical with that from which he suffered on service.
- (2) Present condition is wholly due to service factors.
- (3) Present disability = 80%. The board are of the opinion that 20% is due to condition 40% should be added to his service (pre-existing factor) and 40%

7.—If the claim is in respect of a wound or injury sustained in service, is the present condition solely due to that wound or injury?
If the answer to the above is in the negative the case should be dealt with under question 9 or 10.

No

8.—In the case of other disabilities, is there a record that the officer suffered from the disability during service, or from a disability (naming it) medically identifiable with it?

Yes.

9.—If there is a record of the disability during service—

- (a) Had the officer recovered from the disability before his discharge or 30th September, 1921?
(b) If not, is it established that the present disability is continuous with that recorded in service, and that it is not a fresh attack unconnected with service—
(i) by direct evidence consisting entirely of medical reports and certificates covering the period since discharge or since 30th September, 1921? or
(ii) by a continuous history of overt symptoms of ill-health since discharge or 30th September, 1921, established by evidence partly or wholly of a non-medical character?
(c) Where a part of the period since discharge is not covered by evidence, is it considered that the disability must have persisted throughout, and if so, for what reasons?

No.

Yes.

10.—If there is no record of the disability during service—

Is it established that the disability existed or must have existed during service, and that the present condition is a continuation of that disability, and is not a fresh attack unconnected with service?

- (a) If so, has this been established by direct evidence consisting entirely of medical reports and certificates covering the period since discharge or 30th September, 1921? or
(b) has this been established by a continuous history of overt symptoms of ill-health since discharge or 30th September, 1921, consisting of evidence partly or wholly of a non-medical character? or
(c) where a part of the period since discharge is not covered by evidence, is it considered that the disability must have persisted throughout, and if so, for what reasons? or

No

- (d) in the case of the diseases specified in paragraph 2115 of the Manual—
(i) was there a definite manifestation of the disease within the prescribed period?
(ii) is the clinical or pathological evidence such that the disability then manifested would be universally recognised by medical opinion as having existed in Great War service?
(iii) If the answers to (i) and (ii) are in the affirmative, is there a continuous medical history to connect the present condition with the manifestation, and what is the nature of the evidence for this?

*11.—Attributability or Aggravation.

If a continuous medical history can be certified under Questions 7 to 10 above, state whether—

- (a) The disability from which the officer is now suffering is attributable to conditions which were experienced by him in, and particularly in consequence of, his service during the Great War, and which were operative to give rise to the disability; or
(b) the disability, though not attributable to War Service, was and STILL IS aggravated by conditions which were experienced by the officer in, and particularly in consequence of, his service during the Great War, and which were operative to aggravate the disability; and
(c) state briefly the reasons for the opinion given in answer to Questions 11 (a) and (b) and if the answer to either is in the affirmative, the nature of the conditions which caused or aggravated the disability.

Attrib.

*12.—Exceptional Cases.

If a continuous medical history cannot be certified under Questions 7 to 10, but the disability is one which for exceptional reasons the Board hold to be attributable to the conditions of the officer's War Service, or to have been and still to be aggravated thereby, state fully the Medical grounds for the opinion and the evidence on which it is based. (If space insufficient, annex another sheet.)

No

* Where the Board consider that the medical evidence for and against the claimant is not sufficiently definite, or otherwise feel doubt as to the expression of a confident opinion one way or the other on the question of entitlement, they may leave the question unanswered and instead set out in their report the pros and cons of the medical evidence.

Re-estimate the service factor in this case and they recommended that if the present to other circumstances (in particular social circumstances) that this amount 140% should be made final

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13.—If the disability is not attributable to, nor still aggravated by, naval or military service in the Great War, was it caused or aggravated by:—

- (1) Active service in a previous war,.....
 or (2) Other naval or military service before the Great War,.....*na.*
 or (3) Post-war service (i.e. service after the 30th September, 1921),.....
 or (4) Causes other than the above?.....

14.—Is there any evidence that the disability was due to serious negligence or misconduct on the part of the officer? If so, state the nature of such evidence.

no

15.—(1) In cases where an award has previously been made in respect of another disability or disabilities, state whether the disability now reported upon is:—

- (a) An entirely separate disability,.....
 or (b) Part of or a direct sequela of the former disability,.....
 or (c) Connected with, but not a necessary consequence of, the former disability or disabilities

(2) If the answer to Question 15 (1) (c) is in the affirmative, state whether a change of diagnosis or of entitlement is involved by the additional medical evidence available.

16.—(1) (a) State the degree of disablement at which in the Board's opinion the officer should be assessed in respect of the disability now being reported on, independent of hospital or other treatment?

(b) In the case of aggravation, where there is any definite or presumptive evidence that the disability was present at the commencement of service in the Great War, what in the Board's opinion was the degree of disablement which existed at that time?

(2) If compensation has already been granted in respect of any other disability or disabilities (see page 1), what is the composite assessment for these and the disability now reported on?

(3) If the above assessments have been arrived at after discounting any "other condition" (e.g. personal habits, misconduct, etc.), the facts should be fully stated, and the method of arriving at the assessment indicated (see M.P.M.S.D. 57, Supplement 5).

*40%**Permanent*

NOTES.—(1) Degrees of disablement should be expressed in the following percentages: 100, 90, 80, 70, 60, 50, 40, 30, 20, less than 20, or Nil, and in words as well as figures.

(2) With regard to disabilities assessed at under 20 per cent. see M.P.M.S.D. 57, Supplement No. 3 D. Whenever a 8-14 per cent., or a 15-19 per cent., Indeterminate Duration assessment is given in a case not in a final and stationary condition, an explanation should be given.

17.—Is the disability in a final and stationary condition?.....

If not:—

- (a) How long is the present average degree of disablement likely to last?
 (b) If the present degree of disablement is not likely to last 12 months, can a further assessment at a reduced rate be made with reasonable confidence to cover a period of 12 months in all? If so, the reduced percentage and the period to which it will be applicable should be indicated in the answer to Question 16 (1) (a).

Signatures:—

G. Hallen

Chairman.

A. Williams-Walker

Assessor.

Thomson

Specialist.

Place of Board.

Date *7 Jan* 1929

6. 'PENSIONS APPEAL TRIBUNAL.' (NA PIN 26/20125 Annie Jerrett).

O Nurses
44154
PENSIONS APPEAL TRIBUNAL

MINISTRY
 OF
 PENSIONS
 16 MAR 1927

Form of Appeal by an ~~Officer~~ (or Nurse) against a decision by the Ministry of Pensions that his (or her) disability is neither attributable to nor aggravated by service during the Great War.

This Form, when completed, should be returned to the Officers Branch, Ministry of Pensions, together with the certificates required under Questions 13, 14 and 15.

QUESTIONS.		ANSWERS.	
1. Name ...		Surname <i>Terrett</i>	Christian Names <i>Annie</i>
2. Rank and Regiment...		<i>5/Nurse</i>	<i>D.A.N.S.</i>
3. Address in full ...		<i>119 Bradys Rd Shipley, Yorks.</i>	
	Home address -	<i>39 Belusgate, Siskin, Yorks</i>	
4. Reference number and date of Ministry of Pensions letter rejecting your claim.		<i>44154</i>	<i>Jan'y 18th / 27</i>
5. Occupation before your war service		<i>Nurse</i>	
6. If you served in the ranks during the war.			
(1) Date of entry or enlistment.	(1)	<i>4. 1. 15</i>	
(2) Regimental or Official Number.	(2)		
(3) Name of Ship or Battalion and Regiment or Corps from which finally discharged.	(3)	<i>11. C.C.S.</i>	
(4) Date and place of discharge.	(4)	<i>Date 13. 10. 19</i>	<i>Place Disposal Hotel, Folkestone</i>
(5) Cause of discharge.	(5)	<i>Demobilized</i>	
(6) Rank on discharge.	(6)	<i>5/Nurse</i>	
7. Date of Commission and name of Ship, or Battalion and Regiment or Corps in which you last served.			
Date of retirement, or relinquishment, or resignation of commission or demobilisation and the cause.			

DECEASED

8. Particulars of Service during the Great War.

(a) Periods of Service at home.

Rank.	From	To	Where Stationed.	Regiment.
<i>5/Nurse</i>	<i>4. 1. 15</i>	<i>14. 4. 17</i>	<i>2nd Western General Hospital Whitworth St, Birmingham</i>	<i>D.A.N.S.</i>

3

QUESTIONS	ANSWERS
11. Date and place of origin of each disability.	(1) Impossible to say - but (2) following on P.U.O. (3) (4)

12. If you received any treatment in hospital while serving.	Name of Hospital	Dates		Disability
		From	To	
	No 8 General Bowen	18.6.17	10.7.17	P. U. O.
	No 8 General Bowen	12.9.17	2.10.17	Carbuncle
	No 14 General	28.10.17	34.10.17	Debility
	"Millbank" London	8.12.17	18.12.17	Boils

DECEASED

13. Name and address of Employer or Firm	1. Martin Brownlow Hill Saffman & Dwyer
(1) prior to your war service.	
(2) since your war service.	
Certificates from these persons or firms should be attached showing the periods during which you were employed by them, and the time lost by you through ill-health.	2. Education Authority, Bradford

14. Name and address of National Health Insurance or other Society, if any, from which you were entitled to receive sickness or accident benefit before joining the service.	(a) Nurses Insurance
A certificate from the Society should be attached showing what sickness benefits you received from them.	(b) Municipal Officers
(a) before your war service.	(Benefits - Nil)
(b) since your war service.	received
NOTE.—This certificate must be applied for by you personally.	

15. Name and address of Doctor or Doctors who attended you in any illness or accident.	(a) (Family Doctor)
(a) before your war service.	Dr W. W. Stanthorpe
(b) since your war service.	Sunnyfield House
Certificates from these Doctors should be attached as to your state of health before enlistment and since discharge, the nature and inclusive dates of any illness being stated.	2. Dr Dawson
(No expense to the Public can be allowed on account of these certificates.)	Undercliffe St
	Barkerend Rd
	Bradford
	Dr Kemp
	5 Parish Church
	Ilkley

16. Reasons for making this appeal. You should state here the particular incidents or conditions of your service which you claim caused or aggravated your disability.

(In the case of more than one disability, each should be made the subject of a separate statement.)

Before commencing War service I enjoyed excellent health, in fact I never had a days illness that I remember. In addition I took part regularly in various sports & was a keen tennis player. I never had indigestion.

During my War service my routine was of course upset, my meals were irregular, the food was often of poor quality & badly cooked, & as a result of work which involved an exceptional degree of responsibility, the strain on my nervous system was intense - I contracted Duodenal Ulcer.

My medical advisers are convinced that the unsatisfactory food while living in a atmosphere of anxiety & unrest is directly responsible for the production of my Duodenal Ulcer.

During my service I lost ^{considerable} weight. At present I am in a poorly paid post, merely because my condition of health prevents me from entering a more lucrative branch of my profession. Even in my present post I have to lose time with increasing frequency as a consequence of my disability.

I feel very strongly that I have been ruined in health by serving my country & very reluctantly I have to ask for a pension.

"Ambervale"

Signature in full.....

Annie Jarrett

Place.....

119 Bradford Rd
 Shipley
 Yorks

Date.....

14.3.27

Annie Jerrett).

Registered Nurses 44154.

Two Reps copy

M.P.O. 79.

W.T.B.

Pensions Appeal Tribunal (Entitlement).

PRÉCIS OF CASE.

OFFICER'S
NURSE'S APPEAL

The Appellant claims that her disability, Duodenal Ulcer, is attributable to her military nursing service during the Great War.

102. 1. 27

The Ministry rejects the claim on the ground that the disability is neither attributable to nor aggravated by such service.

1. Surname.....JERRETT..... Christian Names.....Annie.....
2. Address.....119, Bradford Road, Shipley, Yorks.....
3. Rank and Unit.....Staff Nurse T.A.N.S..... 4. Present Age.....39.....
5. Occupation. (A) Pre-War.....Nurse..... (B) Post War.....School Nurse.....
6. (A) Date of Attestation..... (D) Date of Release from Service.....13.10.19.....
- (B) Date of Discharge from Ranks..... (E) Cause of Release.....Demobilised.....
- (C) Date of Commission.....Appointment. 4.1.15..... (F) Medical Category on Release.....
7. Disabilities claimed on Release.....None.....

8. PRE-GREAT WAR SERVICE.			
Units.	Years	From	To

9. GREAT WAR SERVICE.			
Units.	Years	From	To
T. A. N. S.	4.9/12	4.1.15.	12.10.19.

10. FOREIGN SERVICE. (To 30th September, 1921.)			
Country.	Years	From	To
France.	2.5/12	15.4.17.	Sept.1919.

11. POST WAR SERVICE.			
Country.	Years	From	To

12. Retired Pay or Gratuity already awarded :—

Disability.

Entitlement.

Remarks.

MFK.

-2-

13. GREAT WAR SERVICE MEDICAL HISTORY.

8.1.17. Certificate - Major R.T.N. Weld.

(Doc.T)

"I hereby certify that I have carefully examined this Staff/Nurse, and find that she is suffering from anaemia and debility following septic thumb and that in consequence thereof, I am of opinion that she is unfit for military duty. I further declare my belief that she will not be fit to resume her duties in a less period than two weeks."

25. 6.17. Admitted 8th General Hospital, Rouen.

(Doc.N)

"Pyrexia of unknown origin - Trench Fever"

Medical Notes:-

"Spike temp. pains in shin bones -
 lumbar pains, no splenic enlargement.
 History of lice."

9. 7.17. Transferred - Etretat.

12.9.17. Admitted 8th General Hospital, Rouen.

"Carbuncle".

2. 10.17. Discharged to duty.

25.10.17. Admitted - 4th Casualty Clearing Station.

Medical Notes:-

"Miss A. Jerrett joined this Unit for temporary duty on 7.10.17. She has been unwell practically all the time, she has been twice sick since she came to France and is in a run down state of health and requires rest."

25.10.17. Admitted - 14th General Hospital.

"Debility - Severe."

Medical Notes:-

"Onset September 1917.
 Influenza June 1917.
 3 days off duty. Temperature persisted.
 Pyrexia of unknown origin.
 (December ?) 1917.
 Trench Fever 2 spikes of temperature.
 After convalescence - fairly well till
 September. Carbuncle - abdominal wall incised. ?
 Right eye at same time - dry after leaving hospital
 went to C.C.S. (4) 17 days on duty there -
 Patient felt tired ? Mosquito bite -

3 septic

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
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PUBLIC RECORD OFFICE																			

-3-

3 septic patches eyelids.
Sick and vomited 2 days.
No definite physical signs."

31.10.17. Discharged to duty - United Kingdom 21 days
sick leave by Medical Board. (Doc.N)

(The report of this Medical Board is not
available.)

17.11.17. Certificate - Dr. W.W. Stainthorpe. (Copy). (Doc.S)

"This is to certify that Staff Nurse Annie Jerrett
is unable to follow her usual employment.

Illness Boils on body and limbs."

1. 12.17. Medical Board, Middlesborough. (Doc.R)

Disability - Debility - Axillary Abscess.

"She is improving in general health, but is
suffering from axillary abscess which requires
surgical treatment."

8. 12.17. Admitted - Queen Alexandra's Hospital, Millbank. (Doc.N)

"Axillary Furunculosis Left"

Case Sheet:- (Doc.O)

"10.12.17. Incised.

12.12.17. Now healed.

13.12.17. As she has had repeated boils a vaccine
is suggested."

13.12.17. Transferred - Q.A.I.M.N.S. Hospital, Vincent Square.

"Inflammation Connective Tissue, Axilla." (Doc.N)

Case Sheet:- (Doc.O)

"The patient joined the service January 1915
and served at Manchester till April 1917,
went to France till now.
She was off duty 3 weeks last June with Trench
Fever ? and again in September last for three
weeks suffering from Carbuncle on right side.

She came off duty October 25th suffering with
general debility and feeling run down, was given
three weeks leave at a Board held at No.14

General

-4-

General Hospital, Wimereux October 31st.
 She then went home but suffered from boils in ear, on body and afterwards had an axillary abscess. Her own Doctor said she required vaccine. She went before another Medical Board December 1st at Middlesboro, was given an extension of three weeks leave and understood she was to have Surgical treatment for the Axillary abscess.

She then had a wire from the Matron-in-Chief to go to Millbank December 8th, where her arm was opened.

On admission:-
 Patient is convalescent entirely free from boils."

18.12.17. Discharged from Hospital. (Doc.N)

18.12.17. Medical Board, London. (Doc.P)

Disability - Axillary Abscess.

"She went to France April last, October 25th was sent home on 3 weeks leave on account of Debility following Furunculosis. While at home she developed an axillary abscess and further boils for which she was treated at C.A.M.H. Millbank. She was transferred here on convalescence.

Present State -
 Free from Boils but appears debilitated.
 Requires dental treatment which can be carried out at home. Recommended one month's leave."

13.10.19. Demobilised.

27.10.19. Nurse stated on Army Form Z.22 that she did not claim to be suffering from a disability due to her military service. (Doc.Q)

14. MEDICAL REPORTS ETC., FOLLOWING TERMINATION OF ACTIVE SERVICE.

20.12.26. Medical Board, Leeds. (Doc.G)

Disabilities giving rise to claim:- Nervous Debility.
 Gastritis.
 Rheumatism.

"Nurse's Statement:-

Recurrent attacks of pain 1½ hours after food in pit of stomach, used to vomit a good deal, but not now. Relieved by taking more food. Losing weight. The attacks of pain last from 1½ hours after taking a meal, till the next meal. Frequently awake a night, owing to the pain,

also

-5-

also suffers from joint pains, but no swelling, and pains in shins occasionally - better lately.

On examination -

Thin - sallow - not emotional or nervous in conversation.
Weight 7, st. 8. lbs partly dressed.
Cranial nerves normal. Arm reflexes lively.
Abdominal reflexes active. Knee jerks lively.
Teeth well cared for. Satisfactory dentures also.
Tongue, flabby and coated.

Abdomen - Evident loss of weight, prominent gastric outline in epigastrium and quiet peristaltic waves passing from left to right visible.

Localised Tenderness over pylorus.
Marked succussion splash 2 1/2 hours after food.
Heart and Lungs normal.

Diagnosis - Duodenal Ulcer.

This diagnosis includes the rheumatism and debility claimed.

In view of the long history and the marked deformity of the Duodenum, as demonstrated by X-Rays surgical treatment is indicated. From the history and appearances of the duodenum (as revealed by X-Ray) the ulcer is evidently a very chronic one, and has evidently existed for some years."

X-Ray Report.

"Oesophagus normal.
Stomach a little enlarged and somewhat atonic.
No spasm or niche observed.
Peristalsis feeble.
No stasis.
Duodenum - persistent deformity of bulb shown.
Pylorus patent, allowing of easy filling of duodenum.
Small intestine appears normal."

The disability, Duodenal Ulcer, was classified by the Ministry as neither attributable to nor aggravated by the nurse's military nursing service during the Great War.

(Doc. 4)

15. ARTICLE 1.A EVIDENCE.

6.11.26. The nurse applied on M.P.O.13 on account of Nervous Debility, Gastritis and Rheumatism and claimed that they originated in 1919 and resulted from Pyrexia of unknown origin.

She also stated that, after demobilisation she was prevented by ill-health from working until 1.3.20.

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1.11.26 - Certificate - Dr. W.W. Stainthorpe.

(Doc.L)

"I do hereby certify that I have known Annie Jerrett for 25 years. I was her ordinary medical attendant for 20 years before she joined the Forces. During that time I did not attend her.

I formed the following opinion as to her general health:- Good."

1.11.26 - Certificate - Dr. W.W. Stainthorpe.

(Doc.K)

"I do hereby certify that I have known and attended Annie Jerrett since her discharge or demobilisation from the Forces. She first consulted me in 1921 and I found on that date that she was suffering from Nervous Debility.

She subsequently consulted me as under:-

1924. Recurrent septic tonsillitis.

I have formed the following opinion as to her general health:- General deterioration."

4.11.26. Certificate - Dr. P.R. Kemp.

(Doc.J)

"This is to certify that Miss Jerrett has from time to time consulted me with regard to her health.

She suffers from Nervous Debility and is also liable to recurrent attacks of Gastritis and Rheumatism.

In my opinion these disabilities are attributable to war service."

6. 11.26. Certificate - Dr. R. Lawson.

(Doc.H)

"I hereby certify that Miss Annie Jerrett was frequently under my treatment from August 1920 until July 1924, suffering from Gastritis and Rheumatism - at times she was incapacitated from work."

16. GROUNDS OF APPEAL.

14.3.27.

(Doc.A)

"Before commencing war service I enjoyed excellent health, in fact I never had a days illness that I remember. In addition I took part regularly in

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in various sports and was a keen tennis player. Never had indigestion.

During my war service my routine was of course upset, my meals were irregular, the food was often of poor quality and badly cooked, and as a result of work which involved an exceptional degree of responsibility the strain on my nervous system was intense. I contracted Trench Fever.

My Medical Advisers are convinced that the unsatisfactory food while living in an atmosphere of anxiety and unrest is directly responsible for the production of my Duodenal Ulcer.

During my service I lost considerable weight. At present I am in a poorly paid post, merely because my condition of health prevents me from entering a more lucrative branch of my profession. Even in my present post I have to lose time with increasing frequency as a consequence of my disability.

I feel very strongly that I have been ruined in health by serving my Country and very reluctantly I have to ask for a pension."

17. EVIDENCE IN SUPPORT OF APPEAL.

1.3.27. Certificate - Dr. W.W. Stainthorpe. (Doc.D)

"This is to certify that I have known Miss Annie Jerrett for 25 years and until she joined the Army she was a patient of mine - she was always a healthy girl prior to her joining the service, since her discharge her health has only been indifferent and to my knowledge suffered from nervous debility in 1921 and recurrent septic tonsillitis in 1924."

5.3.27. Statement - Matron, Brownlow Hill Infirmary, Liverpool. (Doc.E)

"Records shew that you trained in this hospital from March 7th, 1911 to September 3rd 1914. As you are not shown to be off duty sick during that time I conclude your health was satisfactory."

11.3.27. Certificate - Dr. P.R. Kemp. (Doc.B)

"This is to certify that the diagnosis of Duodenal Ulcer has been arrived at in the case of Miss Jerrett."

In my opinion this condition was caused - aggravated by war service."

14.3.27

-8-

14. 3.27. Certificate - Dr. R. Lawson.

(Doc.C)

"This is to certify that Miss Annie Jerrett was frequently under my care from 1920 to 1924 suffering from gastritis and rheumatism and was at various times incapacitated from work.

I think the condition was brought on by war service."

14.3.27. Certificate - Chief Ass. School Medical Officer, Bradford.

(Doc.F)

"Nurse A. Jerrett has been on the nursing staff of the City of Bradford School Medical Service in the capacity of School Nurse since 2nd March, 1920.

On several occasions she has been allowed sick leave on account of ill-health."

17. GROUNDS FOR REJECTION.

The appellant claims that her disability is attributable to her nursing service during the Great War and particularly to "unsatisfactory food while living in an atmosphere of unrest and anxiety".

Prior to the War she was employed as a Nurse in the Brownlow Hill Infirmary, Liverpool, and at the Borough Isolation Hospital, Derby, and her medical attendant states that her health at that time was good.

She was appointed to the T.F.M.S. on 4th January, 1915, and served at home until 14th April, 1917, and in France from 15th April, 1917 to September, 1919. There is a certificate to the effect that in January 1917 she was suffering from anaemia and debility following a septic thumb, but there is no other record of illness until after she went to France in April 1917. During her service in France she received treatment for Trench Fever in June 1916, Carbuncle in September 1917, Debility in October 1917, and Axillary Furunculosis in December 1917. The Medical Board which examined her on 18th December, 1917, found that she was free from boils but appeared debilitated, and that she required dental treatment, and recommended a month's leave. There is no further record of sickness before demobilisation, and there is no record that she suffered from Gastritis at any time during service.

She was demobilised on 13th October, 1919, and when completing Army Form Z.22 she disclaimed any disability due to Great War Service.

She

-6-

She states that after demobilisation she was prevented by ill-health from working until 1st March, 1920. There is however no record of medical attendance at that time. Since March 1920 she has been employed as a School Nurse by the Bradford Education Authority. Dr. Stainthorpe certifies that she consulted him in 1921 for Nervous Debility and in 1924 for Septic Tonsillitis, and Dr. Lawson that she was frequently under treatment from August 1920 to July 1924 for Gastritis and Rheumatism. The first medical evidence of gastritis is therefore nearly a year after demobilisation. No claim to disability compensation was made until October 1926, nearly seven years after the termination of War Service.

Duodenal Ulcer is not an uncommon complaint among the civil population, and in view of the absence of any record of gastric disorder during service and for nearly one year thereafter and that the present claim did not arise until nearly seven years after demobilisation, the Ministry is of opinion that the condition now present is of constitutional origin, and is neither attributable to nor aggravated by Great War Service, which terminated so long ago.

18.

QUESTION FOR TRIBUNAL.

The Pensions Appeal Tribunal is asked to decide whether the nurse's disability, Duodenal Ulcer, is attributable to or aggravated by her military nursing service during the Great War.

The appellant claims that her disability is attributable to her nursing service during the Great War and particularly to "unsatisfactory food while living in an atmosphere of unrest and anxiety."

Prior to the war she was employed as a nurse in the Brownlow Hill Infirmary, Liverpool, and her medical attendant states that her health at that time was good.

She was appointed to the T. F. N. S. on 4

January 1915 and served at home until 14.4.1917 and in June from 15.4.1917 to 5.6.1917.

There is a certificate that to the effect of 1.6.1917.

1917 she was suffering from anorexia and disability following a rupture of the stomach, and that there is

no other record of illness until after the war to

June in June 1917. During her service in

June she received treatment for Typhoid Fever in

June 1916, continued in September 1917, disability

on October 1917, Chelmsley notes Typhoid Fever in

December 1917. The Medical Board which examined

her on 18.12.1917 found that she was free from

both but appeared debilitated, and that she required

mental treatment, and recommended a month's

rest. There is no further record of illness during

war, and there is no official record that she

suffered from Typhoid at any time.

There is however no record of
medical attendance at that

March 1920

certifies that she consulted him in 1921 for nervous
debility and in 1924 for ~~Septic~~ Septic Toxicities, and
Dr. Lawson that she was frequently under treatment
from August, 1920 to July 1924 for Gastritis and Rheumatism.

Compensation was made until October 1926, nearly seven
years after the termination of his service.

the ^{fact} ~~fact~~ ^{fact} of the absence of any record of gastric
 disorder during ^{and for} ~~about~~ ^{about} nearly one year thereafter
 and that the present clin did not arise until nearly seven

161

years after Reconstruction, the 161 minority to of opinion the the
condition now present is of constitutional origin, and to rectify
attributable to our oppressed by Great War Service, which it
eliminated so long ago.

ANSWER.

From
J. O.

From
To

MEMORANDUM

No.

Army Form C. 348.

10
APR 10
CULTO 4

[1370] W3214/M1270 1750m C/17n-75 UAS 78

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Queen Alexandra's Imperial Military Nursing Service

Died Abroad	5
Died at Home	1
	6

Queen Alexandra's Imperial Military Nursing Service Reserve

Killed or drowned through enemy action	23
Killed or drowned accidentally	6
Died Abroad	37
Died at Home	40
	106

Voluntary Aid Detachments (Includes Special Military Probationers)

Killed or drowned through enemy action	13
Killed or drowned accidentally	3
Died Abroad	29
Died at Home	39
	84

Territorial Forces Nursing Service

Killed or drowned through enemy action	6
Killed or drowned accidentally	0
Died Abroad	9
Died at Home	33
	48

Territorial Force Voluntary Aid Detachments (Including Special Military Probationers)

Killed or drowned through enemy action	3
Killed or drowned accidentally	3
Died Abroad	3
Died at Home	49
	58

Total	302
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