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War Neurosis and Civilian Mental Health in Britain during the Second World War

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Submitted for the degree of Doctor of Philosophy

March 2016

Statement of originality

I declare that, except where explicit attribution is made, the work presented in this thesis is entirely my own

Hazel Croft

Abstract

This thesis investigates the mental health of civilians through an exploration of medical discourse, government policy and psychiatric practice in Britain during the Second World War.

The first section of the thesis analyses how the diagnosis of 'war neurosis' was constructed and theorised in psychiatric thought. It explores the relationship between psychiatric theories and the government's health and pension policies, and argues that psychiatric understandings of what constituted 'normal' and 'abnormal' psychological responses to the war involved a political as well a medical judgement. These official discourses and policy helped to create and sustain the dominant narrative of the war as one that had created few psychological disorders among civilians.

The second section of this study explores wartime mental health as it was practised in the political and social context of the war. It investigates psychiatric interventions at four sites of wartime practice: public mental hospitals, psychiatric outpatient clinics, 'front-line' areas hit by bombing-raids, and industrial factories. Its findings indicate that there was no agreement amongst medical practitioners about the extent and nature of civilian neurosis, and suggest that civilians' psychological reactions to the war were far more diverse than has been portrayed in many histories of the home front.

The thesis contends that the notion of a collective psychological response to the war masks the complexity of diagnostic debates and the multiplicity of emotions that were experienced during the war.

Acknowledgements

My thanks first and foremost are to my supervisor, Professor Joanna Bourke. She has provided support and encouragement throughout this project, as well as showing immense patience with my many demands and missed deadlines. Above all, she had a brilliant knack of restoring confidence in my abilities as a historian just at the times when it was most needed. I am also grateful to the friends and fellow historians who read draft chapters of the thesis, and who always asked stimulating questions, as well as pulling me up on my long sentences and poor punctuation: Kat Burden-Manley, Louise Hide, Simon Joyce, Clare Makepeace and Janet Weston.

Many friends provided encouragement and sustenance during some difficult times during the writing of this thesis. I am thankful to them all, and especially to Steph who provided me with a home for a year. Above all, my brother Stuart provided much love and support for the duration, and listened without complaint to my endless monologues about the thesis over numerous cappuccino breaks.

I would also like to thank my co-organisers of the Alternative Psychiatric Narratives conference, Stef Eastoe, Susanna Shapland and Janet Weston. It was this conference that reminded me that the history of psychiatry is not just an abstract scholarly exercise, but contributes to our understanding of the politics and experiences of mental health in the present as well as the past.

My interest in the history of psychiatry developed from wanting to understand the experiences of two people who were important to me when I was teenager. The first was my Aunt Tina, who committed suicide at the young age of 35. She spent frequent spells in Hill End Psychiatric Hospital, including undergoing rounds of ECT that never seemed to help her depression. The second was Fred, a patient at Napsbury Hospital, where I spent a year as a live-in voluntary worker at the age of 18. Fred had been a patient at Napsbury ever since he was diagnosed with shell-shock in the First World War. He never spoke about his wartime experiences, but I often thought about what he must have endured. I returned to thinking about Tina and Fred's experiences during the course of writing this research, and I dedicate this thesis to their memory.

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Abbreviations

ARP	Air Raid Precautions
BMA	British Medical Association
BMJ	British Medical Journal
BRO	Bristol Records Office
CAB	Cabinet Office
ECT	Electro-Convulsive Therapy
EMS	Emergency Medical Service
FD	Medical Research Council
GP	General Practitioner
HMSO	His Majesty's Stationery Office
HO	Home Office
INF	Ministry of Information
JMS	Journal of Mental Science
LAB	Ministry of Labour
LMA	London Metropolitan Archives
MOA	Mass Observation Archive
MH	Ministry of Health

NHS	National Health Service
PIN	Ministry of Pensions
PTSD	Post-Traumatic Stress Disorder
RAMC	Royal Army Medical Corps
TB	Tuberculosis
TNA	The National Archives

Chapter One: Introduction

'There has been a distinct, perhaps unconscious, tendency to gloss over the serious psychological effects that air-raids have on people, and to insist that the neurotic effects are negligible,' claimed Tom Harrisson in a letter published in the *British Medical Journal* (*BMJ*) in the immediate aftermath of the British Blitz.[1] Harrisson, an anthropologist and one of the founders of the Mass Observation organisation, believed the medical profession had seriously underestimated the psychological effects of bombing-raids on the civilian population. For Harrisson, 'No-one who has spent any time objectively studying behaviour in the "blitztowns" and getting right in among the mass of the people could shut their eyes – however hard they try to – to the very considerable effect that continuous raiding has on people's nervous system, irrespective altogether of the physical impacts.'[2] Harrisson was not alone in expressing concern about the medical profession's complacency about the effects of the war on civilians' mental health.[3] Psychoanalyst Edward Glover, who was the author of a major article about the psychological effects of the London Blitz, considered that the pre-war forecast of millions of psychiatric casualties, which he called the 'the mass neurosis myth', had been transformed during the early years of the war into an equally inaccurate and damaging 'no neurosis myth'.[4]

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[1] Tom Harrisson, 'Obscure Nervous Effects of Air Raids', Letter, *British Medical Journal*, 1, (31 May, 1941), p. 832.
[2] Ibid.
[3] See, for example, B. H. Kirman, 'Psychiatric Casualties', Letter, *British Medical Journal*, 2, (30 November, 1940), p. 761; Arthur Harris, 'Psychiatric Reactions of Civilians in War-Time', *The Lancet*, 2, (9 August, 1941), pp. 152-155; Felix Brown, 'Civilian Psychiatric Air-Raid Casualties', *The Lancet*, 1, (31 May, 1941), pp. 686-691.
[4] Edward Glover, 'Notes on the Psychological Effects of War Conditions on the Civilian Population, (III). The "Blitz" – 1940-41', *International Journal of Psychoanalysis*, Volume 23, (1942), p. 29; p. 36.

These critical voices have rarely been alluded to in the historiography and memorialisation of the Second World War, which have told the story of the home front as one in which ordinary people triumphed over adversity. Richard Titmuss's official social history of the war, first published in 1950, set out the thesis that the war had caused few psychiatric breakdowns among civilians. If anything, he suggested, civilians were strengthened in their psychological resolve due to wartime camaraderie, full employment, and by playing active roles in civil defence. According to Titmuss, the war had proved that 'most people had a greater capacity to adjust themselves than was thought possible: a tough resilience to the changed conditions of life imposed upon them.'[5] This notion of a 'tough resilience' among civilians has dominated subsequent historical understandings of the home front. Historians have largely examined civilian mental health during the war with two questions in mind: whether the inflated pre-war predictions of mass psychiatric casualties materialised and whether morale broke down in incidences of mass fear and panic. The answer to both those questions has invariably been 'No' – there were not millions of psychiatric casualties and there were few incidences of mass fear or panic. This focus on the numbers of psychiatric casualties and whether there was a breakdown in morale has meant that many of the ways in which psychiatrists and medics categorised, assessed and treated civilian neurosis during the war have still not been fully investigated. We still do not know enough about which, why, and

[5] Richard Titmuss *Problems of Social Policy*, (London: HMSO, 1950), p. 350. Titmuss, unlike many subsequent historians, posed his conclusions about the psychological response to the war quite tentatively, writing that states of mind could not be easily classified, and that the possibility of long-term psychological effects could not be ruled out. Ibid, pp. 337-351, p. 337, p. 350. Even 'revisionist' histories which have challenged many aspects of this official view of the war, have rarely challenged the narrative of the *psychological* resilience of civilians. See, for example, Angus Calder, *The People's War: Britain 1939-1945*, (London: Pimlico, 1992. First published 1969), p. 223.

in what ways, civilians experienced nervous disorders. By stepping outside the framework of morale, this research addresses some of these hitherto unexplored questions, and for the first time brings together an analysis of psychiatric theory, policy and practice in the context of the wider medical, political and social circumstances of the war.

The thesis will present three key arguments. Firstly, it will argue that the ways in which the medical profession classified and diagnosed civilians' mental disorders helped to create and sustain the narrative of the war as one that created few psychiatric casualties. Secondly, this study will contend that psychiatric definitions of what constituted 'war neurosis' involved a political as much as a medical judgement, and were linked to the concerns of government officials to limit the social and financial impact of the war. Thirdly, by examining wartime sites of practice, this thesis will suggest that there were tensions between official discourses and psychiatric practice in the conditions of war. In doing so, it will show how civilians' psychological responses to the war were far less uniform and far more complex than the dominant narrative of civilian resilience suggests.

A major aspect of this research has been to unpick the ways in which psychiatric conceptualisations and classifications shaped and altered how doctors assessed and treated their civilian patients during the war. Terminology plays an important role here. Throughout the thesis, and in its title, I have used the phrase 'war neurosis' to refer to the nervous symptoms and conditions that psychiatrists attributed to the war. The government explicitly discouraged doctors from using 'shell-shock', the short-hand term for soldiers' nervous disorders in the First World

War, and war neurosis was the phrase most commonly used to replace it. Like shell-shock, however, war neurosis was a nebulous term, which was open to a wide variety of interpretations.[6] Although war neurosis was rarely used as a clinical diagnosis attached to specific symptoms, it was a term that psychiatrists frequently used in their writings about the psychological effects of the war. In this thesis, I have explored these varied interpretations, and have attempted to unravel the 'tangled skein' of physiological, psychological and social factors that were incorporated into understandings of war neurosis.[7]

My aim here is not to claim that in Britain there existed a large number of psychiatric casualties that the authorities deliberately covered up or that historians have simply failed to unearth. Nor do I claim that people were suffering from a neurosis when neither practitioners nor patients at the time attached a psychiatric label to civilians' psychological or emotional states. Such retrospective diagnosis would risk pathologising past feelings and behaviour, and imposing meanings and definitions that would have been unrecognisable to the subjects of this research.[8] Rather, I have attempted to understand the ways in which psychiatric classifications and diagnoses shaped understandings of the psychological states that emerged during the war, and how these understandings subsequently made possible the interpretation of the war as one with few psychiatric casualties.

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[6] For an account of the 'nebulous' meanings attached to shell-shock see Tracey Louise Loughran, 'Shell-Shock in First World War Britain: an Intellectual and Medical History, c. 1860-1920', unpublished PhD thesis, University of London, 2006, p. 8.

[7] The phrase 'tangled skein' is from Aubrey Lewis, 'Social Effects of Neurosis', *The Lancet*, 1, (6 February, 1943), p. 169.

[8] Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory*, (Princeton, N. J.: Princeton University Press, 1995), p. 341.

Psychiatric theories about the aetiology and symptomology of war neurosis did not take place in a vacuum, but were inextricably linked to wider social, economic and political factors. Throughout this research, I have thus paid attention to what historian Paul Lerner has termed the 'ever-present political and economic dimensions' of psychiatric theory and practice.[9] This is not to posit an economic reductionist explanation, whereby psychiatric diagnoses and practices are viewed as simply reflecting and reinforcing wider political and economic interests. Rather, it is to suggest that the development of the dominant psychiatric narrative of the war was the result of a complex overlapping of socio-economic, political and medical assumptions about the aetiology and manifestation of mental illness. Synergies emerged between government and psychiatric opinion on the types of nervous conditions that would arise, and about which nervous conditions would be attributed to the war. Here I have examined how government officials drew on psychiatric conceptualisations in the formulation of wartime health and pension policies. These policies were crucial in determining the extent and nature of psychiatric provision during the war, and regulated and limited the numbers of hospital beds, clinical services and staff that were available for the treatment of civilians experiencing nervous disorders.

In this research, I have also addressed some of the tensions which developed between official medical discourses and the experiences of doctors in their day-to-day practice amid the exigencies, hardships and social dislocations of

[9] Paul Lerner, *Hysterical Men: Psychiatry and the Politics of Trauma in Germany, 1890-1930*, (Ithaca & London: Cornell University Press, 2003), p. 2.

the war.[10] To do so, I have investigated psychiatric interventions at four main sites of wartime practice: public mental hospitals, psychiatric outpatient clinics, 'front-line' bombing areas, and industrial factories. In each site, I have explored the specific material conditions, geographical locations, and social relationships involved. Exploring such varied sites of practice has enabled me to compare and contrast the ways in which civilians' mental states were assessed, diagnosed and treated. This depended on whether nervous disorders and symptoms were viewed as being long-term or transient, as psychotic or neurotic, or as non-curable or curable. My examination of psychiatric practice has also revealed differences between psychiatric attitudes towards civilians who had directly experienced air-raids and those who experienced what Tom Harrisson characterised as the 'unblitzed aspect of blitzing': the uncertainty and fear created by the anticipation of bombing, and the tedium, loneliness and hardships of everyday life in wartime.[11]

In some ways, my examination of these sites as discrete spaces of practice imposes an artificial boundary between them. Certainly, for both practitioners and patients the boundaries were not always clearly demarcated. Psychiatrists and social workers, as well as patients, often moved between hospital and clinic, First Aid Post and GP surgery, depending on geographical location, the various phases of the war, or for patients, on the stage of their mental illness or emotional

[10] Here I have been influenced by sociologist Nick Crossley's formulation that psychiatric discourse needs to be 'problematised in practice'. Nick Crossley, 'Transforming the Mental Health Field: the Early History of the National Association for Mental Health', *Sociology of Health and Illness*, Volume 20, (1998), p. 462. Historian Mathew Thomson also emphasises the importance of examining psychological discourses in the context of how they were put into practice. See Mathew Thomson, *Psychological Subjects: Identity, Culture and Health in Twentieth Century Britain*, (Oxford: Oxford University Press, 2006), p. 7.

[11] Tom Harrisson, *Living Through the Blitz*, (London: William Collins, 1976), p. 270.

disturbances. Nor are the sites I have chosen to research the only places where civilian psychiatry was practised during the war. There were also public assistance institutions, observation wards in general hospitals, and a host of smaller lodging houses and private institutions that housed and treated psychiatric patients. Nine 'neurosis centres' were also established during the war, under the auspices of the Emergency Medical Service (EMS). These centres mainly treated military psychiatric casualties, and for that reason I have not included a detailed examination of these sites in this thesis. Psychiatric attitudes and treatments at these centres were influential in wartime debates about civilian neurosis, however, and I have thus referred to reports and case studies about civilian patients at the neurosis centres and at other institutions.[12]

Throughout this project, I have examined the diversity of civilians' psychological responses to the war. I have also questioned whether it is possible to conceive of a collective civilian response in the light of the varied social, political and medical contexts in which the war was experienced. I suggest that there was not one civilian psychiatric response to the war but many, depending on multiple social, economic, geographical and cultural factors. The status, identity and mental states of individual civilians was not static during the war but was, like the population itself, constantly shifting. Large numbers of people moved around the country to seek safety or work, especially as evacuation programmes, and military and industrial conscription took their toll.[13] Just as the boundaries between military

[12] The establishment of the neurosis centres, and the reasons for their focus on military casualties, will be discussed in Chapter Three.

[13] A recent example of shifting masculine identities during the war is Linsey Robb, '"The Front Line": Firefighting in British Culture, 1939-1945', *Contemporary British History*, Volume 29, (2015), pp. 179-198.

and home fronts were blurred during the war, so too was the distinction between military personnel and civilians. Hundreds of thousands of civilians, for example, were involved in quasi-military civil defence duties, or served in the ambulance, fire and other emergency services. Others were dismissed from or rejected for military service, and were later treated by civilian psychiatric services.[14] This blurring of the boundaries between military and civilian spheres has thus further complicated this assessment of civilians' psychological responses to the war.

I have chosen to focus this research on civilians who were considered 'adults', although age was obviously also a shifting category over the six years of the conflict. Rather than impose my own view of what age a child became an adult, I have followed how psychiatrists and medics categorised the civilians they encountered and treated at the time. In the 1940s, the school leaving age was 14 and this was the age most frequently used as the dividing line between adult and child. Sociologist Nikolas Rose has suggested that the war provided a new 'visibility' to the child as an object of psychiatric scrutiny. There has subsequently developed a prodigious historical literature on the psychological effects of the war on children, particularly centring on accounts of evacuation or on psychoanalytic studies of infants.[15] The experiences of adult civilians, in contrast, have tended to be

[14] Nafsika Thalassis, 'Useless Soldiers: The Dilemma of Discharging Mentally Unfit Soldiers During the Second World War', *Social History of Medicine*, Volume 23, (2010), pp. 98-115.

[15] Nikolas Rose, *Governing the Soul: the Shaping of the Private Self*, (London, Free Association Books, 1999, second edition), p. 162. Recent historical studies about the psychological focus on the child in the mid-twentieth century include Michal Shapira, *The War Inside: Psychoanalysis, Total War, and the Making of the Democratic Self in Postwar Britain*, (Cambridge: Cambridge University Press, 2013) and Mathew Thomson, *Lost Freedom: the Landscape of the Child and the British Post War Settlement*, (Oxford: Oxford University Press, 2013). Out of the voluminous number of social histories of evacuation, a good recent example is John Welshman, *Churchill's Children: the Evacuee Experience in Wartime Britain*, (Oxford: Oxford University Press, 2010). A selection from the extensive contemporary psychological literature about children includes, Frank Bodman, 'Child Psychiatry in War-Time Britain', *Journal of Educational Psychology*, Volume 35 (May, 1944), pp. 293-

overlooked in the plethora of historical accounts that that have largely viewed the war through the eyes of those who were children at the time.[16] I have attempted to redress this balance by focusing my research on the psychiatric experiences of adult civilians who have been less visible in both popular and scholarly accounts of the war.

By combining an analysis of psychiatric discourse, government policy and wartime practice, and the ways in which these factors shaped the experiences of civilians, this thesis makes an original contribution to historical understandings of mental health during the Second World War. In particular, this research has drawn upon, and contributes to, three areas of historiography – histories of war neurosis and trauma, histories of twentieth-century psychiatry, and histories of the British home front.

Historiographical contexts

War neurosis in its various manifestations has been the subject of extensive historical debate – most notably, in histories of military psychiatry and the psychological effects of combat. At the heart of this debate has been the question of whether war neurosis can be conceived as a universal experience, which

301; E.M. Creak and B.J. Shorting, 'Child Psychiatry', *Journal of Mental Science*, Volume 90, (January, 1944), pp. 265-381; Rosemary Pritchard and Saul Rosenzweig, 'The Effects of War Stress upon Childhood and Youth', *Journal of Abnormal and Social Psychology*, Volume 37, (July, 1942), pp. 329-344; Arthur T. Jersild and Margaret F. Meigs, 'Children and War', *Psychological Bulletin*, Volume 40, (October, 1943), pp. 541-573.

[16] This point is made by historian Helen Jones, who suggests that this has largely been due to the flourishing of eyewitness accounts and oral histories of the war in recent decades. Helen Jones, *British Civilians on the Front Line: Air Raids, Productivity and Wartime Culture*, (Manchester & New York: Manchester University Press, 2006), p. 20.

reappears in each conflict under a slightly different guise, or as a condition which is culturally constructed and can only be understood by examining the specific social, military, medical and historical contexts in which it emerged.[17] Until the last decade, historical debates about war neurosis had almost exclusively centred on the experience of combatants and military personnel. This is perhaps unsurprising in the analysis of conflicts prior to the Second World War, where civilians were distanced from the frontline of battle. It is more surprising in the case of the Second World War, where the dividing line between the home and military front was so blurred.[18]

The most voluminous and extensive historical debate about war neurosis has centred on the First World War and the psychiatric disorders incorporated under the umbrella-term shell-shock. Since the 1980s, historical research into shell-shock has flourished, eliciting a diverse and searching historical debate. Within this vast literature, historians have conceived of shell-shock as a consequence of

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[17] Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*, (Hove & New York, Psychology Press, 2005), p. xvi. Other overviews of military psychiatry include, Hans Binneveld, *From Shellshock to Combat Stress: A Comparative History of Military Psychiatry*, (Amsterdam: Amsterdam University Press, 1997); Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists, 1914-1994*, (London: Jonathan Cape, 2000). An important earlier examination of war neuroses prior to the First World War is George Rosen, 'Nostalgia: A "Forgotten" Psychological Disorder', *Psychological Medicine*, Volume 5, (1975), pp. 340-354. See also, Edgar Jones, 'War and the Practice of Psychotherapy: the UK Experience 1939-1960', *Medical History*, Volume 48, (2004), pp. 493-510; Edgar Jones, 'Historical Approaches to Post-Combat Disorders', *Philosophical Transactions of the Royal Society*, Volume 361, (2006), pp. 533-542; Edgar Jones, 'Framing Mental Illness, 1923-1939: the Maudsley Hospital and its Patients', *Social History of Medicine*, Volume 21, (2008), pp. 107-125; Edgar Jones and Simon Wessely, 'Psychiatric Battle Casualties: and Intra- and Interwar Comparison', *British Journal of Psychiatry*, Volume 187, (2001), pp. 242-247; Edgar Jones and Simon Wessely, 'Hearts, Guts and Minds: Somaticism in the Military from 1900', *Journal of Psychosomatic Research*, Volume 56, (2004), pp. 435-429; Edgar Jones and Simon Wessely, 'A Paradigm Shift in the Conceptualization of Psychological Trauma in the Twentieth Century', *Journal of Anxiety Disorders*, Volume 21, (2007), pp. 164-175.

[18] It should be noted that in the last three decades there have been extensive psychological and anthropological studies of the effects of war on civilians, examining the psychological impact on civilians of the wars following the break-up of former Yugoslavia in the 1990s and recent conflicts in Afghanistan and Iraq, which have yet to be fully examined by historians.

modernity and industrialised warfare, as a phenomenon of mass male hysteria, and as signifying the beginning of the demise of somatically-based asylum psychiatry and theories of hereditary degeneration.[19] Martin Stone's essay, in which he contended that the First World War was a catalyst for the wider acceptance of psychological and psychodynamic explanations for mental disorder, remains one of the most influential works in this historiography.[20] Stone's ground-breaking thesis has rarely been disputed in the decades since its initial publication.[21] More recently, however, historians such as Tracey Loughran and Mathew Thomson have questioned some aspects of Stone's thesis, suggesting that he overstated the psychiatric and social impact of shell-shock, and emphasising the continuities with pre-war medical and psychological thought.[22] These analyses suggest that historians should pay attention not only to ruptures in understandings of war neurosis but also to the ways medics drew on and developed previous theorisations and diagnoses.

The fascination with the First World War has shown no sign of abating, and in recent years historians have widened their enquiry to encompass the impact of

[19] Eric Leed, *No Man's Land: Combat and Identity in World War One*, (Cambridge: Cambridge University Press,1979); Elaine Showalter, *The Female Malady*, (London: Virago Press, 1987), Chapter 7, pp. 167-194; Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War*, (London: Reaktion Books, 1996); For the German case, see Paul Lerner, *Hysterical Men: War, Psychiatry and the Politics of Trauma in Germany, 1890-1930*, (Ithaca & London: Cornell University Press, 2003); Martin Stone, 'Shellshock and the Psychologists', in W. F. Bynum, R. Porter and M. Shepherd (e ds.), *The Anatomy of Madness*, Volume Two, (Cambridge: Cambridge University Press, 1995), pp. 242-271; Ted Bogacz, 'War Neurosis and Cultural Change in England, 1914-22: the Work of the War Office Committee of Enquiry into "Shell-Shock"', *Journal of Contemporary History*, Volume 24, (1989), pp. 227-256.
[20] Stone, 'Shellshock and the Psychologists', pp. 242-248.
[21] Tracey Loughran, 'Hysteria and Neurasthenia in pre-1914 British Medical Discourse and in Histories of Shell-Shock', *History of Psychiatry*, Volume 19, (2008), p. 42.
[22] Ibid; Tracey Loughran, 'Shell-Shock and Psychological Medicine in First World War Britain', *Social History of Medicine*, Volume 22, (2009), pp. 79-95; Thomson, *Psychological Subjects*.

shell-shock on nurses and other non-combatants, and on civilian society and the home front.[23] Many of these accounts explore themes that I take up in this thesis about how psychiatric discourse and practice shaped the lives and experiences of those who had been psychologically shattered by war. Peter Barham and Peter Leese, for example, have each produced excellent monographs examining the struggles of former servicemen for recognition and treatment in the face of unsympathetic government, military and medical officials in the aftermath of the First World War.[24] Other historians have suggested that some shell-shock victims were subsequently able to recuperate a heroic, masculine status as shell-shock became more recognised as a medical condition in the post-war years.[25] Analyses of shell-shock have also been incorporated into a growing field of scholarship which, partly as a reaction to the emphasis on discourse engendered by the linguistic turn, has attempted to capture the 'lived experience' and 'materiality' of the First World War. These studies have not only drawn upon official archival material, such as medical and government records, but have also analysed letters, diaries and other

[23] On the trauma of nurses and orderlies, see Margaret R. Higonnet, 'Authenticity and Art in Trauma Narratives of World War 1', *Modernism/Modernity*, Volume 9, (2002), pp. 91-107; Carol Acton and Jane Potter, '"Those Frightful Sights Would Work Havoc with one's Brain": Subjective Experience, Trauma, and Resilience in First World War Writings by Medical Personnel', *Literature and* Medicine, Volume 30, (2012), pp. 61-85; Laura L. Phillips, 'Gendered Dis/ability: Perspectives from the Treatment of Psychiatric Casualties in Russia's Early Twentieth-Century Wars', *Social History of Medicine*, Volume 20, (2007), pp. 333-350. On the impact of the war on British civilian society, see Trudi Tate, *Modernism, History and the First World War*, (Manchester & New York: Manchester University Press, 1998), Chapter One, pp. 10-40; Susan Kingsley Kent, *Aftershocks: Politics and Trauma in Britain, 1918-1931*, (Basingstoke: Palgrave Macmillan, 2009); Fiona Reid, *Broken Men: Shell-Shock, Treatment and Recovery in Britain, 1914-1930*, (London: Continuum, 2010).

[24] Peter Barham, *Forgotten Lunatics of the Great War*, (New Haven & London: Yale University Press, 2004); Peter Leese, *Shellshock: Traumatic Neurosis and the British Soldiers of the First World War*, (Basingstoke: Palgrave Macmillan, 2002).

[25] Laurinda Stryker, 'Mental Cases: British Shell Shock and the Politics of Interpretation', in Gail Braybon (ed.), *Evidence, History and the Great War: Historians and the Impact of 1914-18*, (New York & Oxford: Berghahn Books, 2003), pp. 154-171; Jessica Meyer, 'Separating the Men from the Boys: Masculinity and Maturity in Understandings of Shell Shock in Britain', *Twentieth Century British History*, Volume 20, (2009), pp. 1-22; Jessica Meyer, *Men of War: Masculinity and the First World War in Britain*, (Basingstoke: Palgrave Macmillan, 2009).

personal effects of soldiers, attempting to capture and understand the emotional experience and subjectivities of the people who lives were the subject of medical and government debates.[26]

In addition, shell-shock has become a focus of a growing body of scholarly work analysing the concept and experience of trauma.[27] Scholars of trauma have traced the continuities between shell-shock and nervous disorders, such as neurasthenia, that were identified in the mid- to late-nineteenth century, and attributed to the fast pace and complexity of life in a modern, industrialised societies.[28] These accounts have placed shell-shock on a historical trajectory from broadly physical to broadly psychological explanations for trauma, from railway spine in the late nineteenth-century through to post-combat stress in Vietnam War veterans. Some scholars have viewed trauma as a universal human experience, albeit known by different names, which has always resulted from disturbing events, including war, accidents and sexual abuse.[29] In her account of the traumatic experiences of First World War nurses who tended to the mangled bodies of the injured, Margaret Higonnet explicitly argues that the modern diagnosis of post-

[26] Although not solely about shell-shock, one outstanding example is the exploration of the emotional relationships between soldiers and their mothers in Michael Roper, *The Secret Battle: Emotional Survival in the Great War*, (Manchester & New York: Manchester University Press, 2009). See also Santanu Das, *Touch and Intimacy in First World War Literature*, (Cambridge: Cambridge University Press, 2005); Ana Carden Coyne, *Reconstructing the Body: Classicism, Modernism and the First World War*, (Oxford: Oxford University Press, 2009).

[27] See, for example, see Judith Lewis Herman, *Trauma and Recovery: From Domestic Abuse to Political Terror*, (London: Harper Collins, 1992); Ruth Leys, *Trauma: A Genealogy*, (Chicago & London: University of Chicago Press, 2000); Mark Micale and Paul Lerner (eds.), *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age, 1870-1930*, (Cambridge: Cambridge University Press, 2001).

[28] Roger Luckhurst, *The Trauma Question*, (Abingdon & New York: Routledge, 2008), p. 51. For an excellent account of this historiography, see Paul Lerner and Mark S. Micale, 'Trauma, Psychiatry and History: A Conceptual and Historiographical Introduction', in Micale and Lerner (eds.), *Traumatic Pasts*, pp. 1-27.

[29] For an early example, see Michael R. Trimble, *Post-Traumatic Neurosis: From Railway Spine to the Whiplash*, (London: John Wiley & Sons, 1981); see also Herman, *Trauma and Recovery*.

traumatic stress disorder (PTSD), first formulated as a diagnosis in 1980, offers a 'vocabulary' to describe the nurses' trauma.[30] Other historians, however, have warned of slippage in usage of the term 'war trauma' when applied to the psychological disorders of all conflicts, regardless of their specific political, social and cultural circumstances. Trauma is not a neutral description, but always operates in what historian Ana Carden Coyne has called a 'highly politicised context', involving various pressure groups, as well as the vested interests of the military, government and medical establishments.[31] Rather than viewing trauma as a universal reaction to the experience of war, in this thesis I take the approach that trauma has to be viewed as being culturally conditioned and historically contingent.

The Second World War, apart from the extensive scholarly literature on the Holocaust, has rarely featured in these analyses of the trauma of war.[32] The historical trajectory of trauma seems to have jumped from the shell-shocked soldier to the post-traumatic syndromes of Vietnam veterans, with rarely a mention of the British military or the civilian experience during the Second World War. This absence can perhaps be explained by the way in which from a British perspective the war has been characterised as a 'good war', especially in comparison with the trench warfare of the 1914-18 conflict. Until recently, accounts of war neurosis in the Second World War have mainly been limited to sections within historical

[30] Higonnet, 'Authenticity and Art in Trauma Narratives of World War 1', p. 92. Das, *Touch and Intimacy,* pp. 175-203. Das refers to Higonnet's studies in his chapter on nurses' experiences, but historicises the concept of trauma.
[31] Carden Coyne, *Reconstructing the Body*, p. 62.
[32] Luckhurst's book on literature and trauma, for example, has only one page on the Second World War. Ruth Leys' genealogical exploration of trauma, in which she analyses the theories of the psychoanalyst Abram Kardiner and the psychiatrist William Sargant is an exception. See Leys, *Trauma*.

overviews of military psychiatry in the twentieth-century. As such, these studies have tended to focus on the neuroses suffered by troops rather than civilians, and have taken a rather top-down approach that has uncritically examined the perspectives of military psychiatrists.[33] Historian Ben Shephard has even argued that historians have tended to eschew the history of military psychiatry in the 1939-45 period because they would rather ignore the 'unfashionable' conclusion that military psychiatrists dealt with war neurosis effectively.[34] According to Shephard, military psychiatric casualties in the later conflict were 'equally dramatic', but were 'more diffuse', occurring over wider and more varied locations.[35] In his positive appraisal of British wartime psychiatry, Shephard argues that the treatment of psychiatric casualties successfully combined 'tough' frontline methods with psychologically-based new techniques in military hospitals, such as 'drug-induced abreaction and Neo-Freudian "object relations" psychiatry.'[36]

Other historians have taken a far more critical view of military psychiatry during this period, however. Joanna Bourke, for example, emphasises that it was dominated by military values of hierarchy, obedience and conformity. Military psychiatrists saw their primary role as restoring the maximum number of men back

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[33] An exception is Bourke, *An Intimate History of Killing: Face to Face Killing in Twentieth-Century Warfare*, (London: Granta Books, 1999); See also her chapter on civilian fears in Joanna Bourke, *Fear: A Cultural History*, (London: Virago, 2005), pp. 222-254. Histories of military psychiatry that include sections of the Second World War include, Shephard, *A War of Nerves;* Binneveld, *From Shellshock to Combat Stress*; Jones and Wessely, *Shell-Shock to PTSD.* Shephard's account is one of the few studies to contrast military and civilian psychiatry during the Second World War.

[34] Shephard, '"Pitiless Psychology": the Role of Prevention in British Military Psychiatry in the Second World War', *History of Psychiatry*, Volume 10, (1999), p. 492. Shephard, *A War of Nerves*, p. xx.

[35] Shephard, *A War of Nerves*, p. 168. In the British context, estimates of military psychiatric casualties have ranged between 20 and 50 per cent of all military discharges. Joanna Bourke, 'Disciplining the Emotions: Fear, Psychiatry and the Second World War', in Roger Cooter, Mark Harrison and Steve Sturdy (eds.), *War, Medicine and Modernity*, (Stroud: Sutton Publishing, 1998), p. 228; Jones and Wessely, 'Psychiatric Battle Casualties', p.244; Thalassis, 'Useless Soldiers' p. 102.

[36] Shephard, '"Pitiless Psychology"', p. 493.

to active duty.[37] According to Bourke, psychiatrists in the Second World War took up the job of returning men to the frontline with more relish, and with less sympathy for neurotic soldiers, than their medical counterparts in the First World War.[38] Historians have also examined how economic pressures placed on psychiatrists by the government and the military establishment influenced the way psychiatric diagnoses were applied, including in the 'therapeutic communities' and psychoanalytically-based therapies deployed at some military hospitals during the war.[39]

Historians have only recently turned their attention to the ways in which psychiatrists conceptualised war neurosis in the Second World War, and have rarely looked at how the construction of diagnoses shaped and altered the types of psychological conditions experienced. A recent exception has been the work of Elizabeth Roberts-Pederson, who has examined how military psychiatrists understood war neurosis by conducting a close reading of articles in the two main British medical journals, the *BMJ* and the *Lancet*. According to Roberts-Pederson, military psychiatrists located the aetiology of neurosis within the bodies of inherently unstable individuals, who were assessed as having weak personalities and defective heredity. Moreover, she argues, the ill-defined concept of 'predisposition' became an all-encompassing explanation for war neurosis. By

[37] Bourke, *An Intimate History of Killing*, pp. 262-265.
[38] Ibid, p. 259.
[39] Binneveld, *From Shellshock to Combat Stress*, p. 93. Shephard, despite his positive overall appraisal of British military psychiatry, did highlight the way that psychiatric priorities were shaped by the drive to curtail pension costs in Shephard, '"Pitiless Psychology"', pp. 491-524; For an analysis of how the military priority to return men to duty dominated the group therapies at Northfield military hospital, see Nafsika Thalassis, 'Soldiers in Psychiatric Therapy: the Case of the Northfield Military Hospital 1942-1946', *Social History of Medicine*, Volume 20, (2007), pp. 351-368, p. 357.

attributing neurosis to pre-existing constitutional weakness or faulty heredity, military psychiatrists thus downplayed the war and the 'martial environment' as causal factors in the development of neuroses.[40] In this thesis, I follow the example of Roberts-Pederson and attempt to develop a similarly thorough analysis of the writings of psychiatrists on civilian neurosis, analysing the ways in which wartime diagnoses were constructed and articulated and how this would shape later understandings of the psychiatric cost of the war.

There have so far been very few accounts providing a similar analysis to Roberts-Pederson in relation to civilian war neurosis. Shephard is one of the few historians of military psychiatry who makes some interesting, if somewhat speculative, observations on the civilian psychiatric experience. In particular, he suggests that civilians were subject to a harsher psychiatric judgement than soldiers diagnosed with neurotic conditions. The British home front, he observes, 'was not an environment that encouraged you to come forward to your doctor – let alone be referred to a psychiatric hospital – unless your symptoms were extreme.'[41] Shephard also hypothesises that the medical profession may have been swayed by the development of the wartime narrative of civilian resilience.[42] This idea that psychiatrists were influenced by a propagandistic 'rhetoric of fortitude' is also pursued by historian Stephen Caspar in his examination of the relationship between British and American psychiatry during the war. Caspar focuses on a major report of civilian neurosis, written by Aubrey Lewis, Medical Director of the Maudsley

[40] Elizabeth Roberts-Pederson, 'A Weak Spot in the Personality? Conceptualising "War Neurosis" in British Medical Literature of the Second World War', *Australian Journal of Politics and History*, Volume 58, (September, 2012), pp. 408-420, p. 409.
[41] Shephard, *A War of Nerves*, p. 179.
[42] Ibid, p. 178.

Hospital, who was one of the most influential psychiatrists during this period, and who features prominently in this thesis.[43] Although Caspar does not claim that Lewis's study was merely a propaganda exercise, he does suggest that its conclusions have to be read in light of the government's anxiety to send a message to Britain's American allies and its German enemies that British civilians were standing up to the bombing. As Caspar writes, 'increases in civilian neuroses would have posed a direct contradiction to that most important claim of courage and fortitude.'[44]

Such themes have also been touched on in two studies by a group of researchers led by historian of military psychiatry, Edgar Jones, which re-examine wartime psychiatric writings and government reports on civilian neurosis. Although directly addressing similar questions to this thesis, the conclusions of the research by Jones *et al* were shaped by present day political concerns. The studies were conducted following the terrorist attacks of 9/11 in New York in 2001 and 7/7 in London in 2005, and the researchers explicitly analysed the texts in order to learn 'historical lessons' about whether civilians would be likely to panic or breakdown during terrorist attacks.[45] Although the authors admitted that civilian morale was notoriously difficult to define, they nevertheless maintained that morale, although

[43] Stephen Caspar, 'The Origins of the Anglo-American Research Alliance and the Incidence of Civilian Neurosis in Second World War Britain', *Medical History*, Volume 52, (2008), pp. 327-346, p. 328. For background on Aubrey Lewis see Katherine Angel, Edgar Jones and Michael Neve (eds.), 'European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s', *Medical History*, Supplement No. 22, (2003).
[44] Caspar, 'The Origins of the Anglo-American Research Alliance', p. 346.
[45] Edgar Jones, Robin Woolven, Bill Durodie and Simon Wessely, 'Civilian Morale During the Second World War: Responses to Air-Raids Re-examined', *Social History of Medicine*, Volume 17, (2004), pp. 463-479; Edgar Jones, Robin Woolven, Bill Durodie and Simon Wessely, 'Public Panic and Morale: Second World War Civilian Responses Re-examined in the Light of the Current Anti-Terrorist Campaign', *Journal of Risk Research*, Vol. 9, (2006), pp. 57-73.

it may have 'fluctuated', never broke down.[46] By framing the research around the question of morale, the authors implicitly assumed that civilian mental health can be equated with and measured in a similar way to morale. Moreover, as has been pointed out by historian Michal Shapira, the authors provide a rather uncritical account of these psychiatric studies, and assess them unquestioningly as representations of the reality of civilians' psychological experience rather than a particular interpretation of them.[47]

Shapira's book, which is a wider study of the influence of psychoanalytic ideas both during and after the war, includes a chapter discussing the published writings of psychiatrists about civilian neurosis.[48] In this analysis, however, Shapira has the very specific aim of highlighting the influence of analytical ideas, even among those psychiatrists who took what she terms a 'functional' or a 'disciplinary' approach. While her account provides many insights into civilian psychiatry during the war, and is critical of historians who take psychiatrists' writings at face-value, Shapira tends to emphasise the psychoanalytic or psychological ideas of the psychiatrists she cites. This means she has often overlooked how many of these psychiatrists held both somatic and psychological ideas about the aetiology of war neurosis, and often practised an eclectic mix of treatments, including physical methods as well as psychotherapy. As such, her account provides a rather one-sided view of psychiatric opinion during the war that overstates the influence of psychoanalytical ideas.

[46] Ibid, p. 69; Jones et al, 'Civilian Morale During the Second World War', p. 478.
[47] A similar criticism of these studies is made by Shapira, *The War Inside*, p. 26, n. 10.
[48] Ibid, pp. 24-47.

Two studies of war neurosis in European countries, by Catherine Merridale for Russia and Paolo Sorcinelli for Italy, have pointed to ways in which historical studies of civilian war neurosis could fruitfully be pursued in a British context. Merridale's work on death, memory and trauma in twentieth-century Russia tackles the 'myth' that there was little civilian mental trauma caused by the war in Stalin's Russia.[49] While being careful not to impose a Western-defined model of trauma on the Russian survivors of war, Merridale suggests that even in a society dominated by official and unofficial discourses that denied the existence of war neuroses, there is evidence to indicate significant cases of neurotic and psychosomatic disorders. 'The idea of unbreakable mental resilience, then, is as much a myth in Russia as it is anywhere else,' she concludes.[50] The approach taken by the historian, Paulo Sorcinelli, in a study of Italian psychiatric institutions, also provides insights into the experience of psychiatric patients, and the way in which psychiatrists attributed, or denied, a link between their mental disorders and the war. Sorcinelli analysed over 400 case files of psychiatric admissions to three Italian psychiatric hospitals between 1940 and 1952. He found a great inconsistency in the way these patients were diagnosed, with some psychiatrists attributing far more cases of neuroses to the effects of the war than others.[51] While specific to the Italian situation, and its conclusions tentative, this research does suggest a way of

[49] Catherine Merridale, 'The Collective Mind: Trauma and Shell-Shock in Twentieth Century Russia', *Journal of Contemporary History*, Volume 35, (2000), pp. 39-55, p. 48; See also Catherine Merridale, *Night of Stone: Death and Memory in Russia*, (London: Granta Books, 2000).
[50] Merridale, 'The Collective Mind', p. 48.
[51] Paulo Sorcinelli, 'War in the Mental Hospitals: Psychiatry and Clinical Files', *Journal of Modern Italian Studies*, Volume 10, (2005), pp. 447-467, pp. 452-454.

examining inconsistencies and tensions between the rhetoric of psychiatric discourse and the reality of practice, a theme that I pursue in this thesis.

The second area of historiography that I have drawn on has been histories of psychiatry and psychology covering the mid-twentieth century period, although not specifically focusing on the war or the relationship between the war and mental health.[52] Most relevant for this research has been the work of historian Mathew Thomson, who has contextualised the psychological response to the war in a broader framework of the social concerns and policy in mid-twentieth century Britain, including during the war period.[53] Thomson convincingly argues that historians' analyses of psychological discourses have to be tested against the 'reality of practice'. Throughout this thesis I have taken into account what he describes as the 'messy politics, competing interests, and economic realities' in my analysis of psychiatric discourse and practice during the war.[54] Historian Rhodri Hayward has also shown how the diagnosis of anxiety was transformed in the 1930s and 1940s through its relationship to political and economic developments, and, in particular, its relationship to various welfare reform schemes.[55] Hayward's analysis has been invaluable for this research in highlighting how psychiatric diagnoses are

[52] Two of the most influential accounts have applied a Foucauldian analysis to developments in psychiatry and psychology during the twentieth century. These focus on the state's attempts to regulate and measure the mental health of the general population and the internalisation of psychological governance, and only briefly refer to events in the Second World War. David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth-Century*, (Cambridge: Cambridge University Press, 1983); Nikolas Rose, 'Psychiatry: the Discipline of Mental Health', in Peter Miller and Nikolas Rose (eds.), *The Power of Psychiatry*, (Cambridge: Polity Press, 1986), pp. 43-84; Rose, *Governing the Soul*.

[53] Thomson, *Psychological Subjects*, see especially, pp. 225-247.

[54] Ibid, p. 111, p.228.

[55] Rhodri Hayward, 'The Pursuit of Serenity: Psychological Knowledge and the Making of the Welfare State' in Sally Alexander and Barbara Taylor (eds.), *History and Psyche: Culture, Psychoanalysis and the Past*, (Basingstoke: Palgrave Macmillan, 2012), pp. 283-304, p. 284. See also Rhodri Hayward, *The Transformation of the Psyche in British Primary Care 1880-1970*, (London: Bloomsbury, 2014).

formulated not only by particular strands of medical thought, but are also 'continually reconstituted as modes of production and social organisation change,' which I explore further in my theoretical framing of this thesis.[56]

There have been some excellent historical examinations of the complex relationship between physiological and psychological explanations for nervous disorders, which have also been pertinent to this research. In particular, Mark Jackson tracks the development of the concept of 'stress' during the twentieth-century, and has shown that there was not a straightforward trajectory from physiological to psychological explanations for particular nervous symptoms and disorders.[57] This analysis complicates narratives of war neurosis that have assumed a progressive move from physical explanations for shell-shock early in the First World War through to a gradual acceptance and adoption of psychological explanations in the Second World War. Jackson's study thus reiterates that the ways in which particular diagnoses or psychological states are conceptualised is not static, but changes over time. This suggests a complex interrelationship between psychological and physiological theories, and the particular historical circumstances in which they are adopted.

Histories of psychiatric institutions, law and policy in the twentieth-century have usually only briefly considered the 1930-45 period. These accounts have

[56] Hayward, 'The Pursuit of Serenity', p. 284.
[57] Mark Jackson, *The Age of Stress: Science and the Search for Stability*, (Oxford: Oxford University Press, 2013). For interesting accounts of how the stress of war may have manifested as physical ailments during the war, particularly in peptic ulcers see, Ian Miller, 'The Mind and Stomach at War: Stress and Abdominal Illness in Britain c. 1939-1945', *Medical History*, Volume 54, (2010), pp. 95-110; Edgar Jones, 'The Gut War: Functional Somatic Disorders in the UK during the Second World War', *History of the Human Sciences*, Volume 25, (2012), pp. 30-48.

provided useful, if sometimes rather teleological, accounts of wider developments in psychiatry during the war period.[58] In the last two decades, as historians have increasingly turned their attention to twentieth-century developments in psychiatry, some excellent studies of individual mental hospitals have examined the Second World War and its detrimental impact on the lives of the long-term patients detained within them.[59] In his study of mental hospitals in Devon, David Pearce has provided an insightful account, which acts as a corrective to histories that have treated the supposed decline in the numbers of admissions to mental hospitals during the war as proof that the war did cause any increase in mental illnesses. Pearce argues that in the Devon area there was a much more complex picture, with an increase in demand for mental hospital beds in the later years of the war. Mental hospitals were severely overcrowded and lacked the resources to adequately care for the increased number of patients, resulting in limited occupational and recreational facilities.[60] Pearce's research is invaluable because it provides one of the few historical examinations of the effects of the war on regimes of care and treatment inside wartime mental hospitals. As yet there have been no

[58] See, for example, Kathleen Jones, *Mental Health and Social Policy 1845-1959*, (London: Routledge & Kegan Paul, 1960; Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, (New York & Chichester: John Wiley & Sons, 1997); Elaine Murphy, *After the Asylums: Community Care for People with Mental Illness*, (London: Faber & Faber, 1991). From a less teleological standpoint, there are excellent overviews in Peter Barham, *Closing the Asylum: the Mental Patient in Modern Society*, (London: Penguin Books, 1992); Tom Butler, *Mental Health, Social Policy and the Law*, (Basingstoke: Macmillan, 1985); Joan Busfield, *Managing Madness: Changing Ideas and Practice*, (London: Unwin Hyman, 1986); Anne Rogers and David Pilgrim, *Mental Health Policy in Britain: A Critical Introduction*, (Basingstoke: Macmillan, 1986); Shulamit Ramon, *Psychiatry in Britain: Meaning and Policy*, (Beckenham: Croom Helm, 1985).

[59] For this thesis I found the following accounts particularly helpful, Steven Cherry, *Mental Health Care in Modern England: the Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998*, (Woodbridge, Suffolk: Boydell Press, 2003); Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913 -1997*, (Abingdon: Routledge, 1998).

[60] David Pearce, 'Evacuation and Deprivation: the Wartime Experience of the Devon and Exeter City Mental Hospitals', *History of Psychiatry*, Volume 22, (2011), pp. 332-343.

comparable histories of mental hospitals in other regions that have focused on the 1939-45 period, or that have attempted to take a wider geographical purview to examine the effects of the war on mental hospitals.

The plethora of social and cultural histories about life on the home front during the war provide the third area of historiography I have drawn on in this study. These histories, much like Edgar Jones' studies of civilian neurosis, have often examined psychological responses to the war within the framework of the highly contested historical debates about whether morale held up during the war. Although this debate has not followed a linear progression, it broadly addresses two competing views of civilian morale – those emphasising the resilience of civilians and 'revisionist' histories that have contested claims of cross-class unity and good behaviour during the war.[61]

The government's attempt to quantify and measure the morale of the civilian population focused on people's behaviour. There were speculative attempts to assess civilians' collective states of mind, but these were not based on a thorough assessment of the ways in which fear, anxiety or depression manifested in individuals. Historians on both sides of the morale debate have taken these speculative assessments at face-value, and in doing so, they have tended to equate morale with mental health.[62] Although the morale debates have lost their critical

[61] This point is made in Penny Summerfield and Corinna Peniston-Bird, *Contesting Home Defence: Men, Women and the Home Guard in the Second World War*, (Manchester & New York: Manchester University Press, 2007), p. 3.
[62] See, for example, Calder, *The People's War*, p.223 and Angus Calder, *The Myth of the Blitz,* (London: Jonathan Cape, 1991), p. 130; Clive Ponting, *1940: Myth and Reality*, (Chicago: Elephant Paperbacks, 1993. Originally published 1990), p. 163; Travis L. Crosby, *The Impact of Civilian Evacuation in the Second World War*, (Beckenham: Croom Helm, 1986), pp. 127-128.

edge over the last two decades, they have not gone away entirely. Indeed, since the late 1990s a counter-revisionist trend has developed, which has re-emphasised the resilience of the civilian population.[63] In a similar way to the older debates, in these accounts insights about the psychological effects of war have all too often been overshadowed by the argument that civilian morale did not break down. Robert Mackay, for instance, admits that there were incidences of hysteria, fear and mental disorder among civilians during the war. He sums up his argument, however, with the claim that civilians adjusted to the war 'in a spirit of stoical endurance that did not exclude good humour' – thereby providing a very similar picture to the one drawn in earlier accounts.[64]

Historian George Quester has rightly argued that claims of psychological toughness during the Second World War need to be assessed alongside the stories of civilian panic in the First World War, pre-war fears about the scale of the bombings, and inflated predictions about the number of psychiatric casualties.[65] Quester also argues that, 'Any increase in major psychiatric disorders (e.g. the incidence of suicide) would be an imperfect indicator of broader depression or psychological upset.'[66] It is surely also the case that a *decrease* or *low* rate of major

[63] See, for example, Robert Mackay, *Half the Battle: Civilian Morale in Britain During the Second World War*, (Manchester & New York: Manchester University Press, 2002); Malcolm Smith, *Britain and 1940: History, Myth and Popular Memory*, (Abingdon & New York: Routledge, 2000); Peter Stansky, *The First Day of the Blitz: September 7, 1940*, (New Haven & London: Yale University Press, 2007).
[64] Mackay, *Half the Battle*, p. 248. A similar conclusion is reached by Helen Jones in her account of workers' behaviour in air-raids, Jones, *British Civilians in the Front Line*.
[65] George H. Quester, 'The Psychological Effects of Bombing on Civilian Populations: Wars of the Past', in Betty Glad (ed.), *Psychological Dimensions of War*, (London, Newbury Park & New Delhi: Sage Publications, 1990), pp. 201-213.
[66] Ibid, p. 212.

psychiatric disorders is an *equally* imperfect indicator of wider incidences of fear, neuroses and depression, or, indeed, as a barometer of civilian morale.

Over the last two decades, a rich body of work has flourished, which has shown how gender, nationality and race altered and conditioned the experience of war. This has provided a much more complex and nuanced picture of civilians' wartime experiences and emotions.[67] Many of these histories have deployed feminist and poststructuralist theories, as well as recent historical and theoretical work on collective memory, to 'destabilise' a nostalgic vision of the home front.[68] Accounts informed by poststructuralism have also emphasised the diversity of civilians' experiences during the war, not only according to class, gender and race, but also with regards to differences between regions, and between different periods of the war.[69] Jose Harris, for example, suggests that previous histories had all too often viewed civilian responses as a uniform experience. In reality, argues Harris, the six years of the war produced ebbs and flows in, for example, the scale and intensity of bombing-raids. These different phases of the war elicited a range of overlapping emotions, moving from periods of excitement and high tension to long

[67] There is a vast literature, for example, on gender during the war, such as Gail Braybon and Penny Summerfield, *Out of the Cage: Women's Experiences in Two World Wars*, (London & New York: Pandora Press, 1987) and Penny Summerfield, *Reconstructing Women's Wartime Lives: Discourse and Subjectivity in Oral Histories of the Second World War*, (Manchester & New York: Manchester University Press, 1998). On gender, race and nationality see Sonya O. Rose, *Which People's War? National Identity and Citizenship in Wartime Britain 1939-1945*, (Oxford: Oxford University Press, 2003). For an excellent exploration of masculinity during the Second World War, see, Martin Francis, *The Flyer: British Culture and the Royal Air Force, 1939-1945*, (Oxford: Oxford University Press, 2008).
[68] Summerfield and Peniston-Bird, *Contesting Home Defence*, p. 5, p. 280.
[69] See, for example, David Thoms, 'The Blitz, Civilian Morale and Regionalism, 1940-42,' in Pat Kirkham and David Thoms (eds.), *War Culture: Social Change and Changing Experience in World War Two Britain*, (London: Lawrence & Wishart, 1995), pp. 2-12; Geoffrey Field, *Blood, Sweat and Toil: Remaking the British Working Class* (Oxford: Oxford University Press, 2011).

stretches characterised by feelings of aimlessness and boredom.[70] Cultural historians have also explored the ways in which the war was represented in popular culture, films, novels and TV programmes, and how these representations have reshaped both individual memories and historical accounts of the war.[71]

Although the experience of the Blitz has become symbolic of the blurring of the boundaries between home and military fronts, Susan Grayzel's cultural history of air-raids has traced this process back to the smaller-scale and less well-known Zeppelin raids of the First World War. Her examination of these earlier raids suggests that they marked the start of changes in the relationship between state and home, whereby the air-raid became 'domesticated and normalised' in everyday life and the home itself became militarised. Moreover, these changes relied on the cultivation of a 'universal stoicism' through the interwar years, as the state realised that civilian psychology would be an important factor in a future air war.[72] Although they took place on markedly different social, political and cultural terrain, Grayzel's account suggests there were important continuities between the two world wars.

The question of how dominant discourses have influenced and shaped civilian emotions, as well as behaviour, has been explored by Sonya Rose in her

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[70] Jose Harris, 'War and Social History: Britain and the Home Front during the Second World War,' *Contemporary European History*, Volume 1, (March, 1992), pp. 17-35.

[71] See, for example, the exploration of how dominant narratives and cultural representations have reshaped the memory of the war in Summerfield, *Reconstructing Women's Wartime Lives*; Summerfield and Peniston-Bird, *Contesting Home Defence*; Lucy Noakes and Juliette Pattinson (eds.), *British Cultural Memory and the Second World War*, (London: Bloomsbury, 2014). It is worth noting, however, that accounts of how memory can be reshaped by changing discourses about the war is not just a recent historical endeavour. In the 1970s Tom Harrisson asked Mass Observation diarists to rewrite their accounts 30 years after the end of the war and found their rewritten versions provided a much more positive appraisal than their original accounts. Harrisson, *Living Through the Blitz*, pp. 324-330.

[72] Susan Grayzel, *At Home and Under Fire: Air-Raids and Culture from the Great War to the Blitz*, (Cambridge: Cambridge University Press, 2012), p. 15.

account of nationality, race and gender in the Second World War. Rose utilises the Gramscian concept of 'hegemony' and Raymond Williams' notion of 'structures of feeling' to investigate the contradictions and instabilities inherent in the dominant wartime mood of national unity. In doing so, Rose makes the important point that the 'hegemonic cultural formation' of national unity produced subversion and resistance, as well as limitations, to the norms of behaviour and expected ways of feeling.[73]

These new cultural histories have thus begun to provide what historian Amy Bell has called 'counter-narratives' to the dominant story of the war as one marked by civilian courage and resolve, investigating fear as well as stoicism, and resistance as well as compliance with expected ways of feeling and doing.[74] Bell suggests that historians need to look 'beneath the veneer of public descriptions of civilian morale and steadfast national identity' to reveal the complexities and nuances in civilians' responses to bombing and to government attempts to police behaviour and emotions.[75] One recent avenue of research in this vein has explored grief and bereavement in wartime, examining why feelings of grief for the loss of family, lovers and friends have so often been absent in descriptions of civilian life. This research has explored the ways in which the 'emotional economy' of wartime Britain, with its promotion of reserve and fortitude in the face of suffering and loss,

[73] Rose, *Which People's War?*, p. 21.
[74] Amy Bell, 'Landscapes of Fear: Wartime London, 1939-1945', *Journal of British Studies*, Volume 18, (January, 2009), pp. 153-175, p. 157. An earlier example was provided by Joanna Bourke's chapter 'Civilians Under Attack' in Bourke, *Fear*, pp. 222-254.
[75] Amy Helen Bell, *London Was Ours: Diaries and Memoirs of the London Blitz*, (London: I. B. Tauris, 2011), p.80.

was able to contain and manage public expressions of grief.[76] Importantly, this work also suggests that although civilians' emotions were shaped by the context of the dominant discourses of wartime Britain, this did not mean that people's emotions were simply moulded or manipulated. Grief, as Lucy Noakes has argued, was a disruptive emotion that could shatter individuals' sense of self despite the dominant emotional codes of the time. Although there were few public displays of grief, suggests Noakes, this did not mean that 'grief was not deeply felt, and that selfhood was not fractured and fragmented by loss.'[77]

The approach of these historians has enriched historical analysis of life on the home front and has suggested that the psychological response of civilians to the war was complex and multifaceted, and cannot be subsumed within the framework of debates about morale. There has as yet, however, been little historical research applying the same level of analysis to the *psychological* effects of the war on civilians or to the ways in which the narrative of 'no psychological breakdown' was constructed and sustained. Indeed, I would suggest that there has been a disjuncture between socio-cultural histories of wartime life and histories focusing more specifically on war neurosis. This has reflected and even inadvertently reinforced the idea that the question of civilian neuroses during the Second World War has been settled. In this study, therefore, I have drawn on insights from histories of war neurosis, psychiatry and the home front to situate psychiatric theories and practice in the context of the political pressures and social conditions

[76] Carol Acton, *Grief in Wartime: Private Pain, Public Discourse*, (Basingstoke: Palgrave Macmillan, 2007), p. 5; pp. 47-79; Lucy Noakes, 'Gender, Grief, and Bereavement in Second World War Britain', *Journal of War and Culture Studies*, Volume 8, (February, 2015), pp. 72-85, pp. 83-84.
[77] Ibid, p.73, p. 84.

that dominated civilian life during wartime. In doing so, this research adds a new dimension to, and makes new connections between, each of these historiographical areas.

Theoretical considerations

Throughout this thesis, I have taken the view that interpretation, manifestation and experience of mental disorder is socially constructed and historically contingent. This social constructionist approach to histories of psychiatry and mental health, as indicated in the above historiography, has now become dominant, largely due to the enduring influence of the writings of Michel Foucault since the 1980s.[78] My analysis has been strongly influenced by the work of scholars, such as historians Paul Lerner and Mark Micale, philosopher Ian Hacking and social anthropologist Allan Young, and particularly their formulation of mental disorders as being both 'real and constructed'. I agree with Hacking when he argues that because, 'a certain type of mental illness appears only in specific historical or geographical contexts' this does not imply that such disorders are 'manufactured, artificial, or in any other way not real.'[79]

This thesis also draws on the theoretical approach of historian Kathleen Canning, whose analysis of a 'fluid and vital' relationship between discourse and

[78] See in particular, Michel Foucault, *Madness and Civilization*, Abridged Edition, (Abingdon: Routledge Classics, 2001); Michel Foucault, *Discipline and Punish: the Birth of the Prison*, (London: Penguin, 1977); Michel Foucault, *Psychiatric Power: Lectures at the College de France 1973-1974*, (Basingstoke: Palgrave Macmillan, 2006); Michel Foucault, *Abnormal: Lectures at the College de France 1974-1975*, (New York: Picador, 2003).
[79] Hacking, *Rewriting the Soul*, p. 12. See also Ian Hacking, *The Social Construction of What?* (Cambridge, Ma: Harvard University Press, 1999).

social context, and between discourse and experience, has been invaluable to this study.[80] These scholars have all, to varying extents, made use of the work of Foucault and other poststructuralist theories. However, following their lead, in this study I have also adapted these formulations to take into account the question of agency, the concrete interactions between historical actors, and the importance of social, political and economic, as well as discursive, factors, in my analysis of psychiatric theory and practice.[81]

To view psychiatric diagnoses as socially-constructed may, to a certain extent, seem self-evident.[82] Particular groups of symptoms are grouped together, named, and then classified as particular types of disorders. These various groupings and classifications are often arbitrary, they change over time, and are constantly reconceptualised or ascribed a different aetiology.[83] The 'diagnosis' and category of shell-shock in the First World War, for example, could be seen as reappearing in the

[80] Kathleen Canning, *Languages of Labour and Gender: Female Factory Work in Germany, 1850-1914*, (Ithaca & London: Cornell University Press, 1996), pp. 10-15; Kathleen Canning, *Gender History in Practice: Historical Perspectives on Bodies, Class and Citizenship*, (Ithaca & London: Cornell University Press, 2006).

[81] See, for example, Hacking, R*ewriting the Soul*; Ian Hacking, 'Between Michel Foucault and Erving Goffman: Between Discourse in the Abstract and Face-to-Face Interaction', *Economy and Society*, Volume 33, (August, 2004), pp. 277-302; Lerner, *Hysterical Men*; Canning, *Languages of Labour and Gender*, pp. 10-15; Kathleen Canning, 'Feminist History after the Linguistic Turn: Historicizing Discourse and Experience', *Signs*, Volume 19, (Winter, 1994), pp. 383-384.

[82] Here I have taken on board Ian Hacking's observation that social constructionism has become a rather tired metaphor, which has limited value when applied without explanation. Hacking, *The Social Construction of What?*, p.24, p. 35.

[83] Analyses of changes in the conceptualisations and meanings of the diagnoses of hysteria and neurasthenia have been invaluable in formulating my approach. See, for example, Mark S. Micale, *Approaching Hysteria: Disease and its Interpretations*, (Princeton, NJ.: Princeton University Press, 1995); Mark S. Micale, 'On the Disappearance of Hysteria: A Study in the Deconstruction of a Diagnosis', *Isis*, Volume 84, (September, 1993), pp. 496-526; Mathew Thomson, 'Neurasthenia in Britain: an Overview', in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia: from Beard to the First World War*, (Amsterdam: Rodophi, 2001), pp. 77-95. For an excellent analysis of the inherent instability of the diagnostic category of schizophrenia, see Sander L. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS*, (Ithaca & London: Cornell University Press, 1988), p. 203.

Second World War, but renamed as 'war neurosis' or, in the case of the military, as 'combat exhaustion' or 'battle neurosis'. However, in this research I have not assumed that shell-shock in the earlier war and war neuroses in the latter are merely different labels for describing the same entity. As historian Chris Feudtner has emphasised, between the two world wars shell-shock was 'reconstituted' to suit changing military, medical and political circumstances.[84] This reconstitution meant more than a new name being ascribed to the same states of mind or body. Rather, when new psychological terms are deployed, as historian Rhodri Hayward has written, 'we constellate certain aspects of life, creating particular connections and associations, and thus creating new psychological states.'[85]

The nervous conditions of civilians in the Second World War were thus not simply the re-emergence of the same symptoms of shell-shock, merely described or labelled differently. Rather, new symptoms and different manifestations of nervousness emerged, such as anxiety states, and minor psychological symptoms that some psychiatrists doubted could even be categorised as a diagnosable 'neurosis'. The development of psychosomatic theories through the 1930s, for example, meant that medics were more likely to conceptualise physical ailments, particularly those of the stomach, as having a psychological rather than a purely physiological aetiology. The rise in gastric problems, particularly of stomach ulcers, could thereby be understood by some doctors as a somatic manifestation of the increased fears and stresses experienced by civilians during the war.[86]

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[84] Chris Feudtner, '"Minds the Dead Have Ravished": Shell Shock, History and the Ecology of Disease-Systems', *History of Science*, Volume 31, (1993), pp. 377-420, p. 408.
[85] Hayward, 'The Pursuit of Serenity', p. 285.
[86] See Miller, 'The Mind and Stomach at War'; Jones, 'The Gut War'.

In this account, I do not view this constitution and reconstitution of psychiatric diagnoses as a one-dimensional labelling process, whereby a powerless patient succumbs to the psychiatric judgement of an all-powerful medic.[87] Although the practitioner-patient relationship during this period was undoubtedly a very unequal one, I agree with social theorist Julie Mulvany that labelling theories tend to construe the person suffering from a psychological disorder as 'the other' or as one amongst an undifferentiated mass of victims, without agency.[88] I interpret the diagnostic practices under scrutiny in this study as part of a much more dynamic process, which was, as highlighted by social theorist David Pilgrim, 'negotiated inter-subjectively', drawing on 'wider-lay-definitions and consensus in society about what is considered "normal".' [89] In this view, psychiatric diagnoses are part of a process through which certain meanings are attached to symptoms, and which can be can be welcomed by the person diagnosed, as providing access to treatment or compensation, for example. Alternatively, the patient can partially and wholly reject such diagnoses and construct their own narrative as to why they are experiencing such symptoms.[90] In some of the psychiatric interviews I have examined in this research, for example, the person interviewed sometimes placed more emphasis than the interviewer, on the war as a major factor in the

[87] See, for example, Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory*, (New Jersey: Transaction Books, 1970); Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, (London: Paladin, 1972).
[88] Julie Mulvany, 'Disability, Impairment or Illness? The Relevance of the Social Model of Disability to the Study of Mental Disorder', in Joan Busfield (ed.), *Rethinking the Sociology of Mental Health*, (Oxford: Blackwell Publishers, 2001), pp. 39-57, p. 43, p. 44.
[89] David Pilgrim, 'The Failure of Diagnostic Psychiatry and Some Prospects of Scientific Progress Offered by Critical Realism', *Journal of Critical Realism*, Volume 12, (2013), pp. 336-358; p. 337, p. 339. See also, David Pilgrim, 'The Survival of Psychiatric Diagnosis', *Social Science and Medicine*, Volume 65, (2007), pp. 536-547.
[90] Pilgrim, 'The Failure of Diagnostic Psychiatry', p. 349.

development of their nervous symptoms. In other interviews, it is the person being interviewed who denies a connection between their nervous ailments and the war.

In addition, psychiatrists understood the psychological disorders of civilians to be differently constituted and experienced than those of military personnel who were on the frontlines of combat and/or under military discipline. This is not to suggest that there were no similarities between the types of psychological suffering experienced in the two world wars, or to deny that psychiatrists drew on conceptualisations of war neurosis from the earlier conflict in their interpretations of civilians' nervous disorders. Rather, it is to highlight the importance of historicising and contextualising the ways that diagnostic categories and aetiological understandings changed between the two wars, and to examine how these categories were specifically applied in a civilian context. There was psychological suffering and emotional pain in both wars, but the ways in which this suffering was understood and experienced was very different, depending on the specific military, medical and social contexts of each conflict.

Moreover, these changes in diagnoses were not sustained by language alone, but were part of wider social, as well as medical, processes.[91] I have, therefore, analysed discourse about the aetiology and symptomology of nervous conditions in the terrain in which it was practised, and in the wider context of the political and economic priorities pursued by the government during the war. As Allan Young has written with reference to PTSD, diagnoses are not the result of

[91] Hayward, 'The Pursuit of Serenity', p. 285. Here I have also been influenced by Peter Sedgwick's analysis of both psychological *and* physical illnesses as being constructed in the context of wider social values and processes. Peter Sedgwick, *Psycho Politics*, (London: Pluto Press, 1982).

free-floating ideas, but are 'glued together' by the particular 'practices, technologies and narratives' in which they are 'diagnosed, studied, treated, and represented by the various interests, institutions, and moral arguments that mobilised those efforts and resources.'[92] During the war certain explanations for the development of neuroses, such as the idea of innate physical or psychological predisposition, were reinforced by those with particular political, economic and institutional interests. As social theorist Ian Parker has argued, the history of psychiatry is also a history of 'other relationships between the powerful and the powerless.' The 'semiotic stuff and material practices', as Parker puts it, have always 'drawn upon, mobilised and transformed a range of other axes of domination and oppression.'[93]

As I show in this thesis, the government relied on a number of trusted establishment psychiatrists in formulating its policy through the war years. In the main, these advisors advocated theories of 'predisposition', which posited that factors inherent within the individual were the primary aetiological factors in the development of war neuroses. I do not view the dominance of these theories to be the result of a conspiracy between powerful interest groups to deny that the war itself created psychological suffering. Rather, dominant psychiatric views about wartime mental health were the outcome of a complex process in which government, medical, and military interests and assumptions overlapped, and sometimes clashed, in the formation of psychiatric policy. Although I am critical of

[92] Young, *The Harmony of Illusions*, p. 5.
[93] Ian Parker, 'Constructions, Reconstructions and Deconstructions of Mental Health', in Alastair Morgan (ed.), *Being Human: Reflections of Mental Distress in Society*, (Ross-on-Wye: PCCS Books, 2008), p. 44.

some of the writings of the psychiatrists I examine, and particularly of the way they often minimised the role of war in creating nervous disorders, the psychiatric profession was not a unified, all-powerful body during the war. Indeed, one of the main contributions of this thesis is to show how psychiatric opinion in this period was marked by intense debates and disputes about the manifestation and extent of nervous disorders.

Neither was it clear at the start of the conflict, despite speculations about the number of psychiatric casualties, how civilians would respond psychologically to the experience of air-raids or to the wider deprivations and dislocations of the war. The prevailing narrative of civilian psychological resilience, as encapsulated in Titmuss's official account, developed through the course of the war and was sustained through government and media propaganda, as well as in the writings of the medical profession and in the subjective experiences of practitioners and patients. Here historian Kathleen Canning's formulation of discourse as being both shaped by and in turn shaping social relationships has been invaluable for my analysis of the ways in which government and mainstream psychiatric discourses were not only mutually reinforcing, but were also related to wider social processes.[94] There was an interlinking of various medical, social and political interests and assumptions about civilians' wartime neurosis that shaped, but was also subsequently shaped by, civilians' subjective experiences of the war.

In my analysis of the development of this narrative, I have drawn on the concept of 'structures of feeling', developed by the Marxist literary theorist

[94] Canning, *Languages of Labour and Gender*, p. 11.

Raymond Williams.[95] For Williams, 'structures of feeling' helped to explain 'meanings and values as they are actively lived and felt', and the relationship of such lived experiences with more formal belief systems. Crucially, Williams saw the development of a dominant mood or belief as part of a developing 'practical consciousness' that contained within it a range of social attitudes, values and meanings.[96] In this theorisation, the development of a hegemonic view of civilian resilience can be viewed not as a manipulation by government propaganda or an imposition by establishment psychiatrists, but rather as an outcome of much wider and more complicated social processes. These processes involved what Williams described as a 'lived system of meanings and values – constitutive and constituting – which as they are experienced as practices appear as reciprocally confirming.'[97] In other words, the dominant narrative of resilience was not set in place from the start of the war, nor was it imposed by government and medical authorities. Rather, it was part of a process that was constantly being shaped, reshaped, reiterated and resisted in psychiatric practice throughout the war. In this study, I have thus attempted to trace the development of this narrative, and its subsequent influence on psychiatric diagnoses, treatment and experience.

Lastly, a word should be included about the civilians whose lives and emotions are debated and discussed on the pages of this thesis. In the psychiatric

[95] Raymond Williams, *Marxism and Literature*, (Oxford: Oxford University Press, 1977). This concept is also used in Rose, *Which People's War?*. There is a useful discussion of what Williams meant by 'structures of feeling' in Paul Filmer, 'Structures of Feeling and Socio-Cultural Formations: the Significance of Literature and Experience to Raymond William's Sociology of Culture', *British Journal of Sociology*, Volume 54 (2003), pp. 199-219.
[96] Williams, *Marxism and Literature*, p. 132. See also Terry Eagleton, *Ideology: An Introduction*, (London: Verso, 1991), p. 115.
[97] Williams, *Marxism and Literature*, p. 110.

case studies and government reports examined here, individual civilians often appear not as embodied, emotional beings, but as objects under scrutiny. Their words, thoughts and feelings are mediated by layers of medical and political judgements about their lives and mental states. Psychiatric investigators often assigned a case number or letter rather than using a name, which tends to decrease the sense that these were real individuals and increase the impression of objectification. I do not view the people who are discussed in this study merely as case studies, but rather as historical actors who had agency, and who could contest, subvert, negotiate, acquiesce or internalise the psychiatric judgements being made about them, albeit within the restraints imposed by their mental disorder, legal status, or their economic and social situation. In this I follow Canning's conception of agency as 'a site of mediation between discourses and experiences'.[98] Canning has written of the difficulty of trying to 'render as subjects' the voices of the female workers described in the official documents she examined in her research on women in the German labour movement.[99] This is perhaps a near-impossible task for the historian whose sources are official medical and government articles and documents. Nevertheless, as I explain the next section, I have attempted to seek out what one historian called the 'presence' of those being discussed by psychiatrists and government officials, usually in dry, anodyne and depersonalised language, and to do justice to the accounts they gave of their lives, health and feelings.[100]

[98] Canning, 'Feminist History after the Linguistic Turn', p. 378.
[99] Ibid, p. 384.
[100] Nancy M. Theriot, 'Women's Voices in Nineteenth-Century Medical Discourse: A Step Toward Deconstructing Science', *Signs*, Volume 19, (Autumn, 1993), p. 2.

Primary sources and methodology

This thesis has traced psychiatric discourse, policy and practice through an analysis of the published and unpublished writings and discussions of members of the medical profession – mainly psychiatrists, but also neurologists, psychologists, psychoanalysts, general practitioners, and psychiatric social workers. I have also drawn on discussions between government ministers and officials, and some of the leading members of the psychiatric profession, as well as a range of psychiatric research conducted during the war.

I have mainly accessed psychiatric opinion through a close reading of the published writings of psychiatric and medical practitioners in the major medical and psychiatric journals between 1930 and 1948. These have included the two main general medical journals, the *BMJ* and the *Lancet*, both of which had a large circulation among the wider medical profession. Although the two journals did not specialise in psychiatry, both carried a range of articles relating to the major issues facing the psychiatric profession in the run-up to and during the war. Also prominent in this research have been articles in the quarterly *Journal of Mental Science*, which was still publishing under this name in the war period, although it would later become the *British Journal of Psychiatry*. This journal had the reputation of being the main journal aimed at psychiatrists working in mental hospitals, although it had a wider readership than asylum doctors. It had a somatic orientation, and, as will be illustrated in Chapter Two, published papers detailing research into the physical causes of mental disorder. Many psychiatrists writing in the journal were hostile to psychoanalysis, although by the start of the war, as with

less specialist medical journals, it began to publish articles by analytically-inclined psychiatrists more frequently, reflecting the wider uptake of psychoanalytical concepts by many more mainstream psychiatrists during this period. I have also examined a wide-range of other medical and psychiatric journals, including the *Proceedings of the Royal College of Medicine*, and prominent psychoanalytical journals, such as the *International Journal of Psychoanalysis*.

Taken together, these journals carried a wide-range of psychiatric opinion, presented in a variety of formats, including academic articles and research reports written by prominent psychiatrists, as well as texts of lectures, reports of meetings, book reviews and correspondence. These articles were written for a variety of purposes – to highlight new empirical research, to express an opinion on controversial and other matters of the day, or to intervene in specific debates about aetiology and/or treatment of specific disorders within the psychiatric profession, or between competing branches of medicine, such as neurology or general medicine. The pursuit of professional interests, and accruing scientific and medical prestige, often formed as much a part of the motivation for publication, as did concern to share the experiences of the patients whose lives were being debated. These articles also tended to represent the opinion of leading practitioners, rather than less established psychiatrists or psychologists, psychiatric social workers and other mental health workers. Often minority or dissenting views were to be found in the debates in the letters pages, and including these in my research has provided a fuller picture of the range of psychiatric and medical opinion during the war.

Published psychiatric reports often included case studies of the civilians psychiatrists assessed and treated during the war. Sometimes these were studies of large cohorts of patients, but were most often illustrative examples of symptomology and treatment given as 'evidence' of the particular line of argument the psychiatrist was pursuing. Such reports frequently appear as rather anecdotal, particularly to the modern reader, and were peppered with the psychiatrist's opinions about the war or about mental disorder more generally. As psychiatrist I. L. Janis observed about wartime reports of civilian neurosis, 'Often the reports contain only impressionistic, unsystematic accounts of civilian reactions without describing the procedures used to obtain the evidence, the number of cases studied, or the composition of the sample on which the observations were based.'[101] Despite these limitations, published case studies provide invaluable clues as to the manifestation of the nervous disorders experienced by patients. The patient's voice is, of course, always mediated by the constraints of the medical encounter and the unequal power dynamic between psychiatrist and patient. In addition, such accounts were subsequently shaped and reshaped by the psychiatrist to suit their purposes in the final published account. In this sense, these writings tell us more about the construction and articulation of psychiatric discourse than they do about patient experience.[102]

Secondly, I have also made extensive use of both published and unpublished material held at the National Archives in Kew, the London Metropolitan Archives,

[101] Irving L. Janis, *Air War and Emotional Stress*, (New York, Toronto & London: McGraw-Hill Book Company, 1951), pp. 68-69.
[102] Canning, *Gender History in Practice*, p. 108. Canning makes this point in relation to the absent voices of women workers in her research on gender and the German Labour market.

the Wellcome Collection in London, and at the Solly Zuckerman archive held at the University of East Anglia (UEA). These have included official government-sponsored reports about morale and civilian neurosis. The published versions of these reports inevitably provide a rather partial account of the provision of services and of the psychiatric disorders experienced during the war. The unpublished letters, memos and other documents produced in the commissioning and creation of these reports often reveal a more candid view of the motivations of the government officials and psychiatrists involved in their construction. Especially valuable has been the unpublished case studies and investigations from both major and small-scale psychiatric investigations during the war. I have also examined a variety of unpublished reports, minutes, memoranda, reports of discussions of meetings and other miscellaneous papers for the Ministry of Health, the Ministry of Pensions, the Ministry of Information and the Home Office. These unpublished papers and documents frequently feature a more frank account of the opinions of government officials and inspectors, and of psychiatrists and other medics, especially in reports of discussions at conferences and meetings, or in unsolicited letters from members of the medical profession to various government ministries.

Medical records for patients during the war have been harder to access. Disappointingly, the medical records I consulted for Bristol Mental Hospital yielded only limited information about the material conditions at the hospital during the war, or the backgrounds and lives of the patients. More fruitful has been my examination of the unpublished reports of the Board of Control, as well as the records and minutes of their wartime meetings, which have provided an illuminating, if partial, picture of the state of mental health services during the war.

Although the collection at the National Archives is incomplete, and some wartime reports were truncated due to wartime pressures, inspectors' reports on individual mental hospitals have provided a valuable resource for this thesis.

The psychiatric experience of those civilians who were not admitted to mental hospitals, or who did not attend psychiatric clinics, has been even harder to capture. Although they provide only partial accounts, I have drawn on the psychiatric reports and unpublished case studies compiled in Hull for the wider study into the effects of bombing on civilian morale by scientists Solly Zuckerman and J. D. Bernal. I have also used psychiatric studies conducted in Bristol by the Mental Health Emergency Committee, which recorded interviews with civilians who had experienced heavy raiding and with those who sheltered in the tunnels on the outskirts of the town. Supplemented with reports made for the Mass Observation organisation and for the Ministry of Information, these interviews and reports have provided a glimpse of the psychological suffering and bombing experiences of a selection of civilians who had mostly not received formal psychiatric assessment or treatment. Like published psychiatric reports, however, these sources have provided what Canning has referred to as 'modest snapshots' of the range and diversity of psychiatric experience during the war. In all these snapshots, I have taken on board Canning's suggestion that 'the photographer must be at least as carefully considered as the subject of the image.'[103]

Lastly, I do not claim that these sources have provided a complete and representative picture of medical and psychiatric views of civilian neurosis, of

[103] Canning, *Gender History in Practice*, p. 109.

diagnoses and treatment in practice, or of civilians' psychological experiences. They have, however, revealed some of the complexities, tensions and nuances in psychiatric discourse and practice, and the diversity of civilians' psychological and emotional responses to the war.

Chapter outline

This thesis is divided into two sections. The first section examines the development of psychiatric theories in the interwar years and the ways such theories were utilised by government officials in their planning and policy in the run-up to and during the war. In contrast to many accounts of war neurosis in the Second World War, Chapter Two emphasises how the theoretical and diagnostic trends of the interwar years would be crucial in reshaping how 'war neurosis' would be conceptualised. The chapter surveys various strands of psychiatric thought, including somatic, psychoanalytical and psychobiological, and assesses the differences and similarities in their conceptualisations. This is followed by an analysis of government planning and policy, which forms the subject of Chapter Three. Here I look at how the government's concern to maintain social order and to limit the numbers admitted to psychiatric institutions dominated the formation of its wartime health and pension policies. The chapter examines how government officials adopted both somatic and psychological conceptualisations of mental disorder, relying on the advice of a few handpicked psychiatric advisors, to justify limiting psychiatric provision. This analysis of the relationship between government

policy and mainstream psychiatric thinking brings out both the synergies and the tensions between psychiatric theories and government concerns.

In the second section of the thesis, 'Sites of Wartime Practice', I explore how mainstream psychiatric theories and government directives to medics were implemented, or not implemented, in practice. This section addresses four major areas of psychiatric intervention during the war. Chapter Four considers the situation for the patients of public mental hospitals, drawing on inspectors' reports and psychiatric case studies to provide a hitherto unexplored glimpse of conditions, spaces and relationships within wartime mental hospitals, and assesses how they were disrupted and changed by the war. These developments would consequently shape how mental health provision would be structured and organised in the post-war era, and helped to cement divisions between psychotic and neurotic patients. Chapter Five considers the psychiatric assessment and treatment of those with more minor nervous disorders, who generally made up the patient population of psychiatric outpatient clinics. Drawing on unpublished material from C. P. Blacker's major wartime survey into the clinics, this chapter explores how the war affected the diagnoses and treatments dispensed to patients. The chapter also unpicks the survey's conclusion that the war did not result in a significant rise in neurotic disorders, despite the clinics being overcrowded and unable to meet patient demand.

Chapter Six moves away from more institutional sites of psychiatric practice, which treated many patients who had not directly experienced bombing raids, to focus on psychiatric intervention in heavily raided areas. These civilians had often

experienced traumatic events, including being buried alive in the rubble of bombed-out buildings, and witnessing the deaths of family members and loved ones. This chapter explores how psychiatrists, doctors and social workers conceptualised and assessed the mental states of bombing victims by exploring psychiatric practice at First Aid Posts, Rest Centres and at GP surgeries. It also provides a detailed analysis of a major survey among workers and their families in the heavily bombed port area of Hull. This included interviews with hundreds of civilians who were considered to be suffering neurotic symptoms, but who had never previously come under the remit of the psychiatric services.

Chapter Seven explores the development of minor psychological disorders during the war at the non-medical site of the factory. Factories were, of course, first and foremost sites of industrial production and workplaces, and were not designated as spaces for medical or psychiatric treatment. Exploring neurosis at the site of the factory, however, has offered a route by which to assess how psychiatrists and medical officers viewed the psychiatric disorders of a section of the civilian population, who were not identified as 'mental patients', and who had not necessarily directly experienced bombing raids. In this analysis, I explore why psychiatric and governmental concern about civilian mental health became focused on factory workers, and the relationship between mental health, social class and gender. This chapter shows how the formation of psychiatric thought in this period was embedded in and shaped by wider economic and political imperatives of the war.

By exploring the relationship between psychiatric theories and practice, this thesis suggests a new way of approaching civilian neurosis. Rather than being considered as merely an adjunct to the now rather tired historical debates about civilian morale, this research puts the psychiatric experiences of civilians at its centre and provides the first detailed analysis of the relationship between the war and mental health during the Second World War. Although this thesis is focused on Britain, the account of civilian mental health that unfolds in the following pages also contributes to wider historical debates about the complexities of the relationship between war, trauma and civilian mental health.

Part 1: Psychiatric theories and policies

Chapter Two: War neurosis: the remaking of a diagnosis

At the start of the Second World War, psychiatrists revisited the experience of shell-shock in their imaginings of the 'war of nerves' about to be waged on the civilian population.[1] In the interwar years articles in medical and psychiatric journals about the diagnosis and treatment of war neurosis, especially in the years following the publication of the report of the government's 1922 Committee of Enquiry into Shell-Shock, were largely framed around the question of compensation and pensions for shell-shocked soldiers. As war approached, many articles replayed these debates almost as if the intervening years between the wars had not happened.[2] As Ruth Leys has commented, 'it took World War II to "remember" the lessons of World War I.'[3] Historians have often replicated this lacuna by downplaying the influence of peacetime, civilian psychiatry on shaping the way psychiatrists approached the question of war neurosis during the later war.[4]

Although the impact of the First World War on psychiatric theory and practice between the wars has been the subject of intensive historical debate, there has been little examination about how these developments in civilian psychiatry would in turn shape the way that psychiatrists would reconfigure the diagnosis of 'war neurosis' in the later war.[5] In this chapter, I focus on the development of the

[1] The phrase 'war of nerves' is from Wilfred Bion, 'The "War of Nerves": Civilian Reaction, Morale and Prophylaxis', in Emanuel Miller (ed.), *The Neuroses in War*, (London: Macmillan & Co, 1940), pp. 180-200.
[2] See, for example, Frederick Dillon, 'Neuroses Among Combatant Troops in the Great War', *British Medical Journal*, 2, (8 July, 1939), pp. 63-66; Frederick Dillon, 'Simulated Mental Disorders Among Soldiers in the War-Time', *The Lancet*, 2, (23 September, 1939), pp. 706-709.
[3] Leys, *Trauma*, p. 15.
[4] See, for example, Shephard, *A War of Nerves,* pp. 161-168.
[5] Shapira makes a similar point about this lacuna in the historiography. Shapira, *The War Inside*, p. 21.

theories of psychiatrists, neurologists, psychologists and psychoanalysts as they were articulated in medical, psychiatric and psychoanalytical journals in the interwar years. These debates about the aetiology and symptomology of mental disorders were embedded in wider social and economic changes in a society that was attempting to come to terms with the devastation of the earlier war while fearing an even greater catastrophe in the next. Extremes of affluence and inequality were eroding old certainties and, as argued by historian of medicine Roy Porter, 'eating away at traditional distinctions between the healthy and the sick, the rational and the crazy.'[6]

I begin the chapter by assessing the influence of somatic theories in British psychiatry following the First World War, and challenge the notion that there was a straightforward, progressive move away from biologically-based theories to psychological or psychoanalytical ideas in the interwar years. I follow this with an examination of the differences, and similarities, between psychoanalytical and biologically-based theories of neurosis and mental disorder. I also explore the development of new conceptualisations about the relationship between emotions and the body in psychobiological and psychosomatic theorisations, which gained increasing prominence in the 1920s and 1930s. I then attempt to untangle some of the debates about diagnostic categories that intensified among doctors in this period as they began to grapple with how to conceptualise the minor neuroses they encountered in clinical practice outside of mental hospitals. I conclude the chapter

[6] Roy Porter, 'Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain', in Hugh Freeman and German E. Barrios (eds.), *150 Years of British Psychiatry. Volume II: the Aftermath*, (London: Athlone Press 1996), p. 393.

by looking at how some of these theories would be deployed as psychiatrists began to speculate on how neuroses would develop and manifest in the forthcoming war.

The reframing of somaticism

As noted in Chapter One, the historiography of war neurosis has been dominated by the thesis that the First World War instigated a watershed in British psychiatry, signifying the beginning of the demise of asylum-based somatic theories of hereditary degeneration and the widespread acceptance of psychological theories.[7] Yet this notion of a somatic to psychological historical trajectory obscures many of the complexities of psychiatric theorisation that took place during the 1914-18 conflict and that continued through to the start of the Second World War. The decline in popularity of 'commotional' theories of shell-shock, which had posited an external physical trauma as the cause of war neurosis, did not did entail the abandonment of all physiological theories of war neurosis. Rather, there was a shift from locating the aetiology of neurosis in an external traumatic physical event to a focus on the physical constitution, inherited defects or diseased pathology of the traumatised individual. Indeed, the War Office Committee of Enquiry into Shell-Shock, headed by Lord Southborough, can be read as an attempt to re-establish somatic approaches to war neurosis. Although the report concluded that shell-shock was caused by emotional rather than commotional factors, it also emphasised heredity and constitutional predisposition as major factors in the onset

[7] Most influential has been Stone, 'Shellshock and the Psychologists', pp. 242-271.

of neurotic symptoms.[8] As historians Edgar Jones and Simon Wessely have suggested, this represented 'reframing' rather than abandoning ideas of heredity degeneration or biological and neurological explanations for mental disorder.[9]

Moreover, the discrediting of commotional explanations for shell-shock did not lead to a weakening of the influence of somatic theories, research and treatment in British civilian psychiatry during the interwar years. Somatic theories garnered strength from being centred on the theories and practice of practitioners in the large asylums, which retained their position as the major site of psychiatric practice throughout the interwar years, despite the changes instituted by the 1930 Mental Treatment Act.[10] Somatic theories were also boosted during this period by the development of medical advances in the fields of brain functioning, the endocrine system and the effect of toxins in the blood and bodily organs. Such theories were further bolstered by the development of a range of physical treatments pioneered on mental hospital patients from the mid-1930s.[11] This revived interest in organic research was part of psychiatrists' continuing attempt to place psychiatry at the cutting edge of medicine and on an equal footing with other medical disciplines. As historian and psychologist Shulamit Ramon has commented

[8] Anon, *Report of the War Office Committee of Enquiry into Shell*-Shock, (London: HMSO, 1922), pp. 92-97. For the ambiguity of the report's conclusions, see Barham, *Forgotten Lunatics of the Great War,* pp. 234-237; Bogacz, 'War Neurosis and Cultural Change in England, 1914-22', pp. 227-256.

[9] Jones and Wessely, *From Shell Shock to PTSD*, p. 56; See also Jackson, *The Age of Stress*, p. 54.

[10] The 1930 Mental Treatment Act and other changes in psychiatric policy and provision are discussed more fully in Chapter Three.

[11] See, for example, Anon, *Committee of the Privy Council for Medical Research for the year 1937-1938*, (London: HMSO, 1939), pp. 135-137. For the use of drugs in mental hospitals see, Anon, *The Twenty-fifth Annual Report of the Board of Control for the Year 1938*, p.36; Andrew Scull, 'Psychiatrists and Historical "Facts", Part One: the historiography of somatic treatments', *History of Psychiatry*, Volume 6, (1995), pp. 227-230. The development of physical treatments in the 1930s and 1940s is also discussed in Chapter Four.

in her assessment of psychiatry in the 1920s, somatically-orientated psychiatrists 'annexed' the new interest in psychiatry that had been fostered by the First World War, 'as if it were an achievement of medicine.'[12]

Throughout the interwar years, the main British publication of asylum psychiatry, *Journal of Mental Science*, frequently published lengthy research papers about the physical aetiology of mental illness. In a major leading article in 1936, the American psychiatrist Max Levin called for a return to the physicalist ideas of the nineteenth-century neurologist Hughlings Jackson and urged psychiatrists to work more closely with neurologists in researching the aetiology of mental disorders. For Levin, mental symptoms were *always* the result of physical damage or disease of the brain or nervous system. 'Every mental act – every thought, recollection, etc. – is concomitant with a physical state of the nervous system,' he asserted.[13]

The psychiatrist and former surgeon T. C. Graves drew on medical research into bacteriology and was an enthusiastic advocate of the idea that mental disorder was the result of toxins caused by underlying bacterial infections.[14] Writing in 1923, Graves advanced his theory that there was a direct relationship between 'prolonged emotional disturbance and chronic septic processes, occurring in hard tissues, especially in connection with the jaws.'[15] Graves would develop these

[12] Ramon, *Psychiatry in Britain*, p. 63.
[13] Max Levin, 'On the Causation of Mental Symptoms: An Inquiry into the Psychiatric Application of Hughlings Jackson's Views on the Causation of Nervous Symptoms, with Particular Reference to their Application to Delirium and Schizophrenia', *Journal of Mental Science*, Volume 82, (January, 1936), pp. 1-27, p.22.
[14] For a review of Graves' life and work, see Andrew Scull, 'Focal Sepsis and Psychosis: The Career of Thomas Chivers Graves, BSc, MD, FRCS, MRCVS (1883-1964)', in Hugh Freeman and German E. Berrios, *150 Years of British Psychiatry: Volume Two, The Aftermath*, (London: The Athlone Press, 1996), pp. 517-536.
[15] T. C. Graves, 'The Relation of Chronic Sepsis to So-Called Functional Mental Disorder', *Journal of Mental Science*, Volume 69, (October, 1923), p. 471; See in the same issue, Henry A. Cotton, 'The

theories of focal sepsis as a cause of 'functional' mental disorders throughout the interwar years, regularly publishing major articles in psychiatric journals. In 1932, for example, *Journal for Mental Science* published a 186-page article by Graves on 'Sinusitis and Mental Disorder', which was based on five years research, including the physical examination of every patient admitted to Birmingham's mental hospitals. Sinusitis, while not responsible for every nervous disorder, 'is singularly liable to evoke mental symptoms,' Graves claimed.[16]

These physically-based theories did not go uncontested, and even psychiatrists who generally upheld physiological explanations for mental illness expressed some scepticism about the theories of hard-line somaticists like Graves.[17] As will be argued later in this chapter, the majority of psychiatrists during the interwar period advocated the idea that mental illness was the result of a combination of physical and psychological factors. It is important to emphasise, however, that psychiatrists who contended that *all* mental disorder had an underlying physical cause were a major force in British psychiatry during this period. Some of the most prominent members of the medical profession advocated physicalist conceptions of mental disorder, and hoped this would enable mental illness to be explained and treated with the same scientific authority accorded to physical illness. In his 1928 address to the Royal Medico-Psychological Association

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Relation of Chronic Sepsis to So-Called Functional Mental Disorder', *Journal of Mental Science*, Volume 69, (October, 1923), pp. 434-465.

[16] T. C. Graves, 'Sinusitis and Mental Disorder: Clinical Manifestations', *Journal of Mental Science*, Volume 78, (July, 1932), pp. 459-644; p. 462. For similar arguments see F. A. Pickworth, 'A New Outlook on the Physiology and Pathology of Mental and Emotional States', *British Medical Journal,* 1, (5 February, 1938), pp. 265-272.

[17] See, for example, Reginald Worth, 'Four Decades of Psychiatry', *Journal of Mental Science*, Volume 81, (October, 1935), pp. 761-763.

about new directions in psychiatry, the respected psychiatrist John Macpherson claimed that brain research had 'resulted in a probability that mental processes can be approached objectively on the physical plane in the same way as physiological processes are approached.' He concluded with an explicit call for psychiatrists to not only continue their research in mental hospitals, but to also utilise the 'scientific facilities' of general hospitals. This, he hoped, would bring the psychiatric profession into 'closer relations with general medicine, whereby its scientific scope would be widened and its therapeutic efficiency improved.'[18]

Biologically-based 'scientific' theories also co-existed alongside more traditional eugenicist-inspired concepts of heredity degeneration and inherited mental disorders. Psychiatrists who claimed their research was at the cutting edge of scientific discovery often used language that could have been taken from nineteenth-century asylum psychiatry. Dublin-based doctor, H. R. C. Rutherford, advocated theories that suggested that thyroid secretion and chronic septic infection were major physical causes of mental disorder. Echoing nineteenth-century theories of degeneration, he also considered that secondary 'exciting' factors, such as adolescence, the menopause, old age, and 'the excessive education of the unfit', alcoholism and excessive smoking, were crucial to the manifestation of mental illness.[19] President of the prestigious Royal Society of Medicine's Section of Psychiatry, Edwin Goodall, even called for a national system of 'pedigree-keeping'. 'I am of the opinion,' he declared, 'that the psychotic and defective should be

[18] John Macpherson, 'The Ninth Maudsley Lecture: The New Psychiatry and the Influences which are Forming it', *Journal of Mental Science*, Volume 74, (July, 1928), pp. 386-399, p. 391, p.399.
[19] H. R. C. Rutherford, 'The Family Physicians Role in the Prevention of Mental Disorder and Defect', *British Medical Journal*, 2, (29 July, 1933), pp. 188-189, p. 190.

examined by some approved scheme for ascertaining stigmata of degeneration, by measurement and observation.'[20] He urged that measures to examine inborn abnormalities and family 'pedigrees' in long-term mental patients be extended to those diagnosed with paranoia, confusional insanity, anxiety neuroses, hysteria and epilepsy.[21]

Many somatically-inclined psychiatrists thereby not only applied theories of degenerative heredity to the disorders of long-term patients incarcerated in asylums, but also to those suffering from milder neurotic conditions. This was the attitude articulated by Edward Mapother, who was a major figure in British psychiatry during the interwar years and the medical director of the Maudsley Hospital from its foundation in 1923 until December 1939.[22] Mapother argued that mental disorders labelled 'functional' were merely those where the physical cause had not yet been found. Patients with neurotic conditions should not be encouraged to discuss their nervous symptoms as this would 'reward' them for their inherent 'weaknesses'. 'Stoicism is still the best course to recommend,' Mapother insisted, in what was perhaps a foretaste of future wartime debates on how to prevent the development of neurotic conditions.[23] In his presidential speech to the Royal Society of Medicine's Section of Psychiatry in 1933, Mapother launched into a polemic against psychoanalysis for being a tender-minded

[20] Edwin Goodall, 'Physical Research in Psychiatry: With Notes on the Need for Research into Hereditary Factors and for a System of Pedigree-Keeping', *Proceedings of the Royal Society of Medicine*, Volume 31, (1937), p. 54.
[21] Goodhall, 'Physical Research in Psychiatry', p. 55.
[22] For background to Mapother's career, see Anon, 'Obituary: Edward Mapother', *The Lancet*, 1, (30 March, 1940), pp. 624-626; Edgar Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley', in Angel et al, *European Psychiatry on the Eve of War,* pp. 3-38.
[23] Edward Mapother, 'The Prevention of Mental Disorder', *The Lancet*, 1 (26 May, 1934), pp. 1131-1135, p. 1131, p. 1135.

conceptual theory, which looked exclusively at subjective processes and 'non-physical entities' in the conscious and unconscious mind. Mapother called for 'tough-mined nominalism', by which he meant the study of concrete phenomena and 'objective facts' about behaviour, and the testing of verifiable hypotheses through observation, experiment and induction. To see neuroses as being 'entirely psychogenic is impossible to conceive', he argued, insisting that every mental syndrome, both neurotic and psychotic, corresponded to physiological processes within the body.[24]

It would be a mistake to see such somatic theories as monolithic, despite their continued influence in interwar psychiatric thought. As in the First World War, when many medics had adopted and utilised psychological and psychoanalytical concepts into their explanations for war neurosis, an eclectic approach to psychiatry would continue throughout the 1920s and 1930s. In particular, some of the insights of psychoanalysis, which posited a psychic rather than a physical cause for neurotic conditions, would increasingly be incorporated into mainstream psychiatric thinking about the causes and symptoms of mental disorder. Such analytically-based ideas, as I show in the next section, did not overtake the prominence of somatic theorisations in British psychiatry, but rather co-existed with them or were incorporated in a rather piecemeal way into a largely somatic framework.

[24] Edward Mapother, 'Tough or Tender: A Plea for Nominalism in Psychiatry', *Proceedings of the Royal Society of Medicine*, Volume 37, (1934), pp. 1687-1711, p.1699, p. 1706, p. 1710.

Psychoanalytic theories

Although the First World War had prompted psychoanalysts to emphasise the role of external events in the creation of neuroses, psychoanalytic thinking about the traumatic neuroses of war remained undeveloped in the interwar years, particularly in the British context.[25] Psychoanalytic ideas only slowly gained credence in mainstream psychiatric circles through the 1920s and 1930s, even though a version of such ideas became increasingly popular among a lay audience.[26] It was not until the late 1930s, when the prospect of a new war seemed inescapable, that psychoanalytic thinking on the aetiology and manifestation of war neuroses would become prominent in medical and psychiatric journals. Psychoanalytical thought had developed in new directions in the intervening period between the wars, and the arguments put forward by psychoanalysts in the run-up to the new conflagration would not be a simple reiteration of the theory of traumatic neuroses developed in the earlier war.

Although Freud did not write extensively about war neurosis, he did succinctly state his position in his introduction to a 1918 symposium on war neurosis and in his short book on the death drive, *Beyond the Pleasure Principle*.[27]

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[25] Eli Zaretsky, *Secrets of the Soul: Social and Cultural History of Psychoanalysis*, (New York: Alfred A. Knopf, 2004), p. 124.

[26] For the take up of psychoanalytical concepts in popular media and culture in the interwar years, see Graham Richards, 'Britain on the Couch: the popularization of Psychoanalysis in Britain 1918-1940', *Science in Context*, Volume 13, (June, 2000), pp. 183-230.

[27] Sigmund Freud, 'Introduction to Psychoanalysis and the War Neuroses' in *The Standard Edition of the Complete Psychological Works of Sigmund* Freud, Volume XV11, (1919), pp. 205-216; Sigmund Freud, *Beyond the Pleasure Principle*, (London: Hogarth Press and Institute of Psycho-analysis, 1974, first published, 1920). There is a debate about whether the English translation of Freud's word '*todestrieb*, translated in the *Standard Edition* as 'death instinct' should be more accurately translated as 'death drive', with its subtly different meaning. See Ian Parker, *Psychoanalytic Culture: Psychoanalytic Discourse in Western* Society, (London: Sage, 1997), p. 88.

For Freud, the development of war neuroses involved an element of surprise or fright, and caused a breach in the mind's protective shield against external stimuli, creating a neurotic reaction.[28] The only factor distinguishing war neurosis from the traumatic neurosis of peacetime was that the war involved a conflict between the soldier's peacetime ego and his new wartime ego, whose actions threatened his life. As Freud put it, the old ego was 'protecting itself from a mortal danger by taking flight into a traumatic neurosis.'[29] In this theorisation, Freud emphasised the individual's struggle with *external* events. As psychiatrist Kurt Goldstein would later point out, Freud 'stressed the struggle against the hostile forces of the external world as the factor from which the war neurosis arises, as contrasted with the conflict between the ego and the repressed forces of the libido that is the basis of the usual neurosis.'[30]

Freud's theory of traumatic neurosis was developed by some of Freud's close associates who had all worked with shell-shock cases – Sandor Ferenczi, Karl Abraham and Ernst Simmel – at a symposium of war neurosis, held in Budapest in September 1918.[31] Although these analysts reiterated Freud's theorisation of traumatic neurosis, they placed less emphasis on the external violence of war as a causal factor. Quoting the work of various German neurologists, Ferenczi argued that for some neurologists the shock of war 'merely' played the role of a 'releasing factor' acting on a degenerative predisposition, whereas others viewed the severity

[28] Freud, *Beyond the Pleasure Principle*, p. 25.
[29] Freud, 'Introduction to *Psychoanalysis and the War Neuroses'*, p. 209.
[30] Kurt Goldstein, 'On So-Called War Neuroses', *Psychosomatic Medicine*, Volume 5, (1943), p. 377.
[31] Zaretsky, *Secrets of the Soul*, p. 122.

of the shock as the main factor in triggering the neurosis.[32] According to Ferenczi, psychoanalysts took a 'median position' on the question of predisposition. Rather than identify *either* innate constitution *or* the severity of the trauma experienced, war neurosis was the result of an 'aetiological succession', involving both factors. 'A trifling predisposition and severe shock can produce the same effects as an increased predisposition and a much lesser degree of shock,' proposed Ferenczi.[33] A similar explanation was espoused by Ernest Jones, the most prominent populariser of Freud's work in Britain, who considered that events external to the individual could not fully explain why one person rather than another developed a neurosis.[34] War neurosis, Jones suggested, was produced by the interplay of three factors – hereditary disposition, unresolved infantile conflicts and the privations of the war that had immediately precipitated the trauma. War neurosis had a complex aetiology, he argued, and could not be explained by the traumatic event alone, but always had to be related to the predisposition of the individual affected.[35]

Apart from Freud's brief exposition on traumatic neuroses in *Beyond the Pleasure Principle*, published in 1920, the theme of traumatic neuroses was rarely revisited by psychoanalytic thinkers during the 1920s and 1930s.[36] One exception was the American psychoanalyst Abram Kardiner, who wrote a long article on the topic in 1932, which would later be expanded into a book on the traumatic neurosis

[32] Sandor Ferenczi, ''Symposium of Psychoanalysis and the War Neurosis Held at the Fifth *International* Psycho-Analytical Congress in Budapest', *The International Psycho-Analytical Library*, Volume 2, (1921), p.13.
[33] Ibid.
[34] Ernest Jones, 'War Shock and Freud's Theory of the Neuroses', *The International Psycho-Analytical Library*, Volume 2, (1921), p. 44.
[35] Ibid, pp. 45-47, p. 54.
[36] See Leys, *Trauma*, pp. 120-152.

published in 1941.[37] Kardiner drew on his experiences of treating chronic war neurotics from the First World War in an American veterans' hospital between 1922 and 1925 to argue that the Freudian application of the theory of the libido to the traumatic neuroses of war was problematic. Kardiner proposed that the reason neurosis persisted after the war was not always due to repression of sexual drives, but could be explained by the subject's failure to adapt to the reality of the outer world. The symptoms of neurosis were not a protective defence mechanism to protect the ego, as suggested by Freud, but rather a way in which the patient adapted to the world around them. Kardiner thus emphasised the need for patients to re-educate themselves after their traumatic experiences and to *consciously* adapt to the new circumstances in which they now found themselves.[38]

Through the interwar years, psychoanalysts based in Britain rarely explored the subject of the traumatic neuroses. Rather, they focused on the development of psychoanalytical theories in two main areas – the psychoanalysis of the child and the application of psychoanalysis to explain trends in wider society and the causes of war. Theories about child development and the unresolved unconscious conflicts of infanthood would increasingly come to dominate the British psychoanalytic movement, influenced by the writings of Melanie Klein and the development of object-relations theory.[39] The publication in 1932 of Klein's *The Psycho-Analysis of*

[37] Abram Kardiner, 'The Bio-Analysis of the Epileptic Reaction', *Psychoanalytic Quarterly*, Volume 1, (1932), pp. 375-483; Abram Kardiner, *The Traumatic Neuroses of War*, (Danvers, Ma: General Books, 2009. First published 1941). For a forensic analysis of Kardiner's work see Leys, *Trauma*, pp. 143-147; pp. 193-194.
[38] Kardiner, 'The Bio-Analysis of the Epileptic Reaction', p. 466; Leys, *Trauma*, p. 194; Young, *The Harmony of Illusions*, pp. 90-94.
[39] Zaretsky, *Secrets of the Soul*, pp. 249-275; J. A.C. Brown, *Freud and the Post-Freudians*, (Harmondsworth: Penguin Books, 1961), p.72.

Children, along with a host of publications by child psychoanalyst Susan Isaacs, would prove particularly influential.[40] As Klein's daughter and psychoanalyst Melitta Schmideberg would later comment about her mother's pre-eminence, 'She convinced many members of the British [Psychoanalytic] Society that the future of psychoanalysis lay in child analysis, and that she had opened up new vistas for theory and practice.' According to Schmideberg, Klein's work had a profound influence on Ernest Jones, who ran the British society and whose children would be analysed by Klein.[41] This influence was notable in some of Jones' writings in the run up to war. According to Jones, the precipitating factor, be it overwork, grief or privation, did not in itself cause a neurosis. A neurosis would only develop, he wrote, 'if certain specific conditions are present in the unconscious – namely, a serious unresolved conflict dating from childhood.'[42] During the interwar years, psychoanalytical theoretical and clinical investigation thus increasingly focused on clinical investigations of the intricate ways unconscious mechanisms in the mind of the individual child would subsequently develop into an adult neurosis.

This is not to suggest that there were no disagreements within psychoanalysis, or that all psychoanalysts emphasised infantile traumas above all other factors.[43] Indeed, the other major development in psychoanalytic thought in

[40] Richards, 'Britain on the Couch', p. 203; Melanie Klein, *The Psycho-Analysis of Children*, (London: Hogarth Press, 1932); Susan Isaacs, *The Nursery Years*, (London: Routledge, 1929); Susan Isaacs, *Intellectual Growth in Young Children*, (London: Routledge, 1930).
[41] Melitta Schmideberg, 'A Contribution to the History of the Psycho-Analytic Movement in Britain', *British Journal of Psychiatry*, Volume 118, (1971), p. 62.
[42] Ernest Jones, 'The Unconscious Mind and Medical Practice', *British Medical Journal*, 1, (25 June, 1938), p. 1357. On the importance of child analysis, see also, David Forsyth, 'The Diagnosis of Neurotic Conditions in General Practice', *British Medical Journal*, 1, (27 February, 1932), pp. 370-371.
[43] Glover, for example, was reportedly sceptical of Kleinian theories. See Schmideberg, 'A Contribution to the History of the Psycho-Analytic Movement in Britain', pp. 63-64. There are good accounts in of various theoretical disputes in psychoanalytical circles in Zaretsky, *Secrets of the Soul*;

Britain during this period was the attempt to apply a psychoanalytic understanding to the causes of the extreme social and political crises of the 1930s. In particular, many psychoanalysts sought to develop an explanation for the economic depression, the rise of fascism in Germany, Spain and Italy, and the threat of a new war. Rather than focusing on the effect of violent and extreme events on the individual's psyche, these writings focused on 'diagnosing' the causes of violence and war.[44] In 1932, the League of Nations invited a correspondence between Freud and Albert Einstein, which focused on how to prevent a new, worldwide conflagration. In his reply to Einstein, Freud re-emphasised his theories of the instincts, suggesting that aggressive human instincts could not be suppressed, but only diverted into channels other than warfare.[45]

In Britain, there were several major psychoanalytical writings on the causes and nature of war. For example, Labour Party economist and activist Evan Durbin and psychologist John Bowlby produced a treatise in 1939 that attempted to provide an account of the links between aggressiveness by individuals and by nations.[46] Drawing on the anthropological work by Solly Zuckerman and the psychoanalytical writings about children by Susan Isaacs, Durbin and Bowlby presented what they saw as a 'fundamentally pluralistic theory of international war'. States were able to conduct wars due to both 'internal' factors within the

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Lisa Appignanesi and John Forrester, *Freud's Women*, (London: Weidenfeld & Nicholson, 1992) and Stephen Frosh, *The Politics of Psychoanalysis: an Introduction to Freudian and Post-Freudian Theory*, (Basingstoke: Macmillan, 1987).

[44] Richards, 'Britain on the Couch', p. 194.

[45] Albert Einstein and Sigmund Freud, *Why War?* (California: International Institute of Intellectual Co-operation, League of Nations, 1933), p. 18.

[46] Edward Glover, *War, Sadism and Pacifism: Three Essays*, (London: George Allen & Unwin, 1933); E. F. M. Durbin and John Bowlby, *Personal Aggressiveness and War*, (London: Routledge & Kegan Paul, 1939).

individual, which they called 'the explosive stores of transformed aggression', and a plethora of 'external' political, economic and social factors. 'There is no single all-embracing cause – no single villain of the piece, no institution or idea that is wholly to blame,' they wrote.[47]

Although differing, and sometimes competing, strands of psychoanalytical thought developed through the interwar period, as the war approached the main emphasis of psychoanalytical writings was not on the traumatic impact of war on individuals but on the instinctual causes of war and the infantile traumas that were seen as root cause of all neuroses. The notion that there was a shift in psychiatry from somatic to psychological explanations during the interwar years thus often supposes a sharper dichotomy between somatic/psychological theorisations than existed in reality. Although psychiatrists sometimes viewed psychoanalysis as the antithesis of somatic psychiatry, both theorisations viewed the aetiology of neurosis as being based in biological and physiological processes.[48] As psychoanalyst Otto Fenichel put it, the psychoanalytic theory of the instincts provided 'the biological basis for psychology.'[49] Not only were there fewer theoretical divergences between biological and psychoanalytical theories than is sometimes assumed, there was a growing trend in the interwar years for new 'psychobiological' conceptualisations. These theorisations would articulate the notion of a synergic relationship between physical and psychological factors in the understanding of mental disorders.

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[47] Durbin and Bowlby, *Personal Aggressiveness and War*, p. 28.
[48] See, for example, Mapother, 'Tough or Tender', pp. 1687-1711.
[49] Otto Fenichel, 'Outline of Clinical Psychoanalysis', *Psychoanalytic Quarterly*, Volume 1, (1932), p.122.

Psychobiology: synergy of body and mind

The notion that mental disorders had multiple aetiologies involving both physical and psychological factors was not new and, as has been shown in this chapter, both somatic and psychoanalytical theories to some extent involved a theorisation of the interrelationship between biology and psychology. During the interwar period there was, however, growing popularity for a theoretical approach that emphasised the dynamism of the relationship between physical and psychological factors. As the Canadian psychiatrist A. G. Morphy expressed it, 'the general trend of opinion is psychobiological, abandoning the dualistic conception of mind and body as distinct entities, and stressing the organism as a whole.'[50] In this view, psychiatrists could not rely on theories that posited a sole or primary aetiology for particular mental disorders, or even make a diagnostic assessment by focusing solely on the overt symptoms of the illness. Rather, psychiatrists needed to take into account the whole person, including all aspects of the patient's lifestyle and personality, as well as their physical and emotional history.

This psychobiological conception of mental disorder drew inspiration from the theories of the Swiss-born psychiatrist Adolf Meyer, who spent most of his professional life practising in Baltimore in the United States, and who was America's most eminent psychiatrist in the 1930s. Meyer's ideas wielded a significant influence over several prominent British psychiatrists who had studied under him. These included David Henderson, who, along with Robert Gillespie, was the author

[50] A. G. Morphy, 'A Review of Recent Literature on Neuroses and Psychoneuroses', *Canadian Medical Association Journal*, Volume 39, (September, 1938), p. 282.

of one of the major psychiatric text books, which underwent several editions between 1927 and the 1960s.[51] Meyer's ideas were also a major influence on the ideas and approach of Aubrey Lewis, the Clinical Director of the Maudsley Hospital from 1936, and who, as will be shown later in this thesis, would have a significant influence on the government's wartime psychiatric policy.[52]

Meyer set out his psychobiological approach during the prestigious Maudsley lecture, which he delivered to members of the Royal-Medico-Psychological Association in 1933.[53] Meyer claimed that psychobiology represented an alternative to both materialist and idealist views of humanity, speaking of the 'intrinsic belonging together' of body and mind, in contrast to Cartesian dualism.[54] Psychobiology was also, according to Meyer, an alternative to a behaviourist approach to human activity, which tended to exclude an assessment of subjective experience.[55] For Meyer, it was vital for the psychiatrist to observe and record the actions and thoughts of the patient, as someone who was a flesh and blood, functioning human being, and not as 'a live corpse or soulless machine.'[56] The psychiatrist needed to know the 'story of events' in the patient's life, Meyer suggested, and 'when and where the event, experience or function occurs or occurred: under what conditions and with what factors, with what working and

[51] Michael Gelder, 'Adolf Meyer and his Influence on British Psychiatry', in German E. Berrios and Hugh Freeman (eds.), *150 Years of British Psychiatry, 1841-1891*, (London: Gaskell, 1991), pp. 419-435; p. 429.
[52] Other leading British psychiatrists influenced by Meyer included Ian Skottowe and Desmond Curran. Gelder, 'Adolf Mayer and his Influence on British Psychiatry', p.429, p. 431; Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley', p. 8.
[53] Adolf Meyer, 'The Fourteenth Maudsley Lecture: British Influences in Psychiatry and Mental Hygiene', *Journal of Mental Science*, Volume 79, (July, 1933), pp. 435-463.
[54] Ibid, p. 440.
[55] Ibid, p. 441.
[56] Ibid, p. 447.

effect, and what range of regularity and plasticity and modifiability.'[57] Psychiatrists had to look at the patient's 'everyday practical life' and personality. It was the unique individuality of every aspect of the whole person that was important, insisted Meyer. 'Anyone who does not sense the interest and individuality of even man's "ordinary" way of doing an ordinary thing should not pose of as a student of man,' he argued.[58]

This theoretical approach had attractions for practising psychiatrists in its refusal to adhere to one particular school of thought, allowing them to emphasise whatever particular aspect of psychiatric theory or practice most appealed to them or suited their purposes. For example, in his Maudsley address Meyer placed more emphasis on the somatic rather than on the psychological ideas of British psychiatrists, such as those of nineteenth-century neurologist Hughlings Jackson, psychiatrist Charles Mercier, and neurologist Frederick Mott, the prominent advocate of concussional theories of shell-shock.[59] On this occasion, Meyer emphasised the 'biological' side of psychobiology more thoroughly than he did the psychic side. Historian Andrew Scull has provided a very critical assessment of Meyer's role in defending the theories and practices of his one-time pupil Henry Cotton, whose focal-sepsis theory of mental disorder led to thousands of operations to remove the tonsils and teeth being carried out on mental hospital patients in the U.S.[60]

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[57] Ibid, p. 448, p. 442.
[58] Ibid, p. 442, p. 447.
[59] Ibid, pp. 438-440, pp. 449-450. Meyer's advocacy of mental hygiene is discussed later in this chapter.
[60] Andrew Scull, *Madhouse: A Tragic Tale of Megalomania and Modern Medicine*, (New Haven & London: Yale University Press, 2005).

Henderson, who perhaps did most to popularise Meyer's views in Britain, similarly praised somatic, neurological, psychological and psychoanalytical approaches to psychiatry. Psychobiology, he argued, 'builds on the hypothesis of the integration of matter and its functions belonging inseparably together and functioning as a unit.'[61] Psychiatry should involve 'a study of the whole personality,' not only in relation to disposition and the environment but also, suggested Henderson, 'in relation to biochemistry and biophysics, anatomy and physiology, psychology, and all the intricate correlating mechanisms.'[62] It was unclear exactly what this call for psychiatrists to assess the total personality of the patient meant in practice, however. Meyer claimed that such an assessment would be objective. He called for psychiatrists to concern themselves with 'performances, actions, reactions and attitudes, thoughts and expressions of a person or group'.[63] But such an assessment could entail a moral judgement of the patient's behaviour, reflecting the background, views or prejudices of the psychiatrist. Indeed, Henderson admitted that assessing the patient's personality could result in 'an interpretation of the facts along subjective lines according to the predilection of the physician.'[64]

Psychobiology was thus an approach that could appeal to neurologists, psychiatrists, psychologists and psychoanalysts alike in their understanding and treatment of the neuroses of war. The psychoanalyst Sandor Rado, writing during the Second World War, expressed hopes that a fuller analysis of war neurosis could be achieved by the fact that doctors were no longer obliged to classify an illness as

[61] D. K. Henderson, 'The Nineteenth Maudsley Lecture: A Re-evaluation of Psychiatry', *Journal of Mental Science*, Volume 85, (January, 1939), pp. 1-21, p. 18.
[62] Ibid, p.19.
[63] Meyer, 'The Fourteenth Maudsley Lecture', p. 448, p. 449.
[64] Henderson, 'The Nineteenth Maudsley Lecture', p. 19.

either psychical or physical. This dichotomy reflected the methods and prejudices of the practitioner, he maintained, and not the nature of the mental disease itself. Every illness, he contended, 'must be explored by both psychological and physical tools, and the findings synchronised and cross-interpreted.'[65] The attempt to dispose of the dichotomy between physical and psychical was also at the heart of research into disorders conceptualised as 'psychosomatic', which would also play an increasingly important role in diagnostic reclassification in the interwar period.

Psychosomatic theories: emotions and the body

Whereas somatic theories held that physical disorders were the primary cause of mental disturbances, psychosomatic understandings of the relationship between the mind and the body posited that disorders of psychological origin manifested as physical illnesses and symptoms. Psychosomatic conditions had been noted in previous wars, such as in understandings of disordered heart during the First World War. But in the 1920s and 1930s a new interest in psychosomatic theories flourished, exploring the effects of the emotions on the physical body and in the development of diseases. A key theorist in the development of psychosomatic medicine during this period was not a psychiatrist, but a physiologist, Walter B. Cannon. Cannon's path-breaking study of the effect of strong emotions on organic bodily processes was first published in 1915 during the First World War, and

[65] Sandor Rado, 'Pathodynamics and Treatment of Traumatic War Neurosis (Traumatophobia)', *Psychosomatic Medicine*, Volume 4, (1942), p. 363.

updated with new research in 1929.[66] Cannon contended that 'the strong emotions, such as fear and anger' exerted a direct influence on bodily processes and changes.[67] In particular, he detailed the ways in which emotions, and even merely 'feelings', produced physiological changes in the body, particularly on the digestive system and the adrenal glands. These processes were not conscious or willed acts on behalf of the sufferers. On the contrary, Cannon maintained that the, 'most significant feature of these bodily reactions in pain and in the presence of emotion-provoking objects is that they are of the nature of reflexes – they are not willed movements, indeed they are often beyond the control of the will.'[68] Cannon argued that his physiological theory of the emotions would enable doctors to 'escape' from the dichotomy between physicalist and psychological views of the relationship between body and mind.[69]

Medical and psychiatric practitioners, including confirmed somaticists and leading psychoanalysts, investigated the complex processes of how emotions altered the physiological processes in the body throughout the 1930s.[70] A growing body of research into psychosomatic conditions identified emotions, and in particular fear and 'anxiety states', as a major cause of illnesses, such as asthma, stomach ulcers, dyspepsia, and rheumatism.[71] Some of this research arose because

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[66] Walter B. Cannon, *Bodily Changes in Pain, Hunger, Fear and Rage: An Account of Recent Researches into the Function of Emotional Excitement*, 2nd Edition, (New York & London: D. Appleton & Co., 1929, first published 1915). See also the obituary by Robert M. Yerkes, 'Walter Bradford Cannon', *The Psychological Review*, Volume 53, (May, 1946), pp. 137-146.
[67] Cannon, *Bodily Changes in Pain, Hunger, Fear and Rage*, p. 220.
[68] Ibid, p. 194.
[69] Ibid, p. 263.
[70] Micale, 'On the "Disappearance" of Hysteria', pp. 522-523; See also, Bourke, *Fear*, pp. 68-69, p.93.
[71] See, for example, Millais Culpin, 'Temperament and Digestive Disorders', *British Medical Journal*, 2, (20 July, 1935), pp. 102-106; Erich Wittkower, 'The Psychological Factor in Cardiac Pain', *The Lancet*, 2, (18 September, 1937), pp. 665-670; T. A. Ross, 'Psychological Factors in Rheumatism', Letter, *British Medical Journal*, 1, (13 March, 1937), pp. 582-583; A. Louise Brush, 'Recent Literature

of concern among government and industrial officials about rising sickness rates in the workforce. In two studies in the 1930s, James Halliday, a regional medical officer for the Department of Health for Scotland, identified an increasing proportion of psychosomatic illness among those claiming insurance on the grounds of incapacity.[72] He claimed there was a psychogenic basis to the disorders of patients who presented with physical symptoms, such as gastritis, rheumatism, anaemia, heart disease, peptic ulcer and chronic bronchitis. Rather than being produced by internal or external physical factors, Halliday believed these illnesses were 'a response to the noxious psychological factors of the environment.' Halliday theorised that 'psychological agents' were transmitted via the nervous system and the endocrine glands, 'bringing about changes in chemistry, rhythm, secretion, and even structure in one or more parts of the body.'[73]

Halliday identified anxiety states as the underlying psychological cause of these physical conditions, whereby bodily symptoms were an 'expression of the emotional reaction of fear.'[74] The physical illness was the result of the individual's unconscious desire to find refuge from anxiety. Halliday highlighted the case of a worker who had developed abdominal pains after he was sacked from his factory job. According to Halliday, the worker 'contrives, though unconsciously, to furnish a

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relative to the Psychiatric Aspects of Gastrointestinal Disorders – A Review', *Psychosomatic Medicine*, Volume 1, (July, 1939), pp. 423-428; J. R. Rees, 'The General Practitioner and Mental Conditions', *British Medical Journal*, 1, (29 June, 1935), p. 1304.

[72] James L. Halliday, 'Psychoneurosis as a Cause of Incapacity Among Insured Persons', *British Medical Journal*, 1, Supplement, (9 March, 1935), pp. 85-88; (16 March, 1935), pp. 99-103; James L. Halliday, 'The Rising Incidence of Psychosomatic Illness', *British Medical Journal*, 2, (2 July, 1938), pp. 11-14. For an account of Halliday's work see Rhodri Hayward, 'Enduring Emotions: James L. Halliday and the Invention of the Psychosocial', *Isis*, Volume 100, (2009), pp. 827-838.

[73] Halliday, 'The Rising Incidence of Psychosomatic Illness', pp. 11-13.

[74] Halliday, 'Psychoneurosis as a Cause of Incapacity Among Insured Persons', p. 86.

more tolerable explanation for his dismissal – namely, he is not working because of ill-health.'[75] Similarly, industrial psychiatrist Thomas Ling considered that physical manifestations of illness permitted the patient to forget the situation that had provoked strong emotions and to concentrate on the 'outward manifestations that are apparently evidences of underlying illness and, therefore, honourable.' Pertinent to explaining war neurosis, Ling believed physical illness was a respectable way that the individual could explain their inability to cope with fear and anxiety, and directly compared the process to the development of the symptoms of shell-shock in the First World War.[76]

The notion of psychic anxiety manifesting as physical illness was particularly attractive to psychoanalytically-inclined theorists, who emphasised the psychic basis to both physiological and psychological disorders. As highlighted earlier in this chapter, psychoanalysis was a biological theory of the psyche, which viewed psychic processes as intimately connected to biological functions. A psychoanalyst from the Tavistock Clinic Erich Wittkower argued, similarly to Cannon, that emotion caused 'a real disturbance of every bodily function', and could lead to definite organic changes in the body.[77] Wittkower also conducted a study that found 48 out of 73 cardiac patients could also be diagnosed as neurotics.[78] He considered the manifestation of cardiac pain to be a form of conversion hysteria, the root of which was a conflict between, on the one hand, 'vital feeling, life and existence' and, on

[75] Ibid, p. 87.
[76] Thomas M. Ling, 'Some Psychological Factors in Sickness Absenteeism', *The Lancet*, 1, (30 May, 1936), p. 1275.
[77] Cited in Anon, 'Reports of Societies: Influence of Emotion on Bodily Functions', *British Medical Journal*, 2, (10 July, 1937), p. 83.
[78] Wittkower, 'The Psychological Factor in Cardiac Pain', p. 666.

the other hand, 'self-preservation and self-assertion'. The roots of this conflict were to be found in infancy and the 'repressed incidents of a strongly emotional content in early childhood.'[79] Wittkower argued that this process was part of the 'flight into illness' common to other forms of conversion hysteria. According to Wittkower, psychosomatic illnesses were an expression of the individual's desire to exchange 'the distrust and bewilderment provoked in the onlooker by psychical symptoms for the tenderness, attention and sympathy generally displayed towards a physically diseased person.'[80] In other words, the stigma attached to mental illness resulted in an unconscious transformation of psychological disorders into bodily manifestations of illness, which would be more sympathetically received and treated.

Psychoanalysts explained this conversion from psychic to physical manifestations of illness in detailed and complex theories, which emphasised the intricacies of the relationship between the mind and organic bodily processes. The psychoanalyst Frank Alexander, for example, criticised some theorists for suggesting that organic symptoms were the *direct* result of psychological factors. Rather, he argued, psychosomatic illness was the end result of a complex chain of various intermediary organic processes, controlled by the vegetative nervous system.[81] This extensive exploration of the relationship between mind and body, and in particular the role of fear and anxiety in creating organic changes and

[79] Ibid, p. 668.
[80] Ibid, p. 669.
[81] Frank Alexander, 'The Influence of Psychologic Factors Upon Gastro-Intestinal Disturbances: A Symposium -1. General Principles, Objectives and Preliminary Results', *Psychoanalytic Quarterly*, Volume 3, (1934), p. 504; See also H. Flanders Dunbar, 'Psychoanalytic Notes Relating to Syndromes of Asthma and Hay Fever', *Psychoanalytic Quarterly*, Volume 7, (1938), pp. 25-68; Kardiner, 'The Bio-Analysis of the Epileptic Reaction', pp. 375-483.

physical illness was also accompanied by an increasing willingness of psychiatrists to consider social and environmental factors in the aetiology of mental disorders, prompted by the expanding remit of psychiatrists to treat milder forms of neurosis. In discussions over diagnoses during this period, as will be shown in the next section, the majority of psychiatrists did not adhere to a strictly somaticist or psychological theorisation. Rather, they often adopted a much more pragmatic viewpoint, basing their conclusions on a clinical assessment of symptoms rather than a clear-cut theoretical position about the aetiology of mental disorder.[82]

Disputed diagnostics

Psychiatric diagnostics were highly contested in the interwar years. Although disagreements over the aetiology and classification of psychiatric disorders were not new to psychiatry, these debates became especially intense in the 1920s and 1930s and the medical journals of the period were full of references to such diagnostic confusions.[83] These debates over the interpretation of diagnoses tended to be concentrated not among asylum doctors, but among general practitioners and medics practising outside of mental institutions. The discussions thus reflected the rise of psychiatric practice outside the asylum, where doctors regularly encountered patients with milder forms of neurosis or the 'more nearly sane'

[82] Allan Young makes a similar point in relation to post-1945 diagnostic trends. Young, *Harmony of Illusions*, p. 35.
[83] See, for example, Doris M. Odlum, 'Nomenclature and Functional Nervous Disorders', *British Medical Journal*, 1, (25 June, 1932), pp. 1169-1171; Hugh Crichton-Miller, 'Classification and Etiology of the Neuroses', *The Practitioner*, Volume 137, (1936), p. 14; A. F. Tredgold, 'So-called "Neurasthenia"', *British Medical Journal,* 1, (15 April, 1933), p. 647.

rather than the 'more nearly mad,' as psychiatrist T. A. Ross put it.[84] The nervous problems of everyday life, such as anxiety, were increasingly coming under psychiatric scrutiny, and required doctors to adapt old concepts and to apply their expert knowledge to new symptoms.

It is also worth noting that in this period there was no standard system of classification, such as later developed in the various editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.[85] In his speech to an annual British Medical Association meeting in Plymouth in 1938, Aubrey Lewis even declared that psychiatric classification had become so derided that the topic was 'almost a shady one'. Lewis argued that what really mattered to the clinician was having 'classes into which he can put his patient's illness after a brief period of investigation.' It did not matter, contended Lewis, how 'illogical, psychologically or pathologically unsound' the classification was, or whether it was 'expressive' of the doctor's own 'idiosyncrasies', as long as the doctor was able to make a prognosis and decide on the best course of treatment.[86] For Lewis, it was the clinical expediency of the diagnosis that overrode theoretical considerations.

In general, most psychiatrists in the interwar years viewed psychotic conditions, such as schizophrenia, manic-depression and delusional states, as 'organic' disorders, whereas milder neurotic conditions, such as anxiety, hysteria

[84] T. A. Ross, 'Mental Factors in Medicine', *British Medical Journal*, 2, (30 July, 1938), p. 209. The growth of psychiatric sites outside of mental hospitals will be discussed more fully in Chapter Three and in following chapters of this thesis.
[85] Young, *The Harmony of Illusions*, p. 94.
[86] Aubrey Lewis, 'States of Depression: their Clinical and Aetiological Differentiation', *British Medical Journal*, 2, (29 October, 1938), p. 875.

and obsessional neuroses, were categorised as 'functional'.[87] The term functional was originally coined in the nineteenth-century to signify the lack of evidence of an organic cause, and this 'negative' definition continued to dominate psychiatrists' conceptions of neurotic disorders.[88] According to one psychiatrist writing in the 1930s, functional nervous disease included, 'all nervous manifestations in which no evidence of pathological changes in the nervous system has been demonstrated.'[89] In this view, it was a lack of proof of a physiological basis to the disorder that determined its classification as functional rather than positive proof the disorder had a psychological cause. Other psychiatrists hotly disputed this 'negative' diagnosis. T. A. Ross argued, for example, that a diagnosis of neurosis should not be based purely on the absence of proof on an organic cause. Rather, neurotic symptoms were positive responses to anxieties and conflicts, he maintained. Psychiatrists must look for evidence of these 'mental irritants' in the same way physicians discovered the 'physical irritants' that caused and provoked somatic symptoms.[90]

Psychiatrist Henry Yellowlees summed up the way in which the division between organic/psychotic and functional/neurotic was generally conceived when he stated: 'Neurotics generally are made, not born. I believe it to be far otherwise with the psychoses, the causes of which are more deeply and more mysteriously

[87] See George Riddoch, 'Differential Diagnosis of Functional and Organic Nervous Disorders', *British Medical Association*, 2, (15 September, 1934), pp. 499-503; C. H. Rogerson, 'The Differentiation of Neuroses and Psychoses, with Special Reference to Depression and Anxiety', *Journal of Mental Science*, Volume 86, (July, 1940), pp. 632-644.
[88] Loughran, 'Hysteria and Neurasthenia in pre-1914 British Medical Discourse', p. 29.
[89] A. A. W. Petrie, 'Differential Diagnosis of Organic and Functional Nervous Disorders', *British Medical Journal*, 2, (15 September, 1934), p. 503.
[90] Ross, 'Mental Factors in Medicine', pp. 209-211; See also R. S. Bruce Pearson, 'Psychoneurosis in Hospital Practice', *The Lancet*, 1, (19 February, 1938), p. 451.

biological. Psychotics are born not made.'[91] This separation of the seemingly more serious, and biologically-based psychoses from the milder, and psychologically-based, neuroses, allowed for some psychiatrists to take a rather dismissive view towards those suffering from neurosis. Ling, who in this period was a medical officer for the Birmingham industrial firm Joseph Lucas, expressed dissatisfaction that the 'organic' and 'functional' split had resulted in neurotic patients being dismissed as not really being ill. 'To divide individuals into "organic" and "functional" must result in a form of therapeutic nihilism,' he wrote.[92] Indeed, in a speech to the Darlington British Medical Association in 1934, G. F. Walker contended that neurotics received 'short shrift' from the medical profession, and described how 'the average doctor bristles with prejudice against those whom he calls neurotic, and against the word "neurosis".'[93] Nervous patients on public assistance, remembered neurologist Eliot Slater in his account of psychiatry in the 1930s, were often 'dismissed with a bottle of medicine', usually bromide.[94] Such was the contemptuous attitude shown by some doctors, the psychiatrist J. R. Rees even felt the need to urge GPs 'not to be sadistic' to their neurotic patients.[95]

Moreover, a moral judgement on the lifestyle and behaviour of the patient was often embedded in the psychiatric diagnosis itself. This is the case with the umbrella-like term 'psycho-neurosis', which increasingly became the preferred terminology in the 1930s for a range of neurotic disorders, such as anxiety states,

[91] Henry Yellowlees, 1932, cited in Rogerson, 'The Differentiation of Neuroses and Psychoses', p. 634.
[92] Ling, 'Some Psychological Factors in Sickness Absenteeism', p. 1274.
[93] G. F. Walker, 'The Springs of Neurosis', *British Medical Journal*, 1, (16 February, 1935), p. 296.
[94] Eliot Slater, 'Psychiatry in the Thirties', *Contemporary Review*, Volume 226, (February, 1975), p. 70.
[95] Rees, 'The General Practitioner and Mental Conditions', p. 1304.

hysteria and obsessional states. To some extent, the moral judgement of the psychiatrist or physician is involved in every medical assessment and diagnosis.[96] This judgement was particularly prevalent in the assessment of the psycho-neuroses, which, according to Gillespie, were conditions characterised by an 'intensification' of the previous personality of the patient.[97] The development of neurosis was 'intimately' bound up with the character of the patient, according to R. S. Bruce Pearson, who worked with outpatients at a general hospital. Diagnosis, he argued, must therefore involve not only taking a detailed family history, but also an assessment of the character of the patient, including their 'manner of conversation' and their 'whole bearing and appearance'.[98] Such diagnoses inevitably involved the psychiatrist making a moral judgement about the lifestyle and character of the patient, and an assessment about what was considered normative behaviour according to prevailing attitudes, or the class and gender biases of the doctor.

This moral judgement was illustrated in the way the diagnosis of hysteria was conceptualised. Historian Mark Micale has noted the decline of hysteria as a diagnosis through the interwar period, and, in particular, he argues that many of the symptoms of hysteria were reclassified as organic ailments or absorbed into more sophisticated psychiatric classifications.[99] Nevertheless, hysteria continued to be a subject of debate in the psychiatric and medical journals of the period. Hysteria, as the diagnosis more commonly applied to working-class, conscript

[96] Hacking, *Rewriting the Soul*, p. 15.
[97] R. D. Gillespie, 'Early Symptoms of Mental Disorders', *The Practitioner*, Volume 137, (1936), p. 33.
[98] Bruce Pearson, 'Psychoneurosis in Hospital Practice', p. 451.
[99] Micale, 'On the Disappearance of Hysteria', pp. 498-526.

soldiers in the First World War, had malingering, albeit unconscious, built into its symptom repertoire. George Riddoch, a psychiatrist based at the London Hospital, described the hysteric as a patient who 'unconsciously welcomes disablement so that he need not continue with disagreeable tasks or can attract sympathy, while at the same time the necessities of life, favoured with luxuries, can be provided for him by others.'[100] Although psychiatrists maintained this was an unconscious process, the language used was extraordinarily similar to the military authorities' accusations of malingering in shell-shocked soldiers. W. Ritchie Russell from the Edinburgh Royal Infirmary described the hysterical patient's mind as 'exercising deliberate fraud' in a process of 'subconscious malingering'. The hysteric, he argued, 'succeeds in shutting off the malingering part of his mind so successfully [that] his ordinary or principal personality does not realise that there is anything unworthy in his behaviour.'[101] For Hugh Crichton-Miller, the central feature of hysteria was 'the exploitation of illness for an emotional end', whether consciously or unconsciously. Hysteria had a 'purposive' element, asserted Crichton-Miller, namely 'to command attention, appreciation, sympathy or admiration', often by exaggerating symptoms of an organic disorder.[102] Although hysterical symptoms could manifest as part of physical, psychosomatic or psychotic illnesses, the aetiology of these symptoms was viewed as psychogenic. As Riddoch put it, 'Hysterical manifestations are mental in origin, and are determined by the individual's idea of what constitutes paralysis, loss of sensibility, or a fit.'[103]

[100] Riddoch, 'Differential Diagnosis of Functional and Organic Nervous Disorders', p. 501.
[101] W. Ritchie Russell, 'Major Hysteria', *British Medical Journal*, 1, (27 April, 1935), p. 873.
[102] Crichton-Miller, 'Classification and Etiology of the Neuroses', p. 18.
[103] Riddoch, 'Differential Diagnosis of Functional and Organic Nervous Disorders', p. 501.

By contrast, many doctors emphasised that the diagnosis of neurasthenia, which had been the prevalent diagnosis for shell-shocked soldiers of the officer class during the First World War, had a physiological basis. Neurasthenia was originally coined in the nineteenth century to refer to nervous exhaustion from a physical depletion of energy, but by the 1930s it had become a catch-all term for a range of nervous disorders.[104] J. R. Rees argued that applying the term 'neurasthenia' to a variety of psychoneurotic states was 'misleading'. He argued neurasthenia should only be applied to 'exhaustion states' that were usually physiological in origin. Rees estimated that just two per cent of the nervous conditions seen as the Institute of Medical Psychology in London when he was director in the mid-1930s, could be diagnosed as neurasthenia.[105] Similarly, Crichton-Miller believed that neurasthenia should only be used for conditions resulting from organically-based infections that caused exhaustion, and not for conditions with a psychogenic aetiology.[106]

Whether the term retained any usefulness for psychiatrists remained a matter of debate in medical and psychiatric journals throughout this period, with some psychiatrists calling for its abandonment as a diagnosis altogether. For E. Farquhar Buzzard from St. Thomas's Hospital in London, the term conveyed 'little or no pathological meaning'. Rather, the diagnosis had become a 'dumping ground' for a range of functional disorders, such as depression, fatigue, insomnia and anxiety,

[104] See Janet Oppenheim, *Shattered Nerves: Doctors, Patients and Depression in Victorian England*, (Oxford: Oxford University Press, 1991); Thomson, 'Neurasthenia in Britain', pp. 77-95.
[105] Rees, 'The General Practitioner and Mental Conditions', p. 1304. J.R. Rees would go on to lead the Army's psychiatric services during the war.
[106] Crichton-Miller, 'Classification and Etiology of the Neuroses', p. 15; See also Tredgold, 'So-Called Neurasthenia', pp. 647-651.

which in Farquhar Buzzard's view required totally different treatment.[107] Psychoanalyst, H. V. Dicks, called neurasthenia 'an obsolete term, expressing an obsolete theory completely obscuring the nature of the conditions it is intended to describe.' For Dicks, neurasthenia was 'a label, devoid of reality', which merely described excessive fatigue under the cloak of a physiological explanation.[108]

The steady decline in the use of the terms 'neurasthenia' and 'hysteria' did not mean these diagnostic categories fell out of use completely. Despite its decline in popularity, neurasthenia continued to be used as a diagnosis in the 1930s and through to the 1950s. As historian Mathew Thomson has noted, one reason for the retention of the diagnosis of neurasthenia was that it was popular with patients. By providing a physical explanation for their nervous troubles, the patient felt absolved from any accusation of malingering, and this made it easier for them to apply for financial relief through the National Insurance Scheme.[109] Neither did the symptoms ascribed to neurasthenia entirely disappear, although they were reconceptualised and incorporated into other diagnoses, taking on new meanings and associations.

Of particular interest for this research, and as noted by various scholars, is the growing prominence of the concept of 'anxiety' in psychiatric theorisations and diagnostics during the interwar period.[110] Although the concept of 'anxiety neurosis' had been part of the psychoanalytic lexicon since the late nineteenth-

[107] E. Farquhar Buzzard, 'The Dumping Ground of Neurasthenia', *The Lancet*, 1, (4 January, 1930), p. 1, p. 2.
[108] H. V. Dicks. 'Neurasthenia: Toxic and Traumatic', *The Lancet*, 2, (23 September, 1933), p. 686.
[109] Thomson, 'Neurasthenia in Britain', especially, pp. 83-88.
[110] Armstrong, 'Madness and Coping', *Sociology of Health and Illness*, Volume 2, (1980), pp. 263-396; Hayward, 'The Pursuit of Serenity'.

century, it was during the 1920s and 1930s that anxiety became a diagnostic category more widely used by mainstream psychiatrists.[111] Anxiety increasingly became viewed as a discrete diagnosis, rather than as an emotional state that contributed to the development of other mental and physical diagnoses. Such was the rise to prominence of anxiety as a diagnosis, in 1935 Rees claimed that half of all psychoneurotic cases could be classified as 'anxiety states'.[112] In a lecture held just a few months before the start of the war, Rees suggested that peacetime anxiety cases outnumbered hysterical cases by three to one, and he speculated that in the forthcoming war civilian psychiatrists would be dealing primarily with anxiety cases.[113]

Despite its previous association with psychoanalysis, anxiety states were not always conceptualised in purely psychological terms. In a major three-part article in *Journal for Mental Science*, psychiatrist Henry Harris combined a Freudian analysis of anxiety neurosis with a version of Pavlovian behaviourism.[114] Harris analysed anxiety in both its physical and mental aspects as a reaction to complex set of bodily processes resulting from unsolved conflicts caused by feelings of inadequacy and inferiority.[115] In this analysis, anxiety neurosis was not only associated with a range of mental and physical symptoms, but its aetiology was viewed as being both

[111] Ibid, p. 289. Hayward has offered a compelling thesis of how the shifting meanings of the concept of anxiety was embedded in changes in British welfare reform, particularly those related to industrial compensation.
[112] Rees, 'The General Practitioner and Mental Conditions', p. 1304.
[113] J. R. Rees, 'Emergency Treatment of Neurotic States', *British Medical Journal*, 1, (4 February, 1939), p. 236; See also Hugh Crichton-Miller, 'Anxiety States', *British Medical Journal*, 1, (28 January, 1939), p. 170.
[114] Henry Harris, 'Anxiety: Its Nature and Treatment', *Journal of Mental Science*, Parts 1 and 2, Volume 80, (July, 1934), pp. 482-512, Part 3, Volume 80, (October 1934), pp. 705 -715.
[115] Ibid, p. 482, p. 487.

somatic and psychic. Similarly, an article by Walter Misch in the same journal identified anxiety as being a 'somato-psychic syndrome', which represented the 'psychical' side or 'primitive organic happenings.'[116] According to Misch, there was an explicit connection between Freudian understandings of the sexual basis of anxiety and the various organic processes in the body that produced acute anxiety states.[117] In many ways, these formulations of the somatic and psychic nature of anxiety underscored the similarities and compatibilities between somatic and psychoanalytic understandings of neuroses.[118] As sociologist David Armstrong has pointed out, these debates did not simply reflect a struggle between psychodynamic and organic theories of mental disorder, but signified more fundamental questions arising from the 'medicalisation of the mind and of certain problems of living.'[119]

This relationship between medicalised notions of neurosis and societal pressures was often articulated around notions of 'mental hygiene', which coalesced into a distinct body of ideas in the interwar period, especially following the founding of the National Council for Mental Hygiene in 1922.[120] The mental hygiene movement aimed to focus on psychiatry in the community, away from prior concerns about psychotic patients in mental hospitals and on to the 'more

[116] Walter Misch, 'The Syndrome of Neurotic Anxiety: the Somatic and Psychic Components of its Genesis', *Journal of Mental Science*, Volume 81, (April, 1935), p. 389.
[117] Ibid, p. 406, p. 408.
[118] See, for example, Joseph C. Yaskin, 'The Psychobiology of Anxiety: A Clinical Study', *The Psychoanalytic Review*, Volume 23 (1936), pp. 1-148 and Volume 25, (1937), pp. 49-93. On the biological foundations of Freud's theory of anxiety neurosis see Micale, 'On the disappearance of Hysteria'.
[119] Armstrong, 'Madness and Coping', p. 297.
[120] For the history of the mental hygiene movement in the interwar years, see Crossley, 'Transforming the Mental Health Field', pp. 458-488; Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health*, (Abingdon, Oxon: Routledge, 2006), pp. 69-89; Thomson, *Psychological Subjects*, pp. 191-194.

normal' nervous ailments experienced in the community at large. Meyer, one of mental hygiene's most prominent advocates, wrote of mental hygiene being 'an intimate study and public education in favour of those factors which make for mental health in a positive, creative, and not merely a passive or mending way.'[121] Supporters of mental hygiene, like Meyer, had a broad vision of emphasising mental *health* rather than mental illness, and of defining mental health as being more than just the absence of illness.[122] Emphasising early treatment in psychiatric and child guidance clinics and the prevention of mental illnesses through public education, mental hygiene was seen as a bridge into the community, whereby psychiatrists and mental health workers could intervene in the psychological heath of the general population, preventing the development of more serious mental disorders.[123]

As will be shown in the next chapter, voluntary organisations that emphasised mental hygiene would have increasing importance during the war in enabling psychiatric intervention to take place outside of hospitals. The ideas of mental hygiene were advocated by a range of psychiatrists, psychologists and medics from all theoretical strands, including prominent psychoanalysts, as well as those influenced by eugenicist ideas. The notion of mental hygiene crossed theoretical boundaries and encompassed an eclectic mix of theories and practical proposals for treatment. Advocates of mental hygiene conceived of the individual's mental health or illness not only as being located within the individual's body or

[121] Meyer, 'The Fourteenth Maudsley Lecture', p. 458.
[122] Crossley, 'Transforming the Mental Health Field', p. 469.
[123] Crossley, *Contesting Psychiatry*, p. 75.

psyche, but also in relationship to wider social conditions.[124] To a certain extent, these ideas were a departure from individualised, and often biologised, conceptions of mental disorder, which dominated most of the psychiatric theorisations discussed in this chapter. At the same time, however, notions of mental hygiene were also infused with normative assumptions about the way in which people were expected to behave.[125] Although ideas of mental hygiene reached out to the community, the way these ideas were expressed emphasised how the individual had failed to adapt to the social environment rather than how the social environment could be changed in order to relieve stresses on the individual.

This emphasis on the adaption of the individual to their social circumstances can be seen in a number of the studies produced in the 1930s. These highlighted how social factors, such as economic hardship, mass production techniques and the wider strains of modern life, could precipitate minor nervous conditions.[126] Psychiatrist G. F. Walker, for example, identified a condition he termed 'environmental neurasthenia', a type of fatigue induced by monotonous, routine work and which was commonly suffered by bus-drivers, telegraphers, school teachers and housewives.[127] Stephen Taylor, who would become Director of Home Intelligence at the Ministry of Information during the war, coined the term 'suburban neurosis'. This referred to the nervous states of middle-class women,

[124] Thomson, *Psychological Subjects*, p. 194.
[125] Crossley, 'Transforming the Mental Health Field', pp. 465-469.
[126] See, for example, Aubrey Lewis, 'Neurosis and Unemployment', *The Lancet*, 2, (10 August, 1935), pp. 293-297 R. Bruce Pearson, 'Psychoneurosis in Hospital Practice', pp. 451-456; Paul Schilder, 'The Social Neurosis', *Psychoanalytic Review*, Volume 25, (1938), pp. 1-19. See also the studies on the effect of increasing competitiveness and acquisitiveness by the American psychiatrist Abraham Myerson, for example. Abraham Myerson, 'Neuroses and Neuropsychoses: the Relationship of Symptom Groups', *American Journal of Psychiatry*, Volume 16, (September, 1936), pp. 263-301.
[127] Walker, 'The Springs of Neurosis', p. 298.

who were isolated on new out-of-town housing estates and who were sexually unfulfilled in their relationships with their husbands.[128] Taylor's study combined an analysis of the effects of the social environment with a theory of the instincts, which linked the development of the neuroses in suburban housewives to the inability of women to satisfy 'race-preserving and herd instincts.'[129] Although the social environment was important in the production of these minor neuroses, they were ultimately, according to Taylor, 'superficial factors', acting as a 'stimulus' on the deeper roots of neurosis.[130]

Social and economic factors were rarely considered as the sole or the primary causal factor in the development on neurotic conditions. For example, in his 1935 study of neurosis and unemployment in London's East End, Lewis set out to find 'other predisposing factors' in addition to the effects of unemployment. He was convinced that there must be underlying factors that would explain why some unemployed people developed neurosis but the majority did not. Lewis's research concluded that neurosis was the result of an interaction between external factors, such as bad housing and malnutrition, with 'inherited predisposition'.[131] There was thus a tendency to highlight the deeper intrinsic factors within the individual rather than precipitating social factors.[132]

[128] Stephen Taylor, 'The Suburban Neurosis', *The Lancet*, 1, (26 March, 1938), pp. 759-761.
[129] Ibid, p. 760
[130] Ibid, p. 761
[131] Lewis, 'Neurosis and Unemployment', p. 293, p. 296.
[132] See, for example, Lindesay Neustatter's influential study of social conditions and neurosis in families. W. Lindesay Neustatter, 'The Effect of Poor Social Conditions in the Production of Neuroses', *The Lancet*, 1, (25 June, 1938), pp. 1436-1441.

An editorial in *The Lancet* in 1936 summed up the prevalent psychiatric view in the 1930s by stating that it was often the patient, unconscious of the real causes, who sought to find the cause of the neurosis in the outside world. They would blame external causes for the neurosis, even though these 'act only as stimuli to the inner tendencies.'[133] Rather than emphasising the ways in which difficult economic or social conditions produced neurosis, psychiatrists also tended to focus on how a diagnosis of neurosis reduced the economic and social capability of the individual and of society more generally.[134] There was thus a reluctance among psychiatrists to attribute all but the very mildest neurotic conditions to adverse social and economic circumstances. How, then, did these interwar developments in psychiatric theorising and diagnostics alter the ways in which psychiatrists would conceptualise the nervous disorders expected to arise during the forthcoming war?

From peace to war

Somatically-based theories of mental disorder, which have been shown to have played an important role in interwar psychiatry, did not suddenly lose their credibility as the Second World War approached. In their speculations about the psychiatric effects of the forthcoming war, many mainstream psychiatrists emphasised both the effects of physical constitutional factors internal to the individual *and* the physical impact that bombs and blasts could have on the individual's body and psyche. W. Mayer-Gross, a psychiatrist who pioneered

[133] Anon, 'The Strain of Modern Life', *The Lancet*, 2, (26 September, 1936), p. 747.
[134] See Halliday, 'Psychoneurosis as a Cause of Incapacity Among Insured Persons', pp. 85-88; Schilder, 'The Social Neurosis'.

research into brain disorders and organic treatments in the interwar years, argued that both neurologists and psychiatrists had tended to 'overrate neurotic symptoms.' [135] Using examples from the First World War, he pointed to the results of post-mortems of 17 patients who had been diagnosed with 'compensation neurosis' and who were all found to have cortical damage to their brains.[136] The desire for financial recompense, even if financially necessary, was thereby construed as the result of a brain disorder rather than a psychological failing. Mapother maintained that the tendency to dismiss head injuries as a cause of neurosis and psychosis during and after the First World War had been 'greatly overdone'. Even though the majority of cases of war neurosis in the earlier conflict had been due to 'neuropathic predisposition and emotional stress', it would be wrong to 'dismiss as negligible the chance that the main factor of this syndrome is the physical effect of head injury,' he insisted.[137]

The question of the psychological impact of head injuries caused by blasts was not only taken up by confirmed somaticists. Crichton-Miller, the founder of the analytically-oriented Tavistock Clinic, argued that both commotional shock and the onset of physically-based mental disorders would be a factor in the forthcoming war. In an article in *The Practitioner* in July 1939, he urged doctors to recognise the possibility of direct physical causes of war neurosis, such as air concussion and suffocation, despite the abandonment of the term shell-shock. It is impossible, he

[135] W. Mayer-Gross, 'Practical Psychiatry in War-Time', *The Lancet*, 2, (23 December, 1939), p. 1329. See also the obituary for Mayer-Gross by Eliot Slater, *British Medical Journal*, 1 (25 February, 1961), pp. 596-597.
[136] Mayer-Gross, 'Practical Psychiatry in War-Time', p. 1329.
[137] Edward Mapother, 'Mental Symptoms Associated with Head Injury: the Psychiatric Aspect', *British Medical Journal*, 2, (27 November, 1937), p. 1056.

contended, 'to eliminate a pathogenic factor by a stroke of the pen, or even diagnostic myopia. Air concussion was, and will be, a definite factor in etiology.'[138]

Interestingly, some advocates of neurological approaches to mental disorder stressed that external environmental factors rather than pre-existing constitutional and hereditary conditions would be a major factor in the development of neurotic symptoms. Mayer-Gross, for example, contended that 'Constitutional mental equipment as an aetiological factor may become entirely negligible when psychological stress, exhaustion or sleeplessness are undermining the moral resistance of the combatant.'[139] Thus it would be external factors, such as the effects of bombs, gas or the longer term deprivations of war, which would play a major aetiological factor in the development of war neurosis in frontline soldiers. Although environmental factors, such as sleeplessness, exhaustion and malnutrition, were considered important in the aetiology of the neuroses suffered by soldiers, it was less clear whether psychiatrists would attach the same significance to similar states of exhaustion, hunger and homelessness in the civilian population.

As in peacetime psychiatry in the 1920s and 1930s, psychiatrists drew on a range of somatic, psychological and environmental factors to explain the development of neuroses in war. As the forthcoming conflict seemed inevitable, there was a host of articles published in the major psychiatric and medical journals

[138] H. Crichton-Miller, 'The Neurosis of Non-Combatants in Time of War', *The Practitioner*, Volume 143, (July-December, 1939), pp. 618-619.
[139] Mayer-Gross, 'Practical Psychiatry in War-Time', p. 1328; see also, Dillon, 'Neurosis Among Combatant Troops in the Great War', p. 66.

written by, or reporting speeches by, psychoanalytic thinkers.[140] This adoption of previously rather marginalised psychoanalytical ideas was at least in part due to the analytical emphasis on the inner, unconscious conflicts of early childhood as the major cause of war neurosis. Rather than returning to the theories of traumatic neurosis as articulated by Freud and his associates after the First World War, these articles emphasised that the war would be the trigger, rather than the primary causal factor, for the onset and manifestation of much deeper, unconscious conflicts buried within the individual.

In a series of pre-war articles published in the major medical journals, psychoanalysts pinpointed three main factors that would condition the psychological reactions of civilians during the forthcoming conflict. Firstly, they highlighted how civilian experience would be different from that of soldiers. Civilians lacked the 'protective armour' of military discipline, and, isolated in their homes, they would lack the benefits of group solidarity. This could produce what Wilfred Bion described as a 'loss of social sense which is one of the characteristics of panic fear.'[141] Secondly, psychoanalysts emphasised that inner, unconscious conflicts would be the primary reason why neurosis would take hold in some individuals and not others. 'The strain of war conditions', psychoanalyst John Rickman argued, could lead to the reactivation of 'latent neurotic conflicts' that had originated infancy.[142] Thirdly, psychoanalysts suggested that the onset of neurosis

[140] The *British Medical Journal*, for example, published notes from a series of six lectures held at the Tavistock Clinic in January 1939. Anon, 'Neuroses in War-Time', *British Medical Journal*, 1, (21 January, 1939) pp. 126-128, (28 January, 1939), pp. 169-170, (4 February, 1939), pp. 234-237.
[141] Emanuel Miller, 'Preface', in Emanuel Miller (ed.), *The Neuroses in War*, (London, Macmillan, 1940), p. viii; Bion, 'The "War of Nerves"', p. 183, p. 185.
[142] John Rickman, 'The Mental Aspects of A.R.P.', *British Medical Journal*, 2, (26 August, 1939), p. 457. John Rickman, 'Panic and Air Raid Precautions', *The Lancet*, 1, (4 June, 1938), p. 1293. See also

could be warded off by the fostering group formations and responsibilities, which could give people a sense of belonging by the 'performance of purposeful acts' and active involvement in helping others through work in civil defence.[143]

This did not mean that psychoanalysts denied completely that the experience of bombing could be traumatic or a major cause of the onset of neurosis. Rickman wrote, for example, that the 'objective external danger' of bombing would be 'not the specific, but an exceedingly important contributory cause' of neurosis.[144] For J. A. Hadfield, the intensity of the bombing trauma would condition the types of symptoms experienced in wartime neuroses. The 'determining cause', he argued, would be 'some external event, usually, of course, bombing or accidents.' The particular way an individual would react to such traumatic experiences, however, depended on the person's earlier pre-war experiences. An earlier trauma could be, Hadfield suggested, 'brought back again by the conditions of war, such as being shut up in an enclosed space or subjected to terrible noise.'[145] Ultimately, the causation of the neurosis lay not only in the traumatic event itself, but also in insecurities arising from the fears and anxieties experienced in early childhood.

Although many psychoanalysts considered that there might be civilian panic and hysteria following the outbreak of war, Maurice Wright from the Tavistock Clinic did not think this was the only possibility. 'There was another reaction of a

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John Rickman's review of a major book by John Langdon-Davies on the physical and mental effects of the bombing of Barcelona in the Spanish Civil War, John Rickman, 'A Discursive Review', *British Journal of Medical Psychology*, Volume 17, (1938), pp. 361-373.

[143] Rickman, 'A Discursive Review', pp. 368 – 372; Rickman, 'The Mental Aspects of A.R.P., p. 457.

[144] Rickman, 'A Discursive Review', p. 363.

[145] J. A. Hadfield cited in Anon, 'Neuroses in Wartime', p. 127, p. 128.

civilian population to war: not anxiety or panic, but the negation of both,' he suggested. Rather than extremes of emotion, there could be an 'exhaustion of the possibility to feel, a stunned apathy, and inability to respond in the way of grief, fear, or joy,' suggested Wright.[146] In many ways, this articulation of a psychological response to the war that manifested differently from the hysterical reactions of shell-shocked soldiers was an astute recognition of the types of emotional states that would later be observed and described during the war itself.[147]

Both somatic and psychological theories about war neurosis and its causes were amenable to a variety of interpretations. Psychiatrists frequently crossed theoretical boundaries when contemplating the effects of war on civilians and in assessing predisposing factors, whether embedded in the physical constitution or in the pre-war personality and psyche of the individual. Whether the psychiatrist emphasised biological constitution, faulty heredity, unresolved psychic traumas from childhood, personality flaws or the intensity of bombing experiences, depended on their theoretical and clinical preferences. There was, however, one consistent theme that dominated all strands of psychiatric thinking on the eve of the war – a focus on the individual's ability to adapt to the conditions of war. Civilians had to learn how to adapt themselves, psychologically as well as physically, if they were to cope with the traumas and conditions of the war to come. The message had to be spread, urged Hugh Crichton-Miller, that it was 'possible to get used to even this hellish manifestation of warfare upon harmless civilians.'[148]

[146] Maurice B. Wright cited in Anon, 'Neuroses in Wartime', p. 126.
[147] See Chapter Six.
[148] Hugh Crichton Miller cited in Anon, 'Neurosis in Wartime', p. 170.

Conclusion

In this chapter, I have argued that the theoretical and diagnostic developments of peacetime psychiatry in the interwar years are crucial to understanding how war neuroses would be conceptualised and treated in the Second World War. I have emphasised the continuing influence of somatic understandings of the development of mental illness, particularly among asylum-based psychiatrists. Theories of the physical causation of mental disorder also retained a provenance beyond the asylum walls, which was connected to psychiatrists' ambitions to elevate their profession to be on an equal footing with general medicine.

Despite the continuing influence of somatic theories, this chapter has also shown how there was not an unbridgeable dichotomy between somatic, psychological, psychoanalytical and social theories of the development of mental disorders. Theories that posited a dynamic interrelationship between the emotions and bodily functions, or between the psyche and physical disease, became increasingly important in the interwar years, and resulted in new conceptualisations and understandings of mental ill-health that would be influential in the forthcoming war. Most practising psychiatrists were not constrained within one particular 'somatic' or 'psychological' way of thinking about mental disorders, but often drew on an eclectic mix of theories that suited their clinical and professional circumstances. Through the interwar period, psychiatrists, general practitioners and other medics, mainly working outside the large public mental hospitals, grappled with trying to understand the aetiology and symptomology of more minor neurotic

disorders, and these debates would be important in understandings of war neurosis.

The Second World War would not, therefore, see a repetition of shell-shock, either in a military context or transposed to the home front. Hysteria and neurasthenia, the most common diagnoses applied to shell-shocked soldiers in the earlier war, had declined in usage, although they did not disappear entirely. New conceptualisation of minor neuroses, now grouped under the umbrella-term 'psychoneuroses', had risen to prominence, most particularly that of 'anxiety neurosis' or 'anxiety states'. These new conceptualisations of minor neuroses would change how psychiatrists and other medics would approach, treat and categorise the types of nervous disorders that would emerge during the war.

Perhaps most importantly, the focus on the neuroses of the 'normal' population in the interwar years, encapsulated by the ideas of the mental hygiene movement, would help make possible the idea that wartime nervous disorders would be short-lived and temporary. Such ideas of temporary neurosis, and the need for preventative measures and early treatment, would form the cornerstone of the government's plans as it contemplated the possible psychiatric cost of the war. In the next chapter, I examine the relationship between psychiatric and government discourse before and during the war, and the ways in which government policy-makers utilised various strands of psychiatric theory.

Chapter Three: The 'official view': government discourse

This chapter critically examines the government's mental health policies before and during the war. These policies would determine the nature and extent of the institutions, services and facilities that were made available for civilians. Moreover, government discourse about civilian psychiatry would also be crucial in defining which mental disorders would be judged as being caused by the war, and consequently which people would be defined as psychiatric casualties. The government's debates and policies were linked to wider economic, political and social concerns about the prosecution of the war, and marked by concern to maintain social order when the civilian population came under sustained bombardment. Although to some extent, the desire to regulate and maintain social order has always been intertwined with mental health policy, these concerns were intensified in the context of the war, and were often framed around debates surrounding the ill-defined concept of 'morale', and a vague, or even imagined, notion of a collective civilian response to the war.[1]

The government's concern to control and regulate the civilian psychological response to the war was also paramount in the discussions held with leading establishment psychiatrists. These discussions helped to formulate official policy, and were summarised in instructions that would be issued to medics and civil defence workers about the most efficient ways to classify and treat mental

[1]Joan Busfield, 'Mental Health Policy: Making Gender and Ethnicity Visible', *Policy and Politics*, Volume 27, (January, 1999), pp. 57-73, p. 58; For general analyses of the relationship of mental health policy to maintaining social order, see David Pilgrim and Anne Rogers, 'Mental Health Policy and the Politics of Mental Health: a Three Tier Analytical Framework', *Policy and Politics*, Volume 27, (January, 1999), pp. 13-24; Butler, *Mental Health, Social Policy and the Law*.

disorders during the war. In this chapter, I will examine the ways in which government policy was influenced by the developments in psychiatric theory discussed in the previous chapter. Government ministers and officials would adopt and utilise both somatic and psychological concepts, including those from psychoanalysis, in the formation of its wartime psychiatric policy. That policy would subsequently help to shape the classification and diagnosis of nervous disorders in practice, and the extent to which nervous civilians would come under the remit of psychiatric services.[2] In this analysis I have focused on what sociologist Joan Busfield has described as a 'complex interplay' between the ideas and practices of psychiatrists and the similarly complex interests and bureaucratic structures of the state.[3]

I begin the chapter by examining the social, economic and political contexts in which in the government made its plans for wartime psychiatric services to deal with the expected high levels of psychiatric casualties. In the second section, I look at how that policy was implemented after the outbreak of war, assessing the types of institutions and services that the government put into place to deal with psychiatric casualties. The relationship between government policies and mainstream psychiatric thinking is then illustrated by an examination of the discussions surrounding the government pensions' policy. Here I assess the synergies between psychiatric theories and the interests of government officials to maintain social order and to limit the financial costs of the war. This relationship

[2] My understanding of the inter-relationship between government policy and psychiatric practice has been influenced by sociological analyses, for example, Lindsay Prior, *The Social Organisation of Mental Illness*, (London: Sage, 1993), p. 48 and Busfield, *Managing Madness*, p. 361.
[3] Ibid, p. 360.

was, I suggest, crucial in creating and sustaining the dominant narrative of the war as one that created very few civilian psychiatric casualties. I conclude the chapter by pointing to some of the tensions between government policy-makers and psychiatric practitioners which began to emerge in the context of wartime psychiatric practice.

The coming 'apocalypse'

The government formulated its plans to deal with psychiatric casualties against the backdrop of widespread fears about the forthcoming calamitous effects of air-raids on civilians' physical and mental health. As historian Richard Overy has written of the interwar years, a 'language of menacing catastrophe' pervaded every area of life, in both public and private discourse.[4] Extreme visions of the forthcoming war became a 'mainstream concern' and, according to Overy, were explained by theories 'derived from serious scientific, medical, economic and cultural descriptions of the present and were not simply rhetoric.'[5] The government began discussing the likelihood of a catastrophic new war, with civilians in the front line, almost as soon as the First World War was over. From the early 1920s, fears that the civilian population would be the target of new and terrifying forms of air-warfare were articulated and fuelled by those at the top of government, encapsulated by prime minister Stanley Baldwin's famous parliamentary statement

[4] Richard Overy, *The Morbid Age: Britain Between the Wars*, (London: Allen Lane, 2009), p.3.
[5] Ibid.

in 1932 that 'the bomber would always get through.'[6] As early as 1924, the government cited reports of panic by civilians in response to the Zeppelin bombing raids in the First World War, and expressed fears there would be 'chaos in the community' and 'loss of morale' in the event of heavier and more deadly air-raids in a future war.[7] By the time of the Munich Crisis in September 1938, government planners speculated that a sixty-day raid on British cities would result in the deaths of some 600,000 civilians.[8] As Tom Harrisson would later write, the 'pattern of British planning was gradually overshadowed by visions of shattering bombardment of the civil population.'[9]

In their extensive planning for civil defence during the 1930s, government officials and planners had underlined the notion that civilian behaviour and morale would be crucial elements of home defence if an air-war were to be launched over British cities.[10] But reports emanating from the Spanish Civil War in the late 1930s gave rise to fears that such stoicism could quickly be shattered when the air-war was unleashed. Some of these reports gave a terrifying foretaste of what might be to come. John Langdon-Davies's report of the bombing of Barcelona in 1938, for example, described how in just 26 minutes bombers 'destroyed the whole mental life of a million and a half people for forty hours.'[11] Fears that a forthcoming war

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[6] Stanley Baldwin, House of Commons Debate, 10 November, 1932. Cited in Titmuss, *Problems of Social Policy*, p.9.
[7] TNA CAB 46/3, Sub-Committee on Air Raid Precautions, April 1924-June 1925, Volume 1, 'Effects of Aerial Attack on the United Kingdom', pp. 4-5; 'Air Staff Notes on an Enemy Attack on Defended Zones in Great Britain', p. 5. See also the account of the panic caused by Zeppelin Raids in H. A. Jones, *The War in the Air*, Volume 5, (Oxford: Clarendon, 1935), p. 7.
[8] Titmuss, *Problems of Social Policy*, p. 13.
[9] Harrisson, *Living Through the Blitz*, p. 9.
[10] Grayzel, *At Home and Under Fire*, pp. 121-148, p. 147.
[11] John Langdon-Davies, *Air Raid: the Technique of Silent Approach High Explosive Panic*, (London: George Routledge & Sons, 1938), p.34.

would result in mass psychiatric casualties among the civilian population were also intensified by the Munich Crisis, when for many British civilians the war moved from being a vague if terrifying prospect to an imminent possibility. Wilfred Trotter, the surgeon and social theorist who had formulated the theory of the 'herd instinct' at the time of the First World War, later wrote of the sense of fearful anticipation that had gripped many London civilians during the crisis. Trotter described witnessing people who 'feverishly scratched open trenches' to protect themselves. Wealthy civilians, who some expected to cope better with the crisis, fled London and many 'confessed to an uncontrollable alarm,' according to Trotter.[12]

Shortly after the Munich Crisis, the Ministry of Health was approached by an unofficial committee of 18 psychiatrists, neurologists and psychologists urging the Ministry to make plans to deal with the impending mental collapse of the population.[13] Unfortunately, there is no surviving record of the original letter sent to the Ministry of Health or the names of the 18 signatories. In his official history, Titmuss claimed that the letter predicted that psychiatric casualties would outnumber physical casualties by three to one in the forthcoming war, resulting 'in some 3-4 million cases of acute panic, hysteria and other neurotic conditions during the first six months of attack.' The letter proposed that a 'large and elaborate' organisation of mental health services be established, records Titmuss, which would include

[12] Wilfred Trotter, 'Panic and its Consequences', *British Medical Journal*, 1, (17 February, 1940), p. 270; Wilfred Trotter, *Instincts of the Herd in Peace and War*, Fourth Edition, (London: Macmillan, 1919).
[13] Titmuss, *Problems of Social Policy*, p. 20; TNA MH 101/1, Sir John Hebb's Report, p. 66.

> Immediate treatment centres in the bombed areas, out-patient clinics running a twenty-four hour service on the outskirts of cities, special hospitals, camps and work settlements in safer areas, and mobile teams of psychiatrists and mobile child guidance clinics.[14]

Titmuss makes little comment on these proposals, except to emphasise how the doctors were spectacularly wrong in their predictions.[15] In his later account, Harrisson rather sarcastically refers to the letter as being from 18 'eminent savants', and similarly emphasises the inaccuracy of these 'mighty calculations'.[16]

The only contemporary accounts of this overture to the government are contained in the writings of psychoanalyst Edward Glover and an unpublished account of the setting up of the EMS written by its director, Sir John Hebb, a former surgeon who had served with the Royal Army Medical Corps (RAMC) in the First World War.[17] Glover was highly critical of the composition of the unofficial committee that approached the Ministry of Health. Although it reportedly included doctors who took psychological approaches to mental health, Glover argued that it was dominated by psychiatrists and neurologists who had served in the First World War and in the Ministry of Pensions, and who took a non-analytical approach. These doctors were preoccupied, claimed Glover, with 'the likelihood of panic developing among the civilian population' and 'the prospect of an epidemic of shell-shock' similar to that experienced in the First World War. Moreover, they assumed

[14] Titmuss, *Problems of Social Policy*, p. 20.
[15] Ibid.
[16] Harrisson, *Living Through the Blitz*, p. 41.
[17] Glover, 'Notes on the Psychological Effects of War Conditions on the Civilian Population (I)', *International Journal of Psychoanalysis*, Volume 22, (1941), pp. 132-146; TNA MH 101/1, Sir John Hebb's Report, pp. 65-67; Anon 'Obituary: Sir John Hebb', *British Medical Journal*, 1, (7 March, 1942), p. 341.

that civilians could be subjected to military discipline like soldiers 'strung-out in battle formation'. Indeed, according to Glover, the prospect of the forthcoming Blitz, 'seemed to arouse a certain military zest which was soon apparent in the outlines given to the projected defence organisation.'[18]

The government rejected the proposals of the 18 London medics. According to Hebb, the Ministry of Health also dismissed offers from the Tavistock Clinic and the West End Hospital for Nervous Diseases to put their facilities and psychological expertise at the government's disposal should war break out.[19] Glover was scathing about the Ministry of Health's rejection of additional 'repeated offers' from the Institute of Psychoanalysis to provide facilities for psychotherapy during the war, along with research and training facilities. 'A scheme was also drawn up to train social workers of both sexes in the elements of mental nursing and so provide an Auxiliary Service for use in the event of extensive or intensive air attack,' he wrote. 'All these offers were rejected without ceremony by the Ministry.'[20] For Glover, the government's refusal to countenance such schemes was ideological, and he accused the Ministry of Health of 'ignoring the existence of the faculty of medical psychology.'[21] According to Hebb, however, the government's rejection of the proposed schemes was more a matter of expediency and cost rather than ideology, as the Ministry objected to being asked to fund such elaborate schemes.[22]

[18] Glover, 'Notes on the Psychological Effects of War Conditions on the Civilian Population (I)', p. 132.
[19] TNA MH 101/1, Sir John Hebb's Report, pp. 66-67.
[20] Glover, 'Notes on the Psychological Effects of War Conditions on the Civilian Population (I)', footnote, p. 132.
[21] Ibid, p. 133.
[22] TNA MH 101/1, Sir John Hebb's Report, p. 67.

As was shown in Chapter Two, many of the articles published in medical and psychiatric journals in the years immediately preceding the war were much more cautious in their approach than the letter from the 18 London medics, and rarely speculated on the numbers of expected psychiatric casualties. Rather they emphasised how the psychiatric casualties of war would show similar symptoms and prognosis to the mental disorders encountered in peacetime. Although it could be speculated that this may have been due to a reluctance to speak publically about the prospect of millions of casualties, this cautious approach also reflected the predominance of articles by analytically-orientated writers in the main medical publications in the run-up to the war. These writers emphasised that the forthcoming war would produce nervous disorders more akin to those of peacetime than those developed during the First World War. For civilians, at least, there would be no repetition of the shell-shock episode.

The Ministry of Health relied on psychiatric advice, but it preferred to select its own hand-picked advisors. As Hebb admitted, before being approached by the London psychiatrists the Ministry had decided to seek advice 'independently' from five psychiatrists and neurologists – Gordon Holmes, Edward Mapother, Hugh Crichton-Miller, Aldren Turner, and Francis Prideaux.[23] Although of varying theoretical persuasions, all five had served in the Army, treating shell-shock patients in the First World War. As historian Ben Shephard has pointed out, the government tended to rely on advice from those who had risen to eminence due to their service as medics in the First World War, while it was a younger generation of

[23] Ibid, p.66.

more analytically-minded psychiatrists who served as medics in the army during the later war.[24] At the end of 1938, the government appointed the neurologist Gordon Holmes and the more psychologically-minded psychiatrist Bernard Hart to act as permanent advisors to the Ministry of Health. Glover railed against these appointments, arguing that the Ministry was 'reverting to the ideologies of the last war but one.' Such a move, he claimed, 'shut the door on any prospect of systematic research on the psychology of a people at war.'[25]

Although both Holmes and Hart had served in the First World War, they favoured different theoretical orientations and methods of treatment. Holmes was renowned for his uncompromising physicalist views of mental disorder and for his unsympathetic attitude towards neurotic soldiers in the First World War. 'He never liked those people,' one medical colleague remembered.[26] Hart was much more sympathetic to psychological theories of the aetiology of mental disorders, and in the 1930s he advocated psychobiological approaches that combined neurological and psychological understandings of mental illness.[27] Indeed, sharp criticism of Hart's 'idealist' approach had been the focus of Mapother's presidential address to the Royal Society of Medicine in 1933, in which he criticised Hart for his sympathies with Freudian concepts.[28] In many ways, the combination of Holmes and Hart as

[24] Shephard, *The War of Nerves*, p.181.
[25] Glover, 'Notes on the Psychological Effects of War Conditions on the Civilian Population (I)', p. 133.
[26] A. J. Murray, cited in Ian Macdonald, 'Gordon Holmes and the Neurological Heritage', *Brain*, Volume 130, (2007), p. 295; For Holmes' lack of empathy with his patients, see A. D. Macleod, 'Shell Shock, Gordon Holmes and the Great War', *Journal of the Royal Society of Medicine*, Volume 97, (February, 2004), pp. 86-89.
[27] See, for example, Bernard Hart, 'Presidents Address: Psychology and Psychiatry', *Proceedings of the Royal Society of Medicine*, Volume 25, (December, 1931), pp. 187-200.
[28] Mapother, 'Tough or Tender', pp. 1687-1712, p. 1695. See Chapter Two for more detail on Mapother's speech.

psychiatric advisors was an interesting choice, and perhaps illustrative of how the government picked its psychiatric advisors carefully from across the psychiatric establishment without adhering to any one particular school of psychiatric thought.

Despite their different theoretical outlooks, Holmes and Hart both emphasised the role of predisposition in the development of neurotic disorders in their advice to the Ministry of Health. The number of psychiatric casualties that would occur, they argued, 'is dependent not merely on external events and forces, such as the number and size of bombs, but on the preceding mental state of the individuals concerned.'[29] Holmes and Hart asserted that the government could prevent large numbers of civilian psychiatric casualties by giving civilians duties to perform, and providing 'efficient protection', such as shelters, to allow people respite from bombing raids. Moreover, they insisted, the government had to ensure that 'neurotic disorder did not carry with it any monetary gain whatever, compensation and pension being absolutely excluded.'[30] As long as patients were dealt with 'efficiently', 'the need for a very wide extension of the Ministry's scheme would probably be avoided.'[31] In other words, Holmes and Hart provided the Ministry of Health with valid psychiatric reasons for utilising the existent limited facilities at its disposal, without demanding huge additional resources at a time of war. Theories of predisposition thus fitted with the government's concerns to avoid civilian panic, maintain social order, and to limit financial costs and resources as far as possible.

[29] Cited in TNA MH 101/1, Sir John Hebb's Report, p.70.
[30] Ibid, p. 71.
[31] Ibid, p.70.

Emergency measures

Having rejected proposals of assistance from psychiatrists and psychoanalysts, what plans were put in place to deal with the expected psychiatric emergency? The government set up a vast scheme that encompassed both general medical and psychiatric services under the auspices of the centrally-directed EMS, a state controlled and directed wartime service. It would be, in the words of the then Minister of Health Walter Elliot, 'capable of undertaking the reception and treatment of large numbers of air-raid casualties.'[32] This extensive military-style system of psychiatric provision, remarkably similar in many ways to the proposals from the London psychiatrists that had been rejected, involved various 'lines' of first aid, clinic and hospital facilities through which patients would be sorted and sifted.[33]

The 'front line' would include First Aid Posts, mobile units, Rest Centres and private GP practices, at which psychiatrists and civil defence volunteers would treat more minor cases of emotional 'shock'.[34] More disturbed patients were to be referred to 'intermediate' sites of treatment, including neurosis centres and psychiatric clinics, after which it was expected they would be sent home swiftly following brief treatment. The government wanted there to be a strict policy of ensuring the 'disposal' of patients at each level of this 'neurological filter'. 'Essential

[32] The organisation of the scheme had been taken over by the Ministry of Health and the Department of Health for Scotland in June 1938. Anon, *Statement Relating to the Emergency Hospital Organisation, First Aid Posts and Ambulances*, Cmd. 6061, (London: HMSO, 1939), p. 1; Titmuss, *Problems of Social Policy*, pp. 54-86.

[33] For details of the plans, see TNA MH 101/1, Sir John Hebb's Report, pp. 68-70; See Chapter Four for an examination of public mental hospitals during the war.

[34] Psychiatric practice at 'front line' sites of treatment is discussed in Chapter Six.

civilian cases' would be separated from the 'non-essential', and doctors would be advised to 'concentrate on treatment for those who were performing national duties'. The aim, according to Hebb, was to 'restrict the treatment of the ordinary civilian to severe and acute conditions so as to ward off any danger of the organisation becoming swamped.'[35] In other words, there were to be two classes of civilians: those who were performing essential civil defence duties, and would merit more attention, and those who were perceived as 'non-essential', whose treatment would be short and swift.

The government made its plans for the anticipated psychiatric emergency in the context of under-resourced institutions and a fragmented system of mental health services. There was no national, centrally-funded psychiatric service, but rather a complex and often uncoordinated system of different hospitals and clinics, which were organised and funded by both local authorities and voluntary organisations. Despite the changes initiated by the 1930 Mental Treatment Act, which enabled local authorities to set up outpatient facilities and for public mental hospitals to admit voluntary and temporary patients, changes to mental health services had been slow to develop in the years before the war. County and borough asylums, renamed mental hospitals in the 1930 Act, remained the primary site of psychiatric treatment, and the mental hospital population continued to rise steadily throughout the 1930s.[36]

[35] TNA MH 101/1, Sir John Hebb's Report', p. 70.
[36] The annual report of the Board of Control recorded an average rise of 1,687 patients per year between 1933 and 1937. Anon, *The Twenty-Fourth Annual Report of the Board of Control for the Year 1937, Part One*, (London: HMSO, 1938), p. 1.

In its last report published before the war, the Board of Control, the government body that oversaw mental health facilities and treatment, noted that some 90 per cent of mental patients were detained in public mental hospitals, as opposed to private institutions. Moreover, the vast majority of these patients were certified – that is, they were compulsory detained – with just over 10,000 out of a total number of 158,723 patients being treated on a voluntary basis.[37] In addition to certified patients in mental hospitals, at the beginning of 1939 there were some 14,634 patients compulsorily detained in public assistance institutions, many of them under 'observation' and waiting to be placed in a mental hospital.[38] Smaller numbers of certified psychiatric patients resided in licensed private and public lodging houses, mostly concentred in urban areas. Each year through the 1930s, the Board of Control reported on overcrowded, under-resourced and understaffed mental hospitals, with outpatient facilities remaining underdeveloped, especially in rural areas and small towns.[39] As well as problems of overcrowding, the majority of mental hospitals were based within Victorian-era asylum buildings, often in a bad state of repair, with no substantial new construction having taken place since 1910.[40] In its 1939 report, the Board of Control reported a shortage of 3,000 beds in public mental hospitals and noted that all new building and repair work had been put on hold due to a labour shortage, as workers were diverted to the armaments

[37] Anon, *The Twenty-fifth Annual Report of the Board of Control for the Year 1938, Part One*, (London: HMSO, 1939), p. 14.
[38] Ibid, p. 36.
[39] Sir Laurence Brock, chairman of the Board of Control, cited in, Anon, 'Mental Hospitals Association', *British Medical Journal*, 2, (22 July, 1939), p. 189; Anon, 'The Twenty-fifth Annual Report of the Board of Control for the year 1938', p. 2.
[40] Hugh Freeman, 'Psychiatry and the State in Britain', in Marijke Gijswijt-Hofstra, Harry Oostahuis, Joost Vijselaar and Hugh Freeman (eds.), *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, (Amsterdam: Amsterdam University Press, 2005), p. 127.

industry. Even without an outbreak of war, the situation was likely to worsen, warned the report, with 'no prospect of any substantial increase in bed accommodation in the near future.'[41]

Despite overcrowded conditions, mental hospitals would play a crucial role in the government's emergency plans – not by providing beds for additional psychiatric treatment, but by moving patients and reconfiguring hospital spaces to provide facilities for physical casualties from air-raids. Various government surveys carried out before the war had estimated that there were 500,000 hospital beds in England and Wales and 67,000 in Scotland, which included 130,000 beds in mental hospitals in England and Wales and 23,000 in Scotland.[42] The wartime emergency scheme was 'essentially an adaption for wartime purposes of existing hospitals', utilising institutions that Hebb described as 'of low standard', 'structurally unsafe' and 'woefully antiquated.'[43] Unlike the plans for general hospitals, in which the government aimed to find additional beds and space by sending patients with minor ailments home, the government declared that mental hospital patients would not be sent home, presumably because it considered it too risky to discharge long-term mental patients into the wartime community. Rather, psychiatric patients were to be, in the government's language, 'crowded' into existing hospital accommodation.[44]

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[41] Anon, *The Twenty-fifth Annual Report of the Board of Control for the year 1938*, pp. 1-2.
[42] Anon, *Statement Relating to the Emergency Hospital Organisation*, p. 7, p. 1.
[43] Anon, *Report of Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, cmd. 6415, (London: HMSO, 1943), p. 8; Sir John Hebb cited in Titmuss, *Problems of Social Policy*, p. 65.
[44] Anon, *Statement Relating to the Emergency Hospital Organisation*, pp. 7-8.

This reconfiguring of space and the movement of patients would be on a vast scale. The Ministry of Health's initial war plans had proposed the wholesale closure of 16 of the 101 mental hospitals in England and Wales, along with the closure of 10 out of 89 mental deficiency institutions, which would be surrendered in their entirety for use by the EMS.[45] The Ministry of Health abandoned these plans at the end of 1938, after the Board of Control insisted that such a scheme would be unworkable, resulting in some areas being left with no accommodation for mental patients, and psychiatric casualties from air-raids having to be shipped across the country to be treated.[46] A revised scheme was devised at the end of 1938 and implemented on the eve of the outbreak of war. Four mental hospitals – Park Prewett Mental Hospital in Hampshire, Horton Mental Hospital in Epsom, Hill End Mental Hospital in Hertfordshire and Hollymoor Mental Hospital in Birmingham, along with the two mental deficiency colonies in Leeds and Newcastle – were totally evacuated and handed to the EMS.[47] In addition, Barrow Gurney Mental Hospital in Bristol was surrendered in its entirety for use by the Navy.[48]

All other mental hospitals in England and Wales were ordered to undertake a partial evacuation of patients, and to vacate one-quarter of their beds, wards and facilities to be adapted by the EMS for the treatment of civilian air-raid casualties.[49]

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[45] TNA CAB 102/716, Statement by the Ministry of Health on Overcrowding, 23 June, 1939; Anon, *The Thirty-Second Annual Report of the Board of Control for the Year 1945*, *Part 1*, (London: HMSO, 1946), p. 7.
[46] Arthur Salusbury MacNalty (ed.), *The Civilian Health and Medical Services*, Volume 1, (London: HMSO, 1953), p. 182; Anon, *The Thirty-Second Annual Report of the Board of Control for the Year 1945*, p. 7.
[47] Ibid. This research does not include Mental Deficiency institutions.
[48] Salusbury MacNalty (ed.), *The Civilian Health and Medical Services*, p. 183.
[49] TNA MH 51/658, Memo from the Board of Control, 23 May, 1939; Anon, *The Thirty-Second Annual Report of the Board of Control* p. 8.

In a few cases, hospitals were ordered to surrender further accommodation. The Middlesex County Mental Hospital in Shenley, Hertfordshire, for instance, was forced to evacuate a substantial section of the hospital containing 600 beds.[50] In Scotland, three mental hospitals – Edinburgh District Asylum, Gartloch Asylum in Lanarkshire and Stirling District Asylum – were completely cleared of patients. This provided a total of 6,000 beds for air-raid casualties, although other mental hospitals were not required to clear wards.[51] These plans would involve squeezing resident patients into already overcrowded and understaffed dormitories and day-care spaces across Britain. The Ministry of Health, however, insisted in a public statement in parliament that such crowding would 'cause no real hardship to the patients'.[52]

A few days before the start of the war, in August 1939, the majority of the earmarked mental hospitals and wards were cleared of their existing patients in just one or two days with 'smoothness and rapidity', according to a retrospective account by the Board of Control.[53] By the end of September, just over 12 per cent of all mental hospital beds in England and Wales (that is, 17,204 out of a total of 132,890) had been surrendered for the use of the EMS, or, in a few cases, to the military services. The number of beds relinquished would steadily increase through the course of the war, with a huge loss of one-fifth of all inpatient mental hospital beds by the end of 1942, providing space for over 40,000 air-raid and military

[50] TNA MH 51/660, Third Report, 26 June 1939.
[51] Anon, *Statement Relating to the Emergency Hospital Organisation, First Aid Posts and Ambulances*, p. 8.
[52] TNA CAB 102/716, Statement by the Ministry of Health on Overcrowding, 23 June, 1939.
[53] Anon, *The Thirty-Second Annual Report of the Board of Control*, p. 7; See also Anon, 'A Civilian Base Hospital', *British Medical Journal*, 2, (23 September, 1939), p. 662.

casualties.[54] An additional five mental hospitals were completely emptied of patients and requisitioned by the War Office for the treatment of military casualties, and by the end of the war ten mental hospitals had been wholly evacuated.[55]

The impact of these upheavals on the lives and health of patients, and on conditions, relationships and treatments inside mental hospitals during the war will be examined in detail in Chapter Four. It is important to emphasise here, however, that mental hospitals and wards were cleared in order to provide space to treat the physical casualties of air-raids rather than for those suffering from mental disorders caused by the bombing. This turns on its head the later claim by Tom Harrisson that thousands of physically sick patients were cleared from hospitals 'to make space for the trembling hordes.'[56] Although general hospitals were cleared of some patients, that space was not used for psychiatric casualties from raids. It was mental hospital patients who had to crowd into more restricted spaces to make way for physical casualties. The clearance of wards within mental hospitals involved not only a reconfiguration of the spaces within the hospital, but the moving in of equipment and materials in order to be able to treat physical casualties. Often the most modern sections of the hospitals, such as admission blocks, were relinquished for this purpose, as they were deemed more suitable locations for the treatment of surgical patients.[57] The remaining mental hospital spaces, which had incurred a

[54] Some 26,428 beds in total had been relinquished by the end of 1942. Anon, *The Thirty-Second Annual Report of the Board of Control*, p. 8; Salusbury MacNalty, *The Civilian Health and Medical Services*, p. 182.
[55] Ibid, pp. 182-183; Anon, *The Thirty-Second Annual Report of the Board of Control*, p. 8.
[56] Harrisson, *Living Through the Blitz*, p. 41.
[57] See, for example, TNA MH 95/11, Report of the Commissioners of the Board of Control, St. Matthew's Hospital, Burntwood, Staffordshire, 8 November, 1939.

dramatic reduction in available beds, were seen as a last resort in the government's schema, reserved for those diagnosed with a psychosis or 'exceptional cases', where the individual's behaviour was seriously disturbed.[58]

The government planned to treat civilian air-raid victims who needed psychiatric inpatient treatment in what it called 'special treatment centres', which would be attached to designated EMS hospitals.[59] The Ministry of Health set up seven specialist 'neurosis centres'. These were initially envisaged as treatment centres for psychiatric cases from air-raids, but they ended up admitting more military than civilian patients.[60] Early in the war the Ministry of Health had agreed with the heads of the three military services that the EMS would take all military cases that could not be accommodated in military hospitals.[61] The absence of air-raids over Britain in the first nine months of the war meant the initial large influx of patients in April and May 1940 were military cases, mainly made up of soldiers from the British retreat at Dunkirk. In January 1941, government figures showed that there were 900 military patients being treated in EMS neurosis centres compared to 40 civilians, and estimated that on average just 25 civilian bomb victims were being admitted per month.[62]

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[58] LMA H12/CH/A/09/07, Disposal of Cases of Neurosis and Psychosis admitted to Hospitals, Memo from F.R. Fraser, Ministry of Health, 24 July, 1940; TNA MH 101/1, Sir John Hebb's Report, p. 70.
[59] Anon, *Summary Report by the Ministry of Health for the period from 1 April, 1939 to 31 March, 1941*, Cmd. 6340, (London: HMSO, 1942), p. 24.
[60] These neurosis centres were at Mill Hill Special Neurological Hospital, Sutton Special Neurological Hospital, Wharncliffe Emergency Hospital, Sheffield, Fazakerley Hospital, Liverpool, Shotley Bridge Emergency Hospital, Durham, Sorocourt Institution, Reading, Stanborough's Hydro, Watford. Two other neurosis centres were established for military cases only, at Muswell Hill in North London and at Cardiff City Mental Hospital. LMA H12/CH/A/09/07, 'Disposal of Cases of Neurosis and Psychosis admitted to Hospitals', Memo from F.R. Fraser, Ministry of Health, 24 July, 1940.
[61] Anon, *Summary Report by the Ministry of Health for the period from 1 April, 1939 to 31 March, 1941*, pp. 23-24.
[62] TNA PIN 15/2208, Notes of a Conference held on Thursday 16 January, 1941.

The low number of civilians being treated at the neurosis centres has been cited by some historians as 'evidence' of the small number of civilian psychiatric disorders during the war.[63] It is important to note, however, that the opening up of the EMS facilities to military casualties occurred before the intensive bombing raids of civilian areas during the Blitz, and the treatment of military patients developed its own momentum. This process was later described by William Sargant, who was working as a neurologist at the Belmont neurosis centre in Epsom in Surrey at the time of the retreat from Dunkirk and the London Blitz. During the period of the 'phony war', he recalled, the hospital had begun to admit 'ordinary' civilian mental patients. These civilians were discharged when the hospital became inundated with military cases and became, in Sargant's estimation, 'a main military neurosis centre' for the duration of the war.[64] The neurosis centre later admitted and treated some civilian cases from the London Blitz and also in 1944 during the V1 and V2 rocket attacks, when such cases were, in Sargant's words, 'permitted us by the Ministry of Health.'[65]

The government instituted strict rules for civilian admissions to the neurosis centres. From 1943 it became a requirement that civilians would have to be admitted for treatment for a neurotic condition in an EMS neurosis centre in order to be able to claim any compensation for psychological injuries caused by bombing.

[63] See, for example, Juliet Gardiner, *The Blitz: the British Under Attack*, (London: Harper Press, 2010), p. 179.
[64] William Sargant, *The Unquiet Mind*, (London: William Heinemann, 1967), p. 114; Also see Titmuss, *Problems of Social Policy*, p. 184. For a detailed account of the therapies soldiers evacuating from Dunkirk received at Sutton Emergency Hospital see Nafsika Thalassis, 'Treating and Preventing Trauma: British Military Psychiatry during the Second World War', Unpublished PhD thesis, University of Salford, 2004.
[65] Sargant, *The Unquiet Mind*, p. 126, pp. 127-129.

Medical staff were instructed not to treat cases of 'simple exhaustion', and to do all that was necessary to send patients home or to redirect them to visit psychiatric outpatient clinics. Nor were neurosis centres allowed to provide treatment for those deemed to have more serious, psychotic conditions. The government insisted that psychotic patients should be referred on to the public mental hospitals, which would remain the primary site of treatment for those diagnosed with psychotic mental illnesses.[66]

The government relied on a fragmented system of mental health services outside of mental hospitals to try to prevent large numbers of civilians being referred for inpatient treatment. During this period, these services were organised in a rather haphazard and uncoordinated way in what historian Rhodri Hayward has characterised as a 'mixed economy' of care, involving a patchwork of services run by voluntary organisations, local authorities, charities and the private sector.[67] Psychiatric outpatient clinics, for example, had been established far more slowly than had been hoped after the 1930 Mental Treatment Act. By the beginning of 1939 there were 177 clinics in operation, treating an estimated 19,000 patients, but this provision was uneven and mainly concentrated in urban areas. 'The needs of the rural areas and small towns have not been met,' reported the Board of Control.[68]

[66] LMA H12/CH/A/09/07, 'Disposal of Cases of Neurosis and Psychosis admitted to Hospitals', Memo from F.R. Fraser, Ministry of Health, 24 July, 1940.
[67] Hayward, *The Transformation of the Psyche in British Primary Care*, p. 68.
[68] Anon, 'The Twenty-fifth Annual Report of the Board of Control for the year 1938', p. 2. Psychiatric practice at outpatient clinics during the war will be examined in detail in Chapter Five.

Four main voluntary organisations – the Central Association for Mental Welfare, the Mental After Care Association, the National Council for Mental Hygiene and the Child Guidance Council – also provided a range of overlapping services, including adult psychiatric services and child guidance clinics. These bodies were dominated by practitioners committed to the ideas of 'mental hygiene', as discussed in Chapter Two, which sought to offer preventative measures and to provide early treatment for mental health problems in the community. As these organisations were under no compulsion to report their services to the government there were no figures collated nationally about how many clinics and services were provided. In 1939, however, the Board of Control estimated that there were at least 32 clinics run by voluntary organisations providing adult psychiatric services.[69] Such was the dispersed and fragmented nature of the voluntary services that the government had established a special committee, presided over by Lord Feversham, in an attempt to bring, as one report put it, 'order out of chaos'.[70]

In January 1939, before the Feversham Committee made its report, the government set up a Mental Health Emergency Committee, amalgamating six voluntary bodies, including the National Council of Mental Hygiene and the Child Guidance Council, to help deal with the expected psychiatric casualties resulting from the war.[71] The committee was charged with providing emergency psychiatric help in bombed-out areas and, in particular, with assisting with psychiatric cases

[69] Ibid. Anon, 'Voluntary Effort in Mental Health', *British Medical Journal*, 2, (29 July, 1939), pp. 231-232.
[70] Ibid, p. 232.
[71] The six organisations involved were Central Association for Mental Welfare, Child Guidance Council, Mental After-Care Association, National Council for Mental Hygiene, Association of Mental Health Workers and Association of Psychiatric Social Workers. Wellcome Collection SA/MAC/E.5/6 'Emergency Measures Committee, 31 January, 1939'.

which might arise from evacuation and the billeting out of homeless and displaced families.[72] Although in his post-war account Titmuss emphasised that the planning of a national medical service was predicated on the pre-war fears of mass physical and psychiatric casualties, it was apparent before the war that psychiatric services would not have been adequate to meet such a demand should such a level of psychiatric need arisen.[73] When setting up the Mental Health Emergency Committee, the Board of Control admitted that existing psychiatric institutions would not be able to cope with the predicted numbers of psychiatric cases, and that services outside of hospitals and clinics provided 'the most hopeful' way of dealing with the psychiatric problems that were envisaged. In the event of an emergency, suggested the Board, civilians 'could be helped in their own homes or by boarding out'.[74]

The government's aim to prevent mental hospitals and EMS facilities from being inundated with psychiatric patients were made clear in a document initially drafted by the Ministry of Health in May 1939, advising medical officers at First Aid Posts how to treat neurotic patients. This document was subsequently printed as a memorandum to the medical profession and was circulated to every medical practitioner in Britain at the beginning of 1940. At the insistence of Lord Horder, the instructions were also reproduced verbatim in December 1939 in the *BMJ* and *The Lancet*.[75] The government advised practitioners that unless treatment was

[72] TNA CAB 102/719, Mental Health Emergency Committee Leaflet, June 1940.
[73] Titmuss, *Problems of Social Policy*, pp, 73-86.
[74] Wellcome Collection SA/MAC/E.5/6 'Emergency Measures Committee, 31 January, 1939'.
[75] TNA PIN 15/2402, Letter from Adair Hore to William Codling at HMSO, 23 February, 1940; *Neuroses in War Time: Memorandum for the Medical Profession*, (London: HMSO, 1940); published in *British Medical Journal*, 2, (16 December, 1939), pp. 1199-1201; Anon, 'Neuroses in Wartime', *The Lancet*, 2, (16 December, 1939), pp. 1278-1279.

delivered swiftly and immediately, 'the morale of the population would suffer'. Terms such as 'shellshock' which 'may suggest that these nervous symptoms have a physical basis or are due directly to injury' had to be 'rigidly avoided,' the government insisted. Rather, the government urged practitioners to convince patients that their symptoms were not serious and insisted that practitioners do everything they could to send patients home as soon as possible. For patients who were frightened or emotional, the government advised, 'reassurance combined with an appeal to personal and patriotic pride and a large dose of bromide will usually be sufficient.' Confused patients should receive 'rest, warmth, hot drinks, with plenty of glucose or alcohol'. Those who exhibited more excitable symptoms should be given morphia and stronger drugs. Above all, the government discouraged practitioners from transferring patients for hospital treatment, warning doctors that if patients were sent to hospitals when it was not 'absolutely necessary', the neurosis 'may be accentuated or prolonged, and the extent of neurotic disorder in the population may be greatly increased.'[76] As Hubert Bond, a senior commission for the Board of Control, characterised the directive to medics, 'Do not talk about these things. Get them home at once, in the next hour, if possible, and give them some drug – morphia, etc., to quieten them down.'[77] The message to medical practitioners was clear: if patients were not treated promptly, the practitioner may be responsible for any increase in the numbers of neurotic

[76] TNA MH 101/2, EMS/Gen/205, 'Advice on the Treatment at First Aid Posts and by Private Practitioners of Neuroses and Other Nervous Manifestations Arising in an Emergency', 3 May, 1939.
[77] TNA PIN 15/2399, Conference of Neurologists and Representatives of the Service Departments: Compensation in Cases of Neurasthenia and Psychosis, 3 July, 1939.

cases, and could thus be partly responsible for damaging the morale of the population during the war.[78]

At the start of the war a consensus appeared to be developing between government officials, psychiatrists and other mental health professionals that fast and efficient treatment of minor neurotic reactions to the war would be able to ward off the forecasted high levels of psychiatric casualties. The idea that neurosis could be treated early and quickly was linked to, and made possible by, the developments in psychiatric theorising about minor neuroses discussed in Chapter Two. Reinforcement of this view also emerged in a report on the psychological effect of the bombing raids in the Spanish Civil War from psychiatrist Emilio Mira. Mira, who had been attached to the Republican side in the civil war, sent his report to the Ministry of Health and it was published in the *BMJ* in June 1939.[79] In contrast to previous reports from Barcelona, Mira asserted that civilians under bombardment in Barcelona and Madrid had adjusted quickly to the raids, and that daily life and cultural pursuits had continued with a high level of normalcy.[80] Mira judged that it was the effects of long-term hunger, rather than air-raids, which had created the greatest psychological stresses on civilians. Although 'a greater part of the population would feel what may be called "normal anxiety",' wrote Mira, the majority 'never needed psychiatric attention.' Those civilians admitted to hospital would usually be discharged after a week following a treatment programme of 'isolation, sedatives, and reassurance' and were rarely seen again in outpatient

[78] In case practitioners were not getting the message, in this short 605 word document the advice to 'return patients to their homes' is repeated four times.
[79] Emilio Mira, 'Psychiatric Experience in the Spanish War', *British Medical Journal*, 1, (17 June, 1939), pp. 1217-1220.
[80] See, for example, the accounts of panic in Barcelona in Langdon-Davies, *Air Raid*, pp. 88-89.

clinics.[81] Mira's report chimed with the psychiatric advice that had informed the government's directives for swift treatment and dispersal home. As a result it would be frequently cited by both the government and psychiatrists in the immediate run-up to the war.

The idea that civilians should not be enabled to 'succumb' to neurosis was thus embedded in official government policy, and formed an essential part of the government's reckoning of the psychiatric cost of the war. As their psychiatric advisors, Holmes and Hart, had insisted, the 'method of treatment adopted would not only affect individual cases, but the incidence of the disorder, and the size of the problem which would have to be faced.'[82] In other words, swift treatment on the 'front line' could help to avoid an unmanageable psychiatric disaster, and could prevent civilians from being referred to overcrowded mental hospitals, whose resources and capacity had been diminished further by the preparations for war.

Government ministers were acutely conscious that official policy could, in theory, exert an influence on the extent of psychiatric problems experienced during the war. Hebb claimed that immediately before the war there was 'a growing feeling in official circles that except possibly in certain districts cases were likely to be few and far between.'[83] According to Hebb, the fact that the reported cases of psychiatric casualties were so few in the first two years of the war had been in no small measure due to the policies enacted. Hebb insisted that, 'the existence of orderly arrangements exerted a control which helped to check what in their

[81] Mira, 'Psychiatric Experience in the Spanish War', p. 1219.
[82] Cited in TNA MH 101/1, Sir John Hebb's Report, p. 71.
[83] Ibid, p. 169.

absence might have led to a larger flow of cases.'[84] The government's desire to keep in check the numbers of civilian psychiatric cases was also illustrated by its discussions with establishment psychiatrists around the question of compensation for psychological injuries in the war, which became intertwined with discussions about the best methods of psychiatric provision and treatment for those diagnosed with neurosis.

Pensions policy

The government had been taken by surprise by the high incidence of psychological disorders in the First World War, and by the huge financial costs that were incurred by the state in its aftermath by the provision of medical treatments and pension payments.[85] According to an official account of psychiatry in the Army, in March 1939 some 120,000 veterans from the Great War were still either receiving a pension or had been awarded a final financial lump sum for psychiatric injuries incurred by the war.[86] The government saw it as a high priority to take steps to avoid a repeat of shell-shock and its costly aftermath by restricting both military and civilian compensation payments. The Ministry of Pensions sought the advice of psychiatrists who had served in the RAMC treating shell-shock, convening two conferences on its pensions policy in July 1939 under the auspices of Lord Horder.[87]

[84] Ibid, p. 71.
[85] See Jones and Wessely, *Shell Shock to PTSD,* pp. 143-158.
[86] R. H. Ahrenfeldt, cited in Jones and Wessely, *Shell Shock to PTSD*, p. 152. From their research of pension records Jones and Wessely suggest that these estimates may have been too high.
[87] TNA PIN 15/2399, Conference of Neurologists and Representatives of the Service Departments: Compensation in Cases of Neurasthenia and Psychosis, 3 July, 1939. Shephard has described these conferences in detail in '"Pitiless Psychology"', pp. 491-524. See also Jones and Wessely, *Shell Shock to PTSD*, pp. 156-158.

The discussions at these conferences reveal the close relationships the government cultivated with leading members of the psychiatric establishment. They also illustrate how psychiatric theorising, especially about individual predisposition, was able to provide the government with a medical justification for its harsh pension policy.

Government officials were explicit from the outset that the aim of these discussions was to institute measures to restrict compensation. This attitude on the part of the Ministry of Pensions was summed up by its secretary, Adair Hore, at the start of the first conference on 3 July 1939 when discussing pensioners from the First World War. 'Very generous allowances were given,' he claimed, 'and the patients got expansive on the subject of their dreams, etc. and they kept coming back for more course of treatment and more money.'[88] Although the conferences focused on compensation for military personnel, psychiatric theories were also deployed to justify the government's intention to deny pension payments to civilians. Indeed, Hoare admitted at the first conference that a bill had already been drafted with the aim of limiting compensation payments to civilians to 'personal injuries resulting from the impact of shell, so as to eliminate the effects of shock, and cut out people who collapse when they hear a shell burst.'[89]

Nearly all the participants at the two conferences, including those psychiatrists who favoured psychological methods of treatment, agreed that compensation for nervous injuries should be denied to civilians. Indeed, Edward

[88] TNA PIN 15/2399, Conference of Neurologists and Representatives of the Service Departments: Compensation in Cases of Neurasthenia and Psychosis, 3 July, 1939.
[89] Ibid.

Mapother, an advocate of 'tough-minded', physically-based psychiatry, was the only one of the 19 attendees at the first conference to object to the 'over-emphasis on the constitutional element'. His was the sole voice arguing that compensation should be given because 'people may suffer from neurotic and psychotic disabilities, which are, as far as ascertainable, entirely the result of the war.'[90] The discussion at the two conferences reinforced the idea that the majority of neurotic disorders suffered by civilians would be transient, and should be distinguished from 'intractable' cases, in which the individual was already predisposed to develop neurosis through inborn or acquired characteristics that pre-dated the war.[91]

In addition, four respected psychiatrists who had experience of treating shell-shock by psychological methods in the First World War, reiterated and reinforced this point of view in a memo written to the Committee for Imperial Defence in the same month as the pensions conferences. The four psychiatrists, J. T. McCurdy, George Riddoch, T. A. Ross and C. S. Myers, admitted the 'apparent callousness' of a policy of denying compensation to those suffering from war neurosis, but insisted that 'a policy be formulated, and announced in advance of hostilities, which excludes neurotic symptoms from the list of disabilities for which there is a right to compensation.' There could be no doubt, they wrote, 'that in the overwhelming proportion of these cases, these patients succumb to "shock" because they get something out of it.' Moreover, these psychologists argued, to grant pensions would be to reward an 'unconscious cowardice' or an 'unconscious

[90] Ibid. See Chapter Two of this thesis for a discussion Mapother's theories.
[91] TNA PIN 15/2401, Report of Committee Meeting held of 31 July, 1939.

dishonesty'.[92] There was an assumption not only that malingering, albeit unconscious, would be commonplace but also that it was embedded in the manifestation and symptomology of the mental disorder itself.

These discussions set the framework for the government's wartime pensions policy and future discussions about which patients would be judged as having war injuries and be considered 'deserving' of compensation. At the beginning of the war, the government instituted its stringent pension policy, which meant that no civilian could claim compensation allowances and pensions unless they had sustained a *physical* injury in a bombing raid. The Personal Injuries (Civilians) Act, passed in 1939, restricted all civilian claims to people who had sustained visible and verifiable physical injuries.[93] No allowances were to be paid for neurosis and other related mental disorders, even if the civilian had undergone traumatic experiences or had been in the vicinity of an air-raid. The legislation excluded those civilians whose neuroses were judged to be caused by fear and anxiety, and also those who did not have corporeal proof that they had been injured in an air-raid. The legislation was thereby designed to prevent large numbers of civilians from claiming war injury pensions.

Government policy restated the view prevalent during the Great War that physical injuries were more deserving of compensation than the emotional and psychological traumas suffered by those who had witnessed the death, injury or mutilation of family, friends and neighbours. Percy Bolus, the medical director of

[92] TNA PIN 15/2399, Memorandum on Subject of Provision of Treatment for Nervous Diseases in the Event of War, 7 July, 1939.
[93] TNA PIN 15/2208, Memorandum 248, War Injuries and War Service Injuries, July 1941.

the Ministry of Pensions, insisted that unless a blast caused physical bodily damage, such as haemorrhaging or lung collapse, symptoms of shock would only persist in those people who had a prior constitutional weakness. Moreover, he argued that most cases of shock were 'the expression of a particular patient's inability to adjust himself to a particular situation.' In this view, the primary reason for the development of neurotic reactions following a bombing raid was not the severity of the traumatic experience, but the failure of the individual to *adjust* in the aftermath of the bombing. Indeed, he argued that the 'constitutional, mental and emotional' make-up of the individual 'swamped and outweighed' other factors in the development of a neurotic reaction.[94]

The government's sharp distinction in its early pension policy between physical and psychological injuries was in some ways a return to the First World War debates between the commotional or psychological causes of shell-shock.[95] As Hugh Crichton-Miller commented in 1941, as 'shell-shock was more respectable than malingering; so will blast-concussion always be more acceptable than hysteria.'[96] As shown in Chapter Two, in the run-up to the war psychiatrists from both somatic and analytical theoretical persuasions considered that the commotional effects of blasts would be an important aetiological factor in the development of neurological symptoms experienced by both soldiers and civilians. Crichton-Miller, for example, continued to emphasise 'blast-concussion' as an aetiology factor in the shock civilians experienced after raids. These symptoms, he

[94] TNA PIN 15/2946, P. R. Bolus, Ministry of Pensions, Letter to Dr. L. W. Nicholson, 22 May, 1941.
[95] Jones and Wessely, *Shell Shock to PTSD*, p. 158.
[96] H. Crichton-Miller, 'Somatic Factors Conditioning Air-Raid Reactions', *The Lancet*, 2 (12 July, 1941), p. 31.

wrote, had 'no intrinsic connexion with psychology', and bore 'no relation to morale, courage, discipline or any other ethical virtue.'[97] He suggested that by positing a psychological aetiology for war neurosis, many psychiatrists implicitly associated the patient's condition with malingering.

Despite emphasising the physical aetiology of air-raid shock, Crichton-Miller still acknowledged that shock was caused by the 'normal' reactions of both body and mind, and was the result of a 'combination of the organic factor of concussion with the emotional factor of fear.' Indeed, according to Crichton-Miller the effects of the blast were likely to be greater if a patient had no physical wound, because the patient would be denied necessary rest for recuperation and would 'feel loss of prestige in being disabled without obvious trauma.'[98] It can perhaps be surmised that Crichton-Miller, who was known to favour analytical approaches to mental disorders, believed that if psychiatrists emphasised physical factors in the causation of their neurosis, the patient would be treated with more sympathy and given more time to recover from their experiences.

In the final months of the Blitz, an outcry from trade unions over decisions to deny compensation to merchant seaman, who had been bombarded at sea, and to frontline civil defence and emergency workers in blitzed areas, forced the government to modify its pensions policy.[99] Rather than formally amend the legislation, however, the Ministry of Pensions kept its changes largely unpublicised.

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[97] Ibid. For a similar argument about the dangers of dismissing the effects of exposure to blasts, see E. W. Anderson, 'Psychiatric Syndromes Following Blasts', *Journal of Mental Science*, Volume 88, (April, 1942) pp. 328-340.
[98] Crichton-Miller, 'Somatic Factors Conditioning Air-Raid Reactions', p. 34.
[99] TNA PIN 15/2208, Letter from Adair Hore, Ministry of Pensions, to G. K. A. Grey, Treasury Chambers, 7 March, 1941; TNA PIN 15/2314, 1235: Cases of Shock, undated.

As Hore admitted, to have formally amended the legislation would have been politically 'dangerous', and would risk a rush of claims for neurosis, which the government were 'anxious to exclude.'[100] Instead, the government issued a memo to all members of the medical profession, including the directors of all mental hospitals and psychiatric outpatient clinics, in which it conceded that 'emotional shock' could be counted as physical injury, even when there was no visible, physical wound.[101]

The restrictions on compensation remained harsh, however. Those diagnosed as suffering from emotional shock would be able to claim compensation under the legislation only when the shock was considered to have originated from 'direct exposure to bomb explosion or blast in which the resulting incapacity for work starts from the time of the incident.'[102] If symptoms persisted for more than three weeks, the civilian would have to be admitted to a neurosis centre in an EMS hospital and be subject to psychiatric investigation, treatment and rehabilitation or lose their rights to compensation.[103] Medical Superintendents were instructed that patients must stay in hospital until they proved themselves capable of the work they had carried out before what the Ministry of Pensions sceptically described as 'the alleged trauma.'[104] Moreover, the government remained adamant that civilians diagnosed with most symptoms of neurosis were to still be excluded from claiming

[100] TNA PIN 15/2208, Letter from Adair Hore, Ministry of Pensions, to G. K. A. Grey, Treasury Chambers, 7 March, 1941, p. 6.
[101] TNA PIN 15/2314, Memo to Medical Superintendents, Neurological Centres, 17 April, 1941.
[102] TNA PIN 15/2208, Memorandum 248: War Injuries and War Service Injuries, July, 1941.
[103] TNA PIN 15/2314. '1235: Cases of Shock', undated.
[104] Ibid, Memo to Medical Superintendents, Neurological Centres, 17 April, 1941.

war injury allowances.[105] As a Ministry of Pensions circular stated, there would be no allowances in cases 'in which the symptoms are induced merely by apprehension and fears occasioned by enemy activity, and which are variously diagnosed as neurasthenia, anxiety neurosis, hysteria, nervous debility, etc.'[106] The types of diagnoses dispensed during the war were thus shaped to some degree by a combination of the demands of compensation legislation and of the political stance of the psychiatric practitioner. The patient's ability to claim compensation depended on how each psychiatrist conceptualised and diagnosed the disorder, and on their decision about whether its development could be attributed to air-raids.

Although the government's main concern over pensions was undoubtedly its desire to minimise the financial encumbrance on the state, the exclusion of neurosis as grounds for compensation was compatible with the view of those psychiatrists who believed that compensation would encourage neurotic conditions to take hold. Hart urged the government not to pay allowances to those with neurosis, despite admitting the difficulties in distinguishing between emotional shock and neurosis. He argued that 'shock' could be defined as a 'directly produced' condition, 'without the intervention of psychological factors'. Thus shock would be temporary, although he suggested that, 'there is a serious risk of it being transmitted into a psychoneurosis under the influence of subsequently acting psychological factors.' For Hart, the difference between shock and neurosis ultimately came down to what he called 'the purposive factor', the idea that the

[105] TNA PIN 15/2208, Letter from Adair Hore, Ministry of Pensions, to G. K. A. Grey, Treasury Chambers, 7 March, 1941, p. 7.
[106] TNA PIN 15/2314, 1235: Cases of Shock, undated.

neurotic unconsciously seeks to gain from his condition. The purposive factor, he argued, 'acts as a drive to secure, by means of the neurosis, either protection from feared danger, or economic security by monetary compensation, or both together.'[107] In other words, by granting compensation the state would encourage individuals to succumb to neurosis by protecting and rewarding them for the disorder. Embedded in this view was the assumption that psychological illnesses were a form of conscious or unconscious malingering.

Perhaps most pertinently for this thesis, Hart warned the government that offering financial compensation would lead to a significant increase in the wider incidence of neurosis. 'This latter effect is of fundamental importance to the Government in wartime', he argued, because 'purposive' and 'suggestive' factors made neurosis 'one of the most infectious of all diseases.' According to Hart, if the government offered financial compensation, there would be a greater likelihood of a wave of psychiatric casualties. The decision to deny allowances to those diagnosed with neurosis could thus be justified in medical rather than financial terms. The denial of compensation may 'appear superficially to be ruthless and unfair to the individual patients,' claimed Hart, but it was 'salutary to the patient himself, because they may save him from the miseries of a protracted and crippling illness.'[108]

These discussions between government officials and leading psychiatrists illustrate that decisions about psychiatric diagnosis and the types of treatment

[107] TNA PIN 15/2208, Letter from Dr. Bernard Hart to Dr. E. Prideaux at the Ministry of Pensions, 27 January, 1941.
[108] Ibid.

offered were not just medical questions, but were inextricably bound up with economic and political concerns, most particularly about the financial costs to the state of paying out compensation claims. If there was no evidence that a patient's mental disorder had been directly caused by bombing, such as an accompanying physical injury or, in the later years of the war, expert opinion following sustained psychiatric interrogation, then the civilian's right to compensation would be questioned and/or denied. The government's psychiatric advisors believed that these policies were justified in the interests of the patient's, and by implication the nation's, mental health.

During the course of the war, other leading members of the psychiatric establishment reinforced the government's view that civilians suffering from psychological disorders should not receive any financial compensation. In 1941, Aubrey Lewis wrote to the Ministry of Pensions urging the government not to compensate those patients who did not have a physical injury. Lewis insisted that financial remuneration would only increase the numbers of patients claiming that their neurosis was due to bombing.[109] As noted in Chapter One, Lewis was the Medical Director of the Maudsley Hospital during the war, and became one of the most influential figures in psychiatry, acting as a trusted unofficial psychiatric advisor to the government.[110] He was also the author of a much quoted study that posited that there were few psychiatric casualties due to air-raids. Like Edward Mapother, his predecessor at the Maudsley, Lewis did not adhere strongly to any

[109] TNA PIN 15/2208, Letter from Aubrey Lewis, Mill Hill Emergency Hospital, to Dr. E. Prideaux, Medical Division, Ministry of Pensions, 15 January, 1941.
[110] For Lewis's psychiatric background and ideas, see, Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley', pp. 3-38.

one theoretical strand of psychiatric thought and embodied the eclectic mix of ideas so dominant in British psychiatry.[111]

Although Lewis doubted that it would ever be possible for psychiatrists to decide whether a neurosis was directly caused by the experience of air-raids, he argued that the only cases that should qualify as civilian psychiatric casualties were those 'in which some form of mental illness in a previously healthy person had developed promptly under a near escape from death or injury by bombing'.[112] Lewis provided the Ministry of Pensions with some illustrative case studies of 37 patients in a mental hospital observation ward in South London, whose relatives had connected the onset of neurosis to the war. Most of these patients had milder forms of neuroses, and had only been admitted to the hospital because the local outpatient clinics were too overcrowded to treat them. Lewis judged that only ten of these 37 patients could possibly be classified as 'civilian casualties' – although none of these ten had officially been reported as war casualties. These cases included a 47 year-old woman, whose house had been bombed just two weeks after her husband's death from natural causes and a young woman of 18 whose family were all poisoned with carbon monoxide, and her father killed outright, when their shelter was hit by a bomb.

Perhaps even more illuminating were the 12 cases in which Lewis considered it was 'doubtful' that air-raids were the cause of the neurosis. These

[111] Aubrey Lewis, 'Incidence of Neurosis Under War Conditions', *The Lancet*, 2, (15 August, 1942), pp. 175-183; Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley', p. 32-34; See also Caspar, 'The Origins of the Anglo-American Research Alliance', pp. 327-346.
[112] TNA PIN 15/2208, Letter from Aubrey Lewis, Mill Hill Emergency Hospital, to Dr. E. Prideaux, Medical Division, Ministry of Pensions, Dated 15 January, 1941. Emphasis in original.

included that of a man aged 34 whose friend was killed alongside him when he was blown off a fire engine. 'Bombs had fallen near them, but there were other factors which seemed more important,' Lewis contended. This particular case was 'doubtful' because he went on to develop schizophrenia, a more serious psychotic disorder. The 'doubtful' cases also included three elderly patients who had been diagnosed with senile dementia. For Lewis, the senile dementia these patients suffered from outweighed the effects of traumas incurred by the war. Nevertheless, he described how these elderly patients 'had been able to manage quite well in the homes of their relatives until air-raids, black-out, etc., upset them so that they became acutely disturbed and had to be sent away.' In other words, the prior senility disqualified these patients from being considered psychiatric war casualties, even though their condition had worsened due to the war. As Lewis admitted, 'Sometimes it was the actual bombing of their home which precipitated their acute illness and institutionalisation.' He also highlighted that in these cases the patients' relatives had been the first to raise the question that the bombing may have been the cause of their loved one's neurosis. Lewis thought that relatives would raise this issue far more frequently if a claim for compensation was possible, 'and that they would then wittingly or unwittingly stress details of bombing which they now make little of.'[113]

Two themes emerge in Lewis's account which, as will be shown in the second section of this thesis, would be important when psychiatrists decided whether the mental illnesses they encountered in practice were caused by the war.

[113] Ibid.

Firstly, there remained a persistent view that predisposing factors, whether prior events or illnesses in the patient's life, were more important than air-raids in the development of the neurotic condition. Secondly, psychiatrists often retained a scepticism as to the veracity of the accounts given by patients, and their families, when they blamed the war for the onset of nervous disorders.

Psychiatric dissent

Government policy reflected and reiterated mainstream psychiatric thought, articulated by Lewis, which posited that more protracted cases of neurosis would only develop in those civilians who were predisposed by 'abnormal' factors in their medical and social history. There seemed to be a synergy between government concerns to limit costs for psychiatric treatment and pension payments, and mainstream psychiatric thinking on the causes, development and treatment of neurosis. It would be wrong, however, to conceive of the relationship between government policy and mainstream psychiatric thinking as a conspiratorial one. There were tensions as well as synergies between the government's policy and the clinical and theoretical views of some psychiatrists. Psychiatric opinion was not a homogenous bloc in this period, and not all psychiatric practitioners simply repeated and reiterated government instructions and assumptions about the aetiology and treatment of the nervous and emotional disorders they encountered. As highlighted in Chapter Two, psycho-biological theories, which sought to overcome mind/body dualism and posit a more dialectical relationship between somatic and mental factors in the aetiology and manifestation of nervous disorders,

had gained credence in the psychiatric profession during the 1930s.[114] In addition, psychoanalytical concepts were also being incorporated into a wide range of psychiatric theorisations and diagnoses, even by those psychiatrists who emphasised a 'functional' rather than analytical approach to treating wartime mental disorders.[115]

Moreover, a handful of psychiatrists explicitly questioned some of the assumptions embedded in the government's directives to medics. This questioning, as will be explored in Chapter Six, was usually related to practitioners' direct experiences of treating patients in the aftermath of bombing-raids. George Pegge, in a study of patients at an EMS hospital in London at the start of the Blitz, noticed that the nervous disorders of the patients he tended in the aftermath of the raids were noticeably different to those in the 'phony war' period. In the early weeks of the war 'fear of unknown terrors' had been the precipitating factor in civilian's war neuroses. After the start of the Blitz, Pegge saw patients who had been knocked down by blasts or trapped in houses that were demolished by high explosive bombs. Pegge challenged the accuracy of accounts that considered most wartime neuroses to be the result of pre-war mental illnesses or an innate abnormality in the patient's psychical make-up. His clinical cases, he asserted, revealed how 'superficial' it was to fail to attribute patients' current nervous problems to the war merely on the basis that they had previously experienced a mental illness or shown signs of stress. As well as asking whether a patient had previously suffered from a nervous disorder, Pegge insisted that psychiatrists needed to ask, 'would the

[114] See the discussion on the development psycho-biological theories in Chapter Two of this thesis.
[115] Shapira, *The War Inside*, p. 35.

patient be in his present condition if it were not for the air-raids?' The answer, he concluded, was invariably 'No'. 'A few cases are seen in which no traces of predisposition can be found, but it is ridiculous to regard these as the only true psychiatric casualties of the air-raids,' he wrote.[116]

Felix Brown, a psychiatrist based at Guy's Hospital in London, disputed that the government's instructions to send patients home as quickly as possible was always the most appropriate course of action for those suffering from emotional shock. Brown maintained that admission to hospital was not always the 'worst thing that could happen' to patients, and rather than resulting in their nervous condition being prolonged it could provide patients with the rest and treatment they needed to recover. Many of those suffering from severe emotional shock needed more than reassurance and bromide, Brown asserted, and to discharge them to public shelters was 'cruel' and 'demoralising to others in the shelter.' Moreover, according to Brown, the official advice to cure hysterical patients, by telling them their symptoms were not real, was 'misleading'. 'It might be interpreted to mean that a terrified, tremulous and tottering patient, who has narrowly escaped death by bombing should be marched up and down to show him that his legs still work still, then told to relax, pull himself together and go home,' he contended.[117]

Some psychoanalysts also expressed unease about the government's exhortations to treat patients swiftly and to rush them home. Bion, for example,

[116] George Pegge, 'Psychiatric Casualties in London, September, 1940', *British Medical Journal*, 2, (26 October, 1940), pp. 553-556, p. 553.
[117] Brown, 'Civilian Psychiatric Air-Raid Casualties', p. 687.

feared that patients returned home risked acting as 'carriers', who would spread anxiety, although he believed that the 'real danger lies not so much in returning a patient home, but in doing that and nothing further.'[118] Analytically-orientated psychiatrist Maurice Wright also worried that patients would have no one to help them after they were discharged home. 'They would return to homes possibly in a bombed area to a family which, even if still intact, would probably be badly shaken,' he wrote.[119] Even those suffering from minor neuroses would need 'all the resources not only of a psychiatric hospital, but later of social workers and every kind of social organisation to rehabilitate these patients and make them feel the need in themselves for life in a community.'[120]

There was also a lack of clarity about exactly what the government and their psychiatric advisors meant when they described patients as being 'predisposed' to nervous disorders. Did they mean a previously diagnosed mental illness or were they referring to the heredity or physical or psychical constitution of the patient? The answer, to some extent, varied according to the theoretical orientation of the psychiatrist, and whether they emphasised physical, psychical or hereditary factors in the aetiology of psychological disorders. Some psychiatrists, for example, seemed to refer to predisposition as meaning an all-encompassing 'abnormal' state of the whole person, including their social and family background and the formation of their personality, rather than a specific physical or psychical flaw.[121] As psychiatrist

[118] Bion, 'The "War of Nerves"', p. 192.
[119] Maurice B. Wright, 'Treatment of Psychological Casualties During War', *British Medical Journal*, 2, (16 September, 1939), p. 615.
[120] Ibid, p. 617.
[121] For a discussion of the development of the idea of an 'abnormal' person as opposed to an abnormal condition, see Foucault, *Abnormal*, p. 312.

Irving Janis wrote in his post-war assessment of the psychiatric cost of the war, the term predisposition was often used in 'an extremely loose and vague fashion' and sometimes as a 'pseudo-explanation or as a mere label for unknown causes of mental disorder.'[122] This flexibility in the meaning of predisposition also allowed psychiatrists to interpret the concept in ways that suited their own medical and political inclinations. For those who were critical of the government's directives to clinicians, the notion of predisposition could be denied or qualified in the particular cases they treated. But for those supportive of the government, the concept of predisposition could be applied extensively as 'proof' that the war was not causing mental disorders.

Psychiatrists also frequently admitted they found it almost impossible to isolate a primary cause of neurosis. Psychiatric diagnosis remained, as the authors of one wartime report highlighted, ill-defined, disputed and complex, with no diagnosis being attributed to one, singular cause.[123] There was also no agreement on which mental symptoms could be attributed to the effects of air-raids or to the wider, longer-term conditions of the war. Lewis himself admitted in his 1942 survey of the psychological effects of war on civilians that it, 'is not easy to decide whether a mental disturbance – neurotic or otherwise – is directly attributable to war conditions, and particularly to air-raids.'[124] These disputes about the aetiology and symptomology of wartime neuroses were in part a continuation of the diagnostic debates of the 1930s. They also invoked new questions as psychiatrists attempted

[122] Janis, *Air War and Emotional Stress*, p. 79.
[123] W. S. Maclay and E. Guttmann, 'The War as an Aetiological Factor in Psychiatric Conditions', *British Medical Journal*, 2, (21 September, 1940), p. 381.
[124] Lewis, 'Incidence of Neurosis Under War Conditions', p. 175.

to understand in practice the nervous symptoms that arose during a war that, unlike previous conflicts, involved the mass bombardment and displacement of the civilian population.

Conclusion

This chapter has examined official mental health policy at the start and during the course of the war, and the ways in which that policy was formulated through discussions between government officials and leading psychiatrists. Expert advisors were carefully selected to provide advice about psychiatric provision, treatment and pensions. The government attempted to create an emergency psychiatric service by coordinating existing institutions and resources, always mindful of limiting the financial encumbrance that would be put on the state. As this chapter has illustrated, the government's economic and social priorities to limit costs and to regulate civilian behaviour influenced and shaped not only the facilities that would be made available for civilians but also the way mental disorders would be judged, diagnosed and managed. The discussions between government officials examined in the chapter have highlighted that psychiatric provision and treatment cannot be understood as purely medical issues, but are also constituted and shaped by political and economic interests, which become particularly acute at a time of war.

The government chose to dismiss offers from various groups of psychiatrists and psychoanalysts for comprehensive psychiatric care at the start of the war, in favour of its own schemes to use existing resources and to encourage psychiatrists to keep civilians away from institutional care. Indeed, the chapter has shown how

the government made a concerted effort, through both private discussions with psychiatrists and its repeated directives to the medical profession, to ensure that mental hospitals were viewed as a last resort for psychiatric treatment.

By enabling and limiting the use of particular institutions and services, government policy determined to a great extent the take up and demand for psychiatric treatment during the war.[125] This helped to create and sustain the narrative of the war as one with few psychiatric casualties. In its discussions with psychiatrists about pensions, the government also imposed a strict definition of what constituted a psychiatric casualty. The development of ideas about minor neuroses, discussed in Chapter Two, were important here because they enabled 'emotional shock' and minor neurotic reactions to the war to be conceived as temporary mental states, which could be treated without recourse to mental hospitals or even to psychiatric clinics. Decisions were often made, however, on the basis of expediency rather than on a fixed ideological position or preference for one psychiatric theory above another.[126] The government utilised psychiatric opinion insofar as it suited its purposes, based on an assessment of what facilities and resources could be made available.

Lastly, this chapter has shown how government policy was a contested domain between different interests and ideologies among policy-makers, and between the government and various strands of psychiatric opinion. As well as

[125] Marijke Gijswijt-Hofstra and Harry Oosterhuis, 'Introduction: Comparing National Cultures of Psychiatry' in Gijswijt-Hofstra, Oosterhuis, Vijselaar and Freeman (eds.), *Psychiatric Cultures Compared*, p. 15.
[126] Butler, *Mental Health, Social Policy and the Law*, p. 106.

synergies between governmental and psychiatric thought, there were also tensions. Some psychiatrists expressed doubts about aspects of the government's directives about how to classify and treat the psychiatric disorders of civilians during the war. Official policy and discourse thus cannot be taken at face value or as statements of how psychiatry was understood and practised during the war itself. In the second section of the thesis, I look beyond the official view of the war to investigate psychiatric practice at some of the main sites of treatment for mental disorders during the war, beginning with an examination of the conditions and experiences of long-term mental patients who were crowded into civilian mental hospitals.

Part Two: Wartime Sites of Practice

Chapter Four: Life inside wartime mental hospitals

> The very remoteness of the places, with their high walls, bleak premises with their locked doors, makes it absolutely clear to those people who are sufficiently rational to think that those who enter may never return and the very thing we are trying to effect is defeated.
>
> John Lewis, Labour MP for Bolton, House of Commons, 6 November, 1945[1]

John Lewis's description of the state of mental hospitals at the end of the war encapsulates a grim picture of neglected and isolated institutions, cut off from the rest of society and housing a hidden and unwanted population. This portrayal of the bleakness of mental hospitals would become more familiar in the 1950s and 1960s, as mental hospitals became the subject of critical analyses of institutional life, fuelling the development of what later became known as anti-psychiatry.[2] Yet very little is known about what life was like in mental hospitals in the wartime years preceding Lewis's description. Historical accounts of mental hospitals during the war have largely been limited to the wartime sections in studies of individual institutions covering a much longer time period, or sections of more general histories of psychiatry and mental health policy.[3]

This chapter provides an overview of conditions inside mental hospitals in England and Wales during the war. It explores the ways in which the war changed

[1] Hansard, House of Commons Debates, Tuesday 6 November, 1945, Volume 415, Columns 1188-1204.
[2] The most famous being Erving Goffman's sociological study of a mental hospital in the United States in the 1950s. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Harmondsworth: Penguin, 1961).
[3] See, for example, Cherry, *Mental Health Care in Modern England*); Gittins, *Madness in its Place*; Pearce, 'Evacuation and Deprivation'. For general histories see, Jones, *Mental Health and Social Policy*; Murphy, *After the Asylums*.

the lives of patients, and the types of care and treatment which they received.[4] I have drawn on Board of Control reports for ten mental hospitals, supplemented by the minutes of national Board of Control meetings, and published and unpublished psychiatric case studies.[5] These reports were kept much less comprehensively during the war than in peacetime years, and were written with an implicit political agenda. Indeed, inspectors were sometimes explicit about their desire to bolster the war effort and in their attempt to give a favourable impression of hospital conditions.[6] The reports also give an official view of conditions in mental hospitals, rather than a first-hand account of what it felt like to be a patient detained within them. Nevertheless, a close reading of the reports offers a rare glimpse of what life was like in the hospitals, and in the following account I attempt to 'salvage the fragments' of these records to provide a new understanding of mental hospitals in the Second World War.[7]

I begin the chapter by looking at what happened to patients at the start of the war, when the government cleared large sections of mental hospitals and handed over entire premises or individual wards to the EMS to treat military and civilian casualties with physical injuries. I follow this by exploring what life was like

[4] For the purposes of this chapter, I will be looking mainly at the public County and Borough mental hospitals in England and Wales.
[5] The hospitals are: Bethlem Royal Hospital, Kent; Bristol Mental Hospital, Fishponds site, Bristol; Cheadle Mental Hospital, Cheshire; Exminster Mental Hospital, Devon; Friern Mental Hospital, London; Napsbury Mental Hospital, Hertfordshire; Rubery Hill Mental Hospital, Birmingham; St. George's Hospital, Staffordshire; St. Matthew's Hospital, Staffordshire; West Ham Mental Hospital, London. I have also referred to conditions at other mental hospitals when applicable. It is also worth noting that none of the reports or minutes of meetings of the Board of Control were made public during the war years, including the Board's Annual Reports, which were not published between 1939 and 1945.
[6] Steven Cherry makes this point about the records of St. Andrew's Hospital in Norfolk during the war years. Cherry, *Mental Health Care in Modern England*, p. 208.
[7] This phrase is from Bill Luckin, 'Towards a Social History of Institutionalization', *Social History*, Volume 8, (January, 1983), p. 93.

for patients inside the mental hospitals, looking at the ways in which bombing raids, ARP drills, overcrowding and staff shortages disrupted routines and relationships. I move on to examine how physical treatments, most of them first instituted in the mid-1930s, continued to be relentlessly pursued, despite wartime shortages of staff and other resources. I conclude the chapter by looking at the ways in which the war changed the patient populations of mental hospitals, exploring the contention of historian and psychologist Shulamit Ramon that the war resulted in the 'abnormalisation' of patients diagnosed with psychotic conditions.[8] Here I ask whether the war years signified merely a temporary halt in the move from asylum to community care, or whether developments during the war helped to shape and constitute how psychiatry and mental health provision would develop in the post-war era.

Evacuation

The evacuation of the mental hospitals, and the dispersal of patients and staff, was a huge logistical operation, which involved an immense upheaval in the lives of thousands of patients. As noted in Chapter Three, at the start of the war five mental hospitals were evacuated in their entirety, and all other mental hospitals in England and Wales were required to empty one-quarter of their wards in order to provide room for surgical and other emergency facilities to be used by the EMS or military authorities. This evacuation and dispersal was in most cases carried out with

[8] Ramon, *Psychiatry in Britain*, p. 152.

incredible rapidity, usually within just one or two days.[9] Some articles in the medical journals put a positive, and propagandistic, gloss on the accounts of this mass manoeuvring of patients. In one account of the evacuation of over 2,000 patients from the Horton Mental Hospital in Epsom in Surrey, an editorial writer in the *BMJ* wrote that the episode 'will make an exciting chapter of history'. The patients were evacuated to seven surrounding mental hospitals in the Surrey area 'almost in a day'. There is no mention of the effects of such an upheaval on the physical and mental well-being of the mental patients being moved, or the impact on the patients in the receiving hospitals, except for a brief reference to the need for 'a large degree of adaption'.[10]

Some of the unpublished Board of Control reports from this period, however, noted the hardships patients encountered, as their living conditions were compromised by lack of space. Patients were transferred into already inadequate premises, which were in urgent need of building works, repairs, renovations, and refurbishment, and which were in many cases already severely overcrowded.[11] In its last annual report published before the war, for example, the Board of Control highlighted a shortage of 3,000 beds in mental hospitals in England and Wales, with overcrowding expected to rise for the following three years until new accommodation could be built regardless of whether there was a war.[12]

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[9] Anon, *The Thirty-Second Annual Report of the Board of Control for the Year 1945)*, p. 7.
[10] Anon, 'A Civilian Base Hospital', *British Medical Journal*, 2, (23 September, 1939), pp. 662-663.
[11] See Anon, *The Twenty-Fifth Annual Report of the Board of Control for the year 1938*, pp. 1-2; Anon, 'Mental Health in 1938', *The Lancet*, 2, (5 November, 1938), p. 1074; See also the descriptions of the bad state of repair of the Fishponds site of Bristol Mental Hospital in BRO 35510/HS/1/1/1 '78th Annual Report of the Visiting Committee for the City and County of Bristol', Report by Medical Superintendent, 31 May, 1939.
[12] Anon, *The Twenty-Fifth Annual Report of the Board of Control for the Year 1938,* p. 1.

Barrow Gurney Mental Hospital, on the outskirts of Bristol, was evacuated in its entirety within three days and handed over for military use by the Navy for the duration of the war. Barrow was a new hospital, which had officially opened in May 1939, just a few months before the war. It had been designed to relieve overcrowding at the nearby Fishponds site of Bristol Mental Hospital, and 300 of Fishponds' long-term patients were transferred there just months before the outbreak of war.[13] The new hospital received notice from the Admiralty on 1 September, which ordered staff to complete the total evacuation of the patients by 3 September.[14] Some 375 patients were returned in just two days to the still overcrowded Fishponds site, returning to the 'shabby and insanitary' wards they had vacated just months earlier, and swelling the patient population of the hospital to 1,204.[15]

There was a similar picture at mental hospitals across the country. In the West Riding of Yorkshire, Storthes Hall Mental Hospital was forced to accommodate some 900 extra patients from two mental hospitals in the region.[16] Although one Board of Control Commissioner described the conditions patients faced as 'adequate', he also indicated that the 'worst effects' of the overcrowding of the hospital was 'the lack of day space', and described how 14 verandas were used for bed space, where the glass roofs had been painted black obscuring day light.[17] In

[13] BRO 35510/HS/1/1/1, '78th Annual Report of the Visiting Committee for the City and County of Bristol', June 1939.
[14] BRO M/BCC/MEH/1/14, Meeting of the Visiting Committee of Bristol Mental Hospital held at Fishponds Hospital on 4 September, 1939.
[15] BRO 35510/HS/1/1/1 , '78th Annual Report of the Visiting Committee for the City and County of Bristol', Report by Medical Superintendent, 31 May, 1939; See also BRO Pamphlet/1630, 'Glenside Hospital 1861-1961', p. 60.
[16] TNA MH 51/655, Report on special visit to Storthes Hall Mental Hospital on 21 September, 1939.
[17] Ibid, p. 2.

nearby Menston Mental Hospital, space for 500 civilian war casualties had to be provided without moving out any of the existing mental patients from the hospital. Patients were crammed into existing wards, a previously disused old isolation hospital in the grounds, and 250 patients were forced to sleep in marquees in the grounds, later to be replaced by huts. In the most overcrowded ward, 103 patients were served by 11 members of staff working in shifts, with patients sharing just one bathroom between them. Beds were placed just one-foot apart, even though the official recommendation for the spaces between beds before the war had been a minimum of five feet.[18] The commissioner summed up the effects of the first month of the war as amounting to

> the loss of three wards, an increased admission rate, the loss of the third assistant Medical Officer... the loss of 20 male staff who have not been replaced, and the reduction of food by 25% in quantity.[19]

There is little evidence that substantial numbers of patients were discharged and sent home or to private lodgings at the time of the initial evacuation and dispersal of patients. Before the war, the government had asserted that no mental hospital patients would be sent home. In October 1939, Minister of Health Dr. Walter Elliot, in answer to a concern raised in the House of Commons, announced that the number of patients discharged to their homes from all mental hospitals in

[18] Anon, *The Twenty-Fourth Annual Report of the Board of Control for the Year 1937,* p. 75.
[19] TNA MH 51/655, Report of special visit to Menston Mental Hospital on 27 September, 1939, pp. 1-2. For similar reports of the upheaval and overcrowding created by the evacuation of mental hospital wards, see TNA MH 95/2, Emergency Medical Service, Letter from G.W. Mackay, Commissioner of the Board of Control', 17 September, 1939; TNA MH 95/9, Report of the Commissioners of the Board of Control, Staffordshire Mental Hospital, 13 September, 1940; TNA MH 95/19, Report of the Commissioners of the Board of Control, Rubery Hill Mental Hospital, Birmingham, 13 September, 1939.

England and Wales 'did not exceed' 200 people.[20] Elliot insisted that no patient was discharged to their home unless there had been, 'careful investigation of all relevant circumstances, including his home conditions, as suitable to be cared for and supervised by his relatives at home.'[21] No figures were collated nationally about the number of discharges at the start of the war, but anecdotal evidence suggested that the numbers discharged were greater than Elliot claimed. Some hospitals, such as Napsbury in Hertfordshire, looked for opportunities to board out patients to lodging houses or public assistance institutions in the community in order to relieve overcrowding.[22] At Bristol Mental Hospital, assistant medical superintendent, R. E. Hemphill, maintained that 100 'partially recovered' patients were sent home when patients were decanted from the Barrow Gurney Hospital at the start of the war, and that in the following six months, 'a further 100, or thereabouts, chronic patients were transferred to Stapleton Public Assistance Institution.' The vagueness of Hemphill's caveat phrase, 'or thereabouts,' indicates that this was an estimate rather than precise data. Hemphill also made the point that some of the discharged patients were readmitted into the mental hospital during 1940, although he does not give the numbers.[23] At Devon County Mental Hospital in Exeter, however, inspectors reported that only 'around 12' patients, out

[20] Anon, *Statement Relating to the Emergency Hospital Organisation*, pp. 7-8; Hansard House of Commons Debates, Thursday 12 October, 1939, Volume 352, Columns 490-494.
[21] Ibid.
[22] LMA H50/A/01/67, Napsbury Hospital Sub-Committee Minute Book, Report of the Commissioners of the Board of Control, 26 February, 1940.
[23] R. E. Hemphill, 'The Influence of the war on Mental Disease: a Psychiatric Study', *Journal of Mental Science*, Volume 87, (April, 1941), p. 171.

of a patient population of approximately 1,500, were sent home or into lodgings to make space for some of the additional 320 emergency casualties.[24]

Overall, there was a decline in the numbers of patients discharged in the early years of the war, although the number of discharges would begin to rise in the later years of the war.[25] At its May 1941 monthly conference, the Board of Control suggested that this decline 'was probably due to a reluctance to discharge patients as "improved" under war conditions.'[26] According to an editorial in *The Lancet*:

> In some areas, patients who for social reasons ought to be in a mental hospital are not being accepted, or are being discharged because medical superintendents say quite fairly that they must keep their accommodation for the acuter cases. These less acute patients may be found causing mild difficulty in their homes or in reception areas by behaviour which would not be tolerated in peace-time.[27]

For the majority of patients, the start of the war thus entailed being crowded into full and run-down mental hospitals. Moreover, the movement of patients from one hospital to another, or between different wards of the hospital, was not a one-off upheaval at the start of the war. The shifting of patients would be a constant feature of life throughout the 1939-1945 period, as hospitals or wards were requisitioned by the EMS or the military authorities, or because mental hospital buildings were destroyed or badly damaged due to air-raids.

[24] TNA 95/2, Letter from G. W. Mackay, Commissioner of the Board of Control to Medical Superintendent, Exminster Hospital, Devon, 17 September, 1939.
[25] See the discussion later in this chapter.
[26] TNA MH 100/3, Board of Control Monthly Conference No. 90, Wednesday 28 May, 1941.
[27] Anon, 'The Mental Hospital Picture', *The Lancet*, 2, (1 November, 1941), p. 529.

Very little is known about how these upheavals affected patients' physical and mental well-being. Indeed, wartime mental hospitals have often been analysed as institutions that instituted a barrier between patients and the 'outside world'. Asylums were built and designed to provide a refuge from the world, however grim the conditions and daily routines were for those detained in them. Many were built in the countryside, or on the edges of towns, with their own grounds and outbuildings, often operating as a self-contained community. As historian Diana Gittins has argued, the hospital gate was seen as marking a boundary between 'the outside and inside, seen and unseen, mad and sane.'[28] In her history of Severalls Mental Hospital in Colchester through the twentieth-century, Gittins writes of how within the hospital, patients developed their own sense of community distinct from the outside world and engendering a 'definite feeling of belonging,' albeit marked by the hierarchies of relationships within the hospital and the restrictions of its rules, regulations and routines.[29] Yet, as Gittins acknowledges, the outside world, and its economic, political, and social relationships, was 'always there', permeating life within the hospital boundaries.[30] Between 1939 and 1945, I will suggest below, the war shaped and altered every aspect of life within the hospital gates.

[28] Gittins, *Madness in its Place*, p. 29.
[29] Ibid, pp. 29-30. For a more recent account of how mental hospitals could provide a sense of belonging and friendship see Barbara Taylor's memoir of her stay as a patient at Friern Hospital. Barbara Taylor, *The Last Asylum: A Memoir of Madness in our Times*, (London: Hamish Hamilton, 2014).
[30] Gittins, *Madness in its Place*, p. 220.

Bomb damage

The war intervened most directly and dramatically in the lives and routines of patients and staff through direct hits by air-raids, which killed and injured thousands of patients and staff during the war. Air-raids also destroyed buildings and facilities, disrupted daily life, and added to the difficulties caused by lack of space, beds and resources. Air-raids were particularly catastrophic during the Blitz period between September 1940 and May 1941. The Board of Control reported that 71 bombing attacks took place during these months, causing death and injury to patients and staff and the demolition of hospital facilities – including in Devonshire, Somerset, the Home Counties, the West Riding of Yorkshire, Durham and Northumberland.[31] In April 1941, for example, two land mines were dropped on Napsbury Hospital in Hertfordshire, causing extensive damage. Fortunately, only one patient was killed, although six patients were seriously injured and 28 patients suffered minor injuries. According to a note by the medical superintendent, 'Very extensive damage occurred, four male wards being rendered uninhabitable, store rooms, windows, doors, etc. were torn from the walls and smashed.' The bomb, he wrote, 'robbed us of proper living space for 257 men', and meant that a female sanatorium ward had to be used for the male patients causing overcrowding on the female side of the hospital, which was already over numbers by 126.[32]

In the London area, where bombing raids were particularly severe, 578 beds in mental hospitals were destroyed by raids during the Blitz, and 77 patients and 15

[31] Anon, *The Thirty-Second Annual Report of the Board of Control (for the year 1945)*, p.10.
[32] LMA H50/A/01/67 'Napsbury Hospital Sub-Committee Minute Book', Report by Medical Superintendent, 17 May, 1941.

staff were killed as a direct result.[33] Friern Hospital in North London had five serious air-raid attacks, causing the deaths of 26 patients and four nurses, with widespread injuries sustained by many more patients and staff.[34] Some of the worst attacks on hospitals during the war were suffered by West Ham Mental Hospital, which was located on the route of German planes heading for London. The hospital was hit by 19 explosive bombs, two flying bombs, and one parachute bomb, four rockets, two oil bombs and approximately 700 incendiaries. As one Board of Control report surmised, 'In actual numbers of missiles falling within the estate the hospital has probably suffered more than any other mental hospital.'[35]

Although air-raid damage was particularly severe in the Blitz period, bombings continued throughout the war, becoming once again relentless in 1944 and early 1945, with 45 mental hospitals being hit by flying bomb and rocket attacks, causing death and injuries at nine institutions. One particularly bad attack at St. Bernard's Hospital in West London killed four patients, and caused such extensive damage nearly 2,000 patients had to be removed to other institutions.[36] At Bexley Mental Hospital, 12 patients and one staff member were killed in a raid that 'demolished' one male ward, caused extensive damage to another and partially destroyed the laundry. This attack resulted in the loss of accommodation for 250 patients, many of whom were transferred to Friern Hospital.[37] Just one month later, Friern itself suffered extensive damage when a large number of

[33] Anon, *The L.C.C. Hospitals: a Retrospect*, (London, London County Council, 1949), pp. 62-63.
[34] Anon, *The Thirty-Second Annual Report of the Board of Control (for the year 1945)*, p. 10; LMA H12/CH/A/08/010, Report by the Medical Superintendent, 7 September, 1945.
[35] TNA MH 95/22, Report of the Commissioners of the Board of Control, West Ham Mental Hospital, Goodmayers, 23 October, 1945.
[36] Anon, *The Thirty-Second Annual Report of the Board of Control (for the year 1945)*, p.10.
[37] TNA MH 100/6, Board of Control Monthly Conference No. 105, 8 March, 1944.

incendiary bombs landed on a villa in the hospital grounds which was being prepared for the admission of 60 new patients. The villa was completely burnt-out, and its furniture, equipment, electrical fittings and wiring all destroyed. This villa had just been rebuilt and reconditioned after the original buildings on the site were destroyed by an incendiary bomb in 1940.[38]

Even when no patients or staff were killed or injured, flying bomb attacks had a disruptive effect on patients and staff, and severely limited the bombed hospitals' ability to accommodate existing patients and to take new admissions. The effects of bombing on patients and staff was very seldom referred to in Board of Control reports, or in psychiatric studies of mental hospital patients, except to brandish platitudes about how well people stood up to the bombing. We can thus only speculate on how the emotions induced by the bombing raids affected the mental states of patients. In his autobiography, psychiatrist William Sargant vividly described the bombing of the Sutton Emergency Hospital, in Surrey, which housed a 'neurosis centre' for both military and civilian neurotic casualties. He writes of how,

> We dug patients out unconscious but still alive, after perhaps trampling on their faces in our rescue efforts. We found many others blown to pieces. Sixteen patients were found killed, and many of the survivors had been badly injured. Heroic feats were performed that night by patients who had hitherto seemed hopelessly incapacitated neurotics, and most of whom relapsed as soon as the crisis ended.[39]

[38] Ibid, Letter from W. Allen Daley, Medical Officer of Health, L.C.C., 24 March, 1944.
[39] Sargant, *The Unquiet Mind*, p. 130.

The two wards destroyed in the hospital bombing accommodated civilians who had been sent to the hospitals from bombed-out hospitals in London. 'Many of the older patients,' Sargant writes, 'could not stand the strain of being moved about this way, farther and farther away from homes and families, and their death rate was high even without having been buried once or twice under a heap of debris.' Sargant also describes the nervous effects of the bombing on staff, including himself, many of whom walked the hospital corridors in a state of fear. The wards, he writes, became 'scenes of complete chaos' on air-raid nights, especially when the sound of sirens was first heard.[40]

Other psychiatrists seemed more dismissive of the effects of raids on patients' mental health. R. E. Hemphill at Bristol Mental Hospital speculated that, 'Probably the noise of guns, sirens and aeroplanes seem to belong to a world too far beyond the walls of the hospital to have any real interest.' He admits that some patients did suffer adversely from the threat of air-raids, with even the warning bell for the raids 'greeted by angry shouts from the disturbed slumberers' in the chronic wards of the hospital. The sound of the warning bell was, he estimated, more disturbing to patients than the continuous sound of gunfire in the distance because it was 'an intrusion on institution life' that came from within the hospital. Moreover, Hemphill argued that the way these patients, mostly diagnosed with schizophrenia, chronic mania, chronic melancholia and epilepsy, ignored the distance sounds of war was 'the reaction of chronic psychotics as a whole'. 'Just as their psychosis insulates them from the ordinary importances and responsibilities of

[40] Ibid, p. 133.

daily life,' he claimed, 'so it shuts out and muffles the sound of the guns that come from a world they have left.' According to Hemphill, the sound of guns and bombs had 'no greater reality than the action on the screen of a cinema'.[41]

In many ways, this is an extraordinary judgement on how the war was felt and experienced by patients diagnosed with psychotic disorders. He did not deny that patients expressed disquiet and fear about the war and air-raids, but he viewed these fears through the lens of the patients' diagnoses, rather than as a reasoned response to the sound of sirens or gunfire. According to Hemphill, patients incorporated the sights and sounds of the war into their own psychotic symptoms, and utilised them as 'fresh material' through which they increased the 'range and texture of the delusions.'[42] Hemphill writes, for example, of the reactions to the war of a 50 year-old female patient diagnosed with schizophrenia. The woman was the widow of a soldier, and through her illness regarded the sirens as sounding directly to her to warn her of spies. For this woman, Hemphill writes, 'Gunfire and sirens belonged both to the fantastic and coincidentally to the real world, and stimulated and built up her psychotic life.' Despite giving further examples of how psychotic patients worried about 'neglecting' war duties or mimicked the noise of air-raid sirens, Hemphill contends that psychosis provided a 'protective shield' that 'effectively damps out the realities of war.'[43] Patients' fears are thus explained as part of their already-existing psychotic illness, rather than as a rational response to the events of war.

[41] Hemphill, 'The Influence of the War on Mental Disease', p. 177.
[42] Ibid, pp. 177-178.
[43] Ibid, p. 178.

Hemphill was unusual, however, in describing and analysing the effects of air-raids and sirens on patients within the mental hospital. Although there were some psychiatric reports that analysed the impact of bombing raids on civilians' homes and neighbourhoods, there were very few accounts, either published or unpublished, that described or analysed the effects of the raids on patients inside mental hospitals.[44] In many ways, this reflected the dominant psychiatric view that if a patient was suffering from a mental disorder prior to experiencing bombing, then the raids would not have a major impact on the manifestation and outcome of their illness, particularly if the patient was diagnosed with a psychotic illness. As will be discussed later in this thesis, this led to a tendency for psychiatrists to minimise the effects of the raids on patients' mental health, and can perhaps partly explain why there was such a paucity of studies examining how air-raids altered the ways in which mental disorders were experienced by patients. Yet, as the Board of Control noted in its post-war assessment of 1939-1945, 'enemy action and the disturbance to patients caused by "alerts", undoubtedly produced abnormal conditions', causing stress to patients far greater and more intense than that experienced by mental patients in the First World War. This was due not only to the 'mental and physical strain' of the air-raids, but also because of the much more unfavourable conditions in the wartime hospitals, caused by overcrowding, black-out regulations, poor ventilation and acute shortages of male and female staff.[45]

[44] See Chapters Five and Six for an account of the psychiatric effects of air-raids on civilians outside of mental hospitals.
[45] Anon, *The Thirty-Second Annual Report of the Board of Control for the Year 1945*, p. 18.

Overcrowding

Although there were references in wartime psychiatric reports and surveys to overcrowding and other wartime privations, there were very few references as to how these conditions affected the mental and physical health of patients. Yet overcrowded conditions had a profound impact on the quality of patients' daily lives, and on their physical and mental health. Before the war, the Board of Control claimed that expected overcrowding would only affect dormitories and sleeping spaces. 'There will be no undue interference with the ordinary day time amenities of the patients (dining rooms, recreation rooms, etc.,' and 'no real hardship to the patients,' declared a Ministry of Health statement in June 1939, prepared in response to concerns about overcrowding raised in the House of Lords.[46]

In many hospitals, however, the reconfiguration of space demanded by the influx of extra patients affected all areas of hospital life, with patients having to sleep in areas usually reserved for daytime activities, and compromising the spaces available for eating, work and recreation.[47] In the early years of the war, some patients were forced to sleep on mattresses on the floor, which were then folded up and stored so that the spaces could be reconverted for daytime use.[48] At Staffordshire Mental Hospital, the single rooms were turned into doubles, and doors were kept open at night denying patients privacy, with another 141 patients forced to sleep on mattresses placed on the floor of the dayrooms. Patients were

[46] TNA CAB 102/716, Note on Lord Addison's Statement Regarding the Crowding of Mental Hospitals', 22 June, 1939.
[47] TNA MH 100/3, Board of Control Monthly Conference No. 88, Wednesday 5 February, 1941.
[48] See, for example, TNA MH 95/19, Report of the Commissioners of the Board of Control, Rubery Hill Mental Hospital, Birmingham, 8 May, 1941.

frequently supplied with unclean bed linen that had already been slept on by other patients, noted one Board of Control report.[49] A later report suggested that severe overcrowding inside the hospital could have been the cause of physical injuries to patients. The inspectors speculated that the unusually high level of fractures of the arms and other limbs occurring among female patients may have been due to the overcrowding of the female day rooms, although they do not state exactly how these injuries might have occurred.[50] Indeed, the ways in which wartime conditions compromised safety was frequently referred to by Board of Control inspectors. At West Ham Mental Hospital, for example, an inspector wrote of the 'cumulative effect' on patients of overcrowding which had lasted for years, with wards packed so tightly that 'beds were too close together for safety.'[51]

Moreover, patients were living in places which sociologist Erving Goffman would later characterise as 'total institutions', whereby every aspect of patients' lives – sleeping, washing, eating, working, relaxing and socialising – was conducted within communal spaces, under a regime imposed and enforced by hierarchical layers of staff.[52] Individual identity was thus already severely compromised in mental hospitals, with personal possessions routinely removed from patients, and communal clothes and bedding often handed out indiscriminately. Although the notion of 'privacy' would have had different meanings for patients, depending on

[49] TNA MH 95/9, Report of Commissioners of the Board of Control, Staffordshire Mental Hospital, 13 September, 1940.
[50] TNA MH 95/11, Report of the Commissioners of the Board of Control, Staffordshire County Mental Hospital, Burntwood, 6 November, 1942.
[51] TNA MH 95/22, Report of the Commissioners of the Board of Control, West Ham Mental Hospital, Goodmayes, 22 April, 1943.
[52] Goffman wrote of how patient's agency in mental hospitals was 'contaminated' by forced interpersonal contact and social relations with others. Goffman, *Asylums*, p. 35.

their home lives and experiences of institutional life prior to the war, the deterioration of conditions inside the hospital during the war years made it even harder for patients to be able to assert their individual needs. The Board of Control recognised this in its post-war assessment of mental hospitals stating that

> When beds are too near to each other and contact between patients during the day is too close, the patient seems to become part of a mass rather than an individual member of a group; physical and mental discomfort is increased and nursing and medical treatment loses much of its value.[53]

Many inspectors' reports tended to downplay the effects of overcrowding on patients' well-being and autonomy, however. Indeed, in the early years of the war, the Board of Control tried to discourage reports that mentioned overcrowding in 'alarmist terms', and urged inspectors to 'exercise care' with reference to overcrowding when they entered their reports. The Board was worried that the visiting committees of mental hospitals, made up of notable public figures and dignitaries who oversaw the running of hospitals, might take offence, and that negative reports would have an adverse effect on morale. There was 'nothing to be gained by pessimistic comment on a condition of affairs which the war makes inevitable,' recorded a note from the minutes of a Board meeting in February 1941.[54] Inspectors' reports subsequently became so anodyne, however, that the Board later criticised inspectors for making notes that were 'a mere catalogue of unimportant items', and feared that such accounts would in future be viewed as

[53] Anon, *The Thirty-Second Annual Report of the Board of Control (for the year 1945)*, p. 13.
[54] TNA MH 100/3, Board of Control Monthly Conference No. 88, Wednesday 5 February, 1941.

being dismissive of the effects of overcrowding.[55] 'Praise should be given for minimising the evil consequences of overcrowding', the committee's minutes from December 1942 recorded, 'but care should be taken that in years to come references in entries should not be quoted as justifying overcrowding in different circumstances.'[56]

Despite the bland tone in which they were often written, it is possible to surmise from the reports that severe shortages of space, clothing, fuel and food had a detrimental effect on patients' health. The requirements of the blackout, for example, transformed the atmosphere in the hospitals. Dormitories, day rooms and corridors were described as being very dim and gloomy, with windows painted black or covered over with boards and cloth, and sealed up with tape. Blackout conditions also created a severe lack of ventilation, creating a stultifying atmosphere. At St. George's Mental Hospital in Staffordshire, for example, one inspector described how windows were sealed up with, 'blinds of thick brown paper', and worried that corridors and staircases had such 'inadequate' light that there was an increasing risk to the safety of patients.[57] Conditions at this mental hospital had barely improved by the later years of the war, when inspectors reported on 'shortages of staff, black-out and ventilation problems, overcrowding and increasing shortages of supplies of all kinds.' These difficulties were 'enhanced'

[55] TNA MH 100/4, Board of Control Monthly Conference No. 97, Wednesday 7 October, 1942.
[56] Ibid, Board of Control Monthly Conference No. 98, Wednesday 2 December, 1942.
[57] TNA MH 95/9, Report of Commissioners of the Board of Control, Staffordshire Mental Hospital, 2 December, 1939.

by ‘out of date buildings’ and an ‘insufficient heating system’, according to the report.[58]

It is important to note that these wartime conditions did not just entail slight discomforts. They also seriously affected patients’ physical health. As had been the case in the First World War, there was an increase in the incidence of major diseases and the spread of serious infections, such as tuberculosis (TB) and dysentery. There was a rise in the death rate from just over seven per cent in 1939 to over nine per cent in 1941.[59] The death rate from TB, for example, rose dramatically in the first three years of the war, from a pre-war figure of 3.77 deaths per every thousand patients resident in mental hospitals to a figure of 9.01 per thousand in 1942.[60] Deaths from TB in mental hospitals were at a much higher rate than in the general civilian population, although they did not reach the astronomical levels that occurred during the First World War.[61] The chairman of the Board of Control, Laurence Brock, maintained the high death rate from TB was in part due to the poor physique and lower of resistance to infection that put young male patients, in particular, at risk from infection. He also acknowledged, however, that the primary cause of the high death rate was overcrowding, combined with poor ventilation, and the ‘lowered standard of nursing’ because of severe staff

[58] Ibid, Report of Commissioners of the Board of Control, Staffordshire Mental Hospital, 10 February, 1944.
[59] Salusbury MacNalty (ed.), *The Civilian Health and Medical Services*, p. 185; TNA MH 100/3, ‘Board’s Annual Report for 1940’, Board of Control Monthly Conference No. 93, Wednesday 3 December, 1941.
[60] Salusbury MacNalty (ed.), *The Civilian Health and Medical Services*, p.186.
[61] TNA FD 1/4563, Tuberculosis in Mental Hospitals, July 1943; TNA MH 100/4, Board of Control Monthly Conference No. 96, Wednesday 1 July, 1942.

shortages.[62] High levels of dysentery were 'almost entirely attributable to overcrowding', he argued, which made it impossible to isolate patients to prevent the spread of the disease. The spread of dysentery was also exacerbated by the numbers of patients transferred between institutions, exposing patients to new strains of the disease.[63]

Poor physical health was also connected to the lack of a nutritious diet in hospitals, caused by rationing and a lack of fresh fruit and vegetables in those hospitals without adequate grounds, and the consequent weight loss among patients.[64] The Board of Control carried out a study in 17 mental hospitals using hospital records to monitor weight loss between 1937 and 1941. The results showed that weight loss had accelerated during the war years, and had been especially rapid among female patients.[65] The full extent of weight loss, and whether there was an increase in more minor physical ailments, was not documented during the war on a national level, however, and evidence remains largely anecdotal.[66]

These physical hardships were exacerbated by severe shortages of psychiatrists, nurses and domestic staff, which affected all mental hospitals during

[62] TNA FD 1/4563, Memorandum from Sir Laurence Brock, Board of Control, to the Ministry of Health, 21 February, 1942; TNA MH 100/4, Board of Control Monthly Conference No. 94, Wednesday 4 February, 1942; For a detailed study of tuberculosis in Bristol Mental Hospital see Donal F. Early. 'Preliminary Tuberculosis Survey in a Mental Hospital', *Journal of Mental Science*, Volume 92, (January, 1946), pp. 96-109.
[63] TNA MH 100/3, 'Board's Annual Report for 1940', Board of Control Monthly Conference No. 93, Wednesday 3 December, 1941; Salusbury MacNalty, *The Civilian Health and Medical Services*, p.186.
[64] TNA MH 100/4, Board of Control Monthly Conference No. 94, Wednesday 4 February, 1942.
[65] TNA MH 51/242, Board of Control, Circular No. 921, 27 October, 1942.
[66] See, for example, the account of concerns about hygiene and minor physical ailments during the war in David H. Clark, *The Story of a Mental Hospital: Fulbourn, 1858-1983,* (London: Free Association Books, 1996).

the war, and became particularly acute towards the end of the war. In total, 198 psychiatrists were released from public mental hospitals to in order to serve in the Armed Forces during the course of the war, the majority having been recruited into military service by the end of 1942.[67] This had a huge effect on the kind of psychiatric attention that could be offered to patients. After an order for the release of 100 doctors in 1942, for example, the number of psychiatrists working in mental hospitals was reduced to a ratio of approximately one doctor for every 400 patients.[68] Shortages of mental hospital nurses were so severe that in 1941 the government issued an order, often called the 'standstill order', forbidding mental nurses with more than one year's service to leave their jobs without the consent of their employing body or the Chairman of the Board of Control.[69] This shortage, particularly of female nurses, would worsen throughout the war. As the Board of Control reported in 1945, 'In all but a few mental hospitals there was an increasing shortage of nurses – particularly of female nurses, and in some areas the shortage amounted to one-third of the normal staff.'[70]

Staff shortages, combined with lack of space and resources, often meant that the day-to-day life of patients was characterised by inactivity, except for the interruptions of air-raids in blitzed areas or the drills and preparations necessitated by ARP preparations. Work duties, entertainments and leisure activities were curtailed or run down due to lack of facilities, materials and staff. At the Staffordshire County Mental Hospital, for example, a Board of Control inspector

[67] Anon, *The Thirty-Second Annual Report of the Board of Control (for the year 1945)*, p. 9.
[68] Salusbury MacNalty, *Civilian Health and Medical Services*, p. 187.
[69] TNA MH 51/242, Board of Control, Circular No. 899, September, 1941.
[70] Anon, *The Thirty-Second Annual Report of the Board of Control (for the year 1945)*, p. 9.

lamented that the recreational and dining halls had been appropriated by the EMS to accommodate 75 beds for civilian casualties, but still lay empty at the time of the report in November 1939. For the patients, recorded the inspector, this meant 'the complete dislocation of normal hospital routine as far as recreational and entertainments are concerned.' The report described how

> The men and women in the greatly overcrowded wards are now compelled to use their day rooms for the purposes of all meals, no indoor physical training or dancing classes can be held; and the weekly cinematograph show which means so much to the average mental patient has been stopped. In addition the regular winter dances and concerts which serve to introduce some variety into institutional life cannot now, of course, take place.[71]

In this case, limited recreational activities were reinstated the following year. Patients were still forced, however, to eat their meals on the wards, aggravating the 'ill-effects of overcrowding'.[72] The cessation of concerts, film shows, dances and other entertainments, which had often broken the boredom of patients' everyday routines, had a particularly detrimental effect on patients' mental well-being.[73]

The provision of occupational therapy, which was considered a priority in the treatment of patients in mental hospitals by the Board of Control in 1940, was either abandoned altogether or reduced to the carrying out of repetitive jobs for the war effort.[74] Craft and sewing sessions, for example, often had to take place in

[71] TNA MH 95/11, Report of the Commissioners of the Board of Control, Staffordshire County Mental Hospital, Burntwood, 8 November, 1939.
[72] Ibid, 11 September, 1940.
[73] This point is made by Senior Board of Control Commissioner, Hubert Bond, in TNA MH 95/31, Report of the Commissioners of the Board of Control, Bethlem Royal Hospital, 7 December, 1944.
[74] Ibid, 4 November, 1940; LMA H50/A/01/67, Napsbury Hospital Sub-Committee Minute Book, Report of the Commissioners of the Board of Control, 26 February, 1940.

the dormitories, where patients sat on their own, rather than in the more communal and sociable setting of the day rooms.[75] The therapeutic value of these 'occupations' was also seen as questionable by inspectors – with patients given gardening (male patients) or knitting and sewing (female patients) to do, often for the war effort. While recognising that these tasks may have offered patients a sense of purpose, the Board of Control admitted that such tasks could 'hardly be regarded as occupation therapy'. It highlighted how

> occupations were not selected because of their special suitability to the patients, and in many cases they called for so little thought and attention as to leave the patients free to brood over their real or imaginary troubles.[76]

Patients' experience of life in wartime mental hospitals was not a homogenous and uniform one, but greatly varied as to local circumstances and in accordance to the ebbs and flows in the course of six years of war. Experiences at London mental hospitals, such as Friern or West Ham, not only differed from those in more rural areas, but were also more intense and chaotic during the intense raids of the Blitz period in 1940-41 than in relatively calm years. How patients coped with wartime conditions were also highly personalised, related to the way an individual experienced their mental disorder and symptoms, their relationship with other patients, how long they had been in a particular hospital or ward, whether they were a certified or voluntary patient, and the extent of the involvement of relatives

[75] Anon, *Suggestions and Instructions for the Arrangement, Planning and Construction of Mental Hospitals*, (London: HMSO, 1940); BRO Pamphlet/1630 J. L. Davis, 'Glenside Hospital 1861 – 1961', p. 61; BRO M/BCC/MEH/1/13 'Minutes of the Mental Hospital Visiting Committee and Sub-Committees,', 5 January, 1941.
[76] Salusbury MacNalty (ed.), *The Civilian Health and Medical Services*, p.190.

and loved ones in their care. The attitudes of staff, and the relationships they developed with patients, were also important factors in shaping how individuals were able to cope with the fears and feelings induced by bombing raids and with the privations caused by overcrowding and shortages. The stance taken towards the causes and treatment of mental disorders by the medical superintendent in charge of the hospital was also crucial in determining the priorities of the institution and its staff, the atmosphere within the hospital and the attitudes taken towards patients. This was especially the case when it came to determining which therapies and treatments were prioritised in the context of wartime conditions.

Treatment: control or cure?

When war broke out, British mental hospitals were run by medical superintendents who were overwhelmingly committed to somatic theories of mental disorder, as has been highlighted in Chapter Two. From the mid-1930s, there was a wave of experimentation in British mental hospitals into new physical treatments.[77] Physical treatments were not new, but prior to this period they had been very crude, and in the early 1930s had still included the use of cold baths, laxatives and palliative drugs, such as barbiturates, bromides and frequent use of the drug paraldehyde.[78] The new somatic treatments offered not only palliative treatment or sedation to control the behaviour of patient, but also the hope that a 'cure' would

[77] Busfield, 'Mental Health Policy: Making Gender and Ethnicity Visible', p. 60; Busfield, *Managing Madness*, p. 330.
[78] Rogers and Pilgrim, *Mental Health Policy in Britain*, p. 63; Joanna Moncrieff, 'An Investigation into the Precedents of Modern Drug Treatment in Psychiatry', *History of Psychiatry*, Volume 10, (1999), pp. 481-482, p. 483.

be found for mental disorders, including for serious psychotic disorders such as schizophrenia.[79] These treatments included insulin coma therapy and 'shock therapy' of chemically induced convulsions, via injections of the drugs cardiazol and triazol, electrically-induced shocks commonly known as Electro-Convulsive Therapy (ECT) from 1939, and from 1940, the most extreme physical intervention of all – prefrontal leucotomies, which involved surgically removing parts of the patient's brain. It was in this period, as sociologist Lindsay Prior has observed, that the mental hospital came to be regarded 'as a place where therapy could be legitimately imposed on patients "for their own good".'[80] By the outbreak of war, insulin coma treatment and cardiazol therapy were already used widely in British mental hospitals. A pre-war survey by the Board of Control, carried out at the end of 1938 and published in 1939, found that insulin and/or cardiazol treatment had been carried out at 92 mental hospitals in England and Wales, involving 3,531 patients. Some 19 people had died directly as a result of receiving such treatment. Overall, the outcomes of the treatments were mixed, with one-third of those who were released from hospital after treatment having to be readmitted, and relief from symptoms occurring in only one-fifth of those who continued to be detained in hospital.[81]

Despite such inconclusive outcomes, the new somatic treatments were developed, extended and, in some cases, relentlessly pursued during the war, even in the context of severe overcrowding, staff shortages and pressure on resources. A

[79] David Healey, 'Some Continuities and Discontinuities in the Pharmacotherapy of Nervous Conditions Before and After Chlorpromazine and Imipramine', *History of Psychiatry*, Volume 11, (2000), p. 404.
[80] Prior, *The Social Organisation of Mental Illness*, p. 31.
[81] TNA MH 51/644, Draft paragraph for Annual Report of Board of Control.

majority of the hospitals examined in this chapter carried out a variety of methods of physical treatment for most of the period of the war – most commonly ECT, followed by Cardiazol convulsion therapy. The exception was Napsbury Hospital in Hertfordshire, which did not use ECT until 1944, and did not carry out insulin coma therapy or perform any lobotomies until after the war in 1947.[82] As Elizabeth Bott noted in her study of Napsbury from 1957-1972, from as early as 1930 the hospital had 'a reputation for being unusually humane and kindly'– although she does not spell out the reasons.[83] At other hospitals, such as Bristol Mental Hospital and Bexley Hospital in Kent, there was extensive use of physical treatments, along with pathological research into physical causes of mental disorder throughout the war.[84]

Some medical superintendents were zealous in their use of physical treatments. The Medical Superintendent at Rubery Hill Hospital in Birmingham, Thomas C. Graves, who was well known for his theory that toxins caused by bacterial infections were the primary cause of mental disorder, relentlessly pursued somatic treatments for the duration of the war.[85] Year after year, Board of Control reports highlighted problems at the hospital caused by overcrowding, poor ventilation, shortages of food and clothing, unclean bed linen and other insanitary conditions. Yet inspectors noted that great attention had been given to the

[82] LMA H50/A/01/67 'Napsbury Hospital Sub-Committee Minute Book', Report of the Commissioners of the Board of Control, 26 February, 1940; Busfield, *Managing Madness*, p. 335.
[83] Elizabeth Bott Spillius, 'Asylum and Society', in Eric Trist and Hugh Murray (eds.), *The Social Engagement of Social Science: A Tavistock Anthology*, (London, Free Association Books, 1990), pp. 587-588.
[84] BRO 40513/C/14/8 'Electrical Treatment Record, 1938-1944'; BRO 40513/C/14/14 'Leucotomy Consent Register'; BRO 35510/HS/1/1/1 'Annual Reports of the Visiting Committee of the Mental Hospital', 85th Annual Report of the Medical Superintendent, 1 July, 1946; BRO Pamphlet, J. L. Davis, 'Glenside Hospital 1861-1961, pp. 63-64; BRO InfoBox/32/37 'Glenside Hospital 1861-1992: historical background'.
[85] Graves' theories are discussed in Chapter Two.

correction of physical defects and, particularly, investigating the probability of toxaemia, whereas 'the use of occupation as a supplementary mode of treatment is not pressed at this hospital.'[86] The use of physical treatments was also extensive at other hospitals. At Manchester Royal Hospital, for example, Board of Control inspectors noted in 1942 that 70 per cent of patients (225 out of a total hospital population of approximately 320) had been given ECT over a period of two years, with leucotomies being performed on two female patients.[87] One year later it was noted that treatments at the hospital included, 'malaria treatment for general paralysis, insulin shock therapy, electro-convulsion therapy and prolonging narcosis', in addition to leucotomies.[88]

Although the war seemed to have little effect on the pursuit of these physical treatments, wartime shortages of staff and resources did influence which particular therapies were developed and adopted. In the early years of the war, the most commonly applied new treatment was injections of the drug cardiazol, which produced violent seizures and spasms in the patient. Cardiazol treatment was used much more extensively than insulin coma therapy, which was a much more complex procedure, requiring more intensive use of staff and resources. Wartime shortages of sugar and staff also drastically reduced the take up of insulin coma as a

[86] TNA MH 95/19, Report of the Commissioners of the Board of Control, Rubery Hill Mental Hospital, Birmingham, 12 February, 1942; Hubert Bond, the senior Commissioner of the Board of Control, paid tribute to Graves' 'single-minded' pursuit of physical treatments on his retirement, see Report of the Commissioners of the Board of Control, 'Dr. Graves – continuing experimentation in physical treatments for mental disorders', 17 and 18 July, 1944.
[87] TNA MH 95/24, Report of the Commissioners of the Board of Control, Manchester Royal Hospital, Cheadle, 1939-1956, 17 September, 1942.
[88] Ibid, Report of the Commissioners of the Board of Control, Manchester Royal Hospital, Cheadle, 6 November, 1943.

treatment, although it was still carried out in many mental hospitals.[89] Cardiazol shock therapy required fewer, and less skilled, staff to administer than insulin coma treatment, although it also incurred dangers to patients' health. During the procedure, patients had to be manually restrained to prevent physical injuries to their spine and the violent spasms induced by the drug often caused patients to suffer from compression fractures.[90] The treatment could also be fatal, with one study recording that the injections directly caused the deaths of four patients out of a total of 85 cases.[91]

Cardiazol injections were dreaded by patients. One advocate of the treatment, psychiatrist L. C. Cook from Bexley Mental Hospital in Kent, even admitted that the 'chief drawback' to cardiazol was that the patient experienced 'a feeling of horror and apprehension, often quite indescribable'.[92] In a study of 160 patients given cardiazol treatment in Glasgow, psychiatrist Rankine Good contended that although psychiatrists tended to 'cloak' patient's dread of the injections under terms such as 'undue apprehension', these were a 'euphemistic expression for intense fear or terror'. He graphically described how this terror took hold of patients, who would resort to extreme measures, including plunging through windows, running barefoot through hospital grounds and scaling the roof,

[89] TNA MH 51/644, Dr. Leonard Russell, St Bernard's Hospital, Southall, Middlesex, August, 1940; R. A. Sandison, 'Treatment in Psychiatry', Letter, *British Medical Journal*, 2, (26 December, 1942), p. 765; Niall McCrae, '"A Violent Thunderstorm": Cardiazol Treatment in British Mental Hospitals', *History of Psychiatry*, Volume 17, Issue 1, (2006), p. 71; Joanna Moncrieff, *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*, (Basingstoke: Palgrave Macmillan, 2008), p. 28.
[90] L. C. Cook, 'Convulsion Therapy,' *Journal of Mental Science*, Volume 90, (January, 1944), p. 435; L. C. Cook and D. E. Sands, 'Spinal Injuries in Convulsion Therapy', *Journal of Mental Science*, Volume 87, (April, 1941), pp. 230-240.
[91] Cited in Cook, 'Convulsion Therapy,' p. 435.
[92] Ibid.

to avoid the feeling of 'being roasted alive in a white-hot furnace' induced by the drug.[93]

Moreover, evidence that such treatment 'cured' patients was very mixed.[94] In one small-scale study of 16 schizophrenic patients treated with cardiazol at the City Mental Hospital in Leicester, just one patient showed any sign of improvement during treatment. As A. J. Bain, the author of the study pointed out, 'recovery' was usually measured by whether patient's behaviour on the wards had improved.[95] Moreover, according to Bain, cardiazol treatment was often used to treat chronic patients explicitly because it 'reduces nursing supervision and expenditure.'[96] The only way such a procedure could be justified, he argued, was if the attitude was adopted that life-long hospitalisation was inevitable for these patients, and that 'it is better to have to nurse a docile, demented patient rather than, possibly, an impulsive and difficult one.'[97] Indeed, the control of patients' behaviour appeared to be psychiatrists' prime motivation in selecting patients for treatment, especially in the context of wartime staff shortages, which increased medical staff's desire for a more 'docile' patient population.

Cardiazol treatment began to fall from favour among psychiatrists in the overcrowded and understaffed mental hospitals during the course of the war, especially with the development of the shock treatment of ECT, which needed

[93] Rankine Good, 'Some Observations on the Psychological Aspects of Cardiazol Therapy', *Journal of Mental Science,* Volume 86, (May, 1940), p. 493.
[94] See, for example, TNA MH 95/9, Report of Commissioners of the Board of Control, Staffordshire Mental Hospital, 2 December, 1939.
[95] A. J. Bain, 'The Influence of Cardiazol on Chronic Schizophrenia', *Journal of Mental Science*, Volume 86, (May, 1940), pp. 502-513, p. 507.
[96] Ibid, p. 506.
[97] Ibid, p. 512.

fewer and less skilled staff to administer it. Within months of its first use in Britain, at the Burden Institute in Bristol in 1939, ECT was in regular and widespread use in British mental hospitals and, as will be shown in the next chapter, was also in use at some psychiatric outpatient clinics. ECT became the 'shock' method of choice because psychiatrists believed that it relieved certain symptoms, especially those of depression and other affective disorders, despite the mixed evidence that it provided a cure. ECT was also preferred over cardiazol therapy and insulin coma treatment because patients were more compliant with its administration and because the seizures were less violent, resulting in fewer spinal and other injuries.[98] The after-effects of ECT were often debilitating, however, and included prolonged memory loss. In some cases the spasms induced by the electrical shocks caused severe injuries to the jaw.[99] At St. Ebba's Mental Hospital in Surrey, staff devised makeshift ways to prevent injuries. They would apply a splint to the patient's jaw, made up of a chin pad strapped over the head, and then wrap the patient up in a sheet with arm holes and straps, and tie them up to a trolley before each ECT treatment.[100]

The rapidity with which ECT was taken up as a treatment in mental hospitals divided psychiatric opinion throughout the war, and the pros and cons of ECT was the subject of often heated debate in the letters and opinion pages of many of the leading psychiatric and medical journals.[101] Despite qualms among some

[98] Cook, 'Convulsion Therapy,' pp. 435-436.
[99] M. B. Brody, 'Prolonged Memory Defects Following Electrotherapy', *Journal of Mental Science*, Volume 90, (July, 1944), pp. 777-779.
[100] TNA 100/4, Board of Control Monthly Conference No. 96, 1 July, 1942.
[101] See, for example, the letters in the *British Medical Journal*, 1, (8 January, 1944), pp. 60-61; (15 January, 1944), p 94; (15 April, 1944); pp. 537-539.

psychiatrists, by the end of war, ECT had become a standard procedure in the majority of mental hospitals in England and Wales, with some hospitals holding ECT clinics several times a week, and ward routines often structured around preparing patients' treatment.[102] Although ECT was taken up with enthusiasm, it is important to note that it did not immediately replace cardiazol and other chemically-induced shock treatments. Cardiazol continued to be used in many mental hospitals until the end of the war, and tended to be the preferred shock treatment for those patients diagnosed with psychotic disorders, whereas ECT became a routine treatment for those with depressive or affective disorders.[103]

Although war conditions were important in entrenching ECT as the preferred 'shock' treatment, this did not preclude the development of newer physical procedures, including prefrontal leucotomies. This operation, which was the most invasive and risky of all the new physical procedures, was performed frequently during the war period, following the first operation carried out at the Burden neurological unit in Bristol in 1940. Within three years, 350 leucotomy operations had been performed in total on patients in mental hospitals in England and Wales.[104] In the London County Council region alone, 102 leucotomies were carried out between the first operation at Bexley Hospital in December 1941 to July 1945. Yet only 15 of these patients were able to be discharged as 'recovered' from their mental disorder.[105] The operation entailed a risky procedure, especially during

[102]Moncrieff, *The Myth of the Chemical Cure*, pp. 30-31.
[103] McCrae, '"A Violent Thunderstorm"', p. 84.
[104] G. W. T. H. Fleming, 'Prefrontal Leucotomy', *Journal of Mental Science*, Volume 90, (January, 1944), p. 486.
[105] Anon, *Interim Report of the County Medical Officer of Health and School Medical Officer for the year 1945*, (London: London County Council, King and Staples, 1946), pp. 62-63.

the war, when surgeons reportedly undertook short-cuts in the surgical procedures so that operations could be completed in a shorter timeframe, due to shortages of anaesthesia and the equipment needed to perform the surgery.[106]

There was little evidence that the operation improved patients' mental states. Indeed, according to some studies leucotomies worsened patients' mental health, creating 'undesirable' symptoms, such as 'loss of initiative and spontaneity, persistence of delusions or hallucinations, development of emotional facility or euphoria, of retardation, or perseveration, irritability or aggressiveness (in the melancholias) and volubility'.[107] Patients often reported feeling dull and emotionless weeks after the operation, and displayed only limited signs that the underlying disorder had improved. In one case study, for example, a 42 year-old female patient, interviewed a few days after the operation, 'admitted that the voices were continually talking to her and that they still worried her.' According to the psychiatrist, her emotions appeared flattened out, and she was described as being 'apathetic' and 'retarded' in her speech. 'Her habits had deteriorated. She was now incontinent of urine and faeces,' the case study concluded.[108]

The control of patient behaviour often appeared to be psychiatrists' main motivation in selecting patients for the operation. Those who were viewed as the most violent and destructive, and who caused the most trouble for medical staff, were more frequently chosen to undergo surgery. As one study reported, patients

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[106] E. Cunningham Dax and E. J. Radley Smith, 'The Early Effects of Prefrontal Leucotomy on Disturbed Patients with Mental Illness of Long Duration', *Journal of Mental Science*, Volume 89, (April, 1943), pp. 182-188, p. 184.
[107] R. Strom-Olsen, S.L. Last and B. Brody, 'Results of Prefrontal Leucotomy in Thirty Cases of Mental Disorder', *Journal of Mental Science*, Volume 89, (April, 1943), pp. 165-174, p. 168.
[108] Ibid, p. 172.

who were deemed to have 'undesirable disorders of conduct' were most likely to be selected for surgery, and included the 'most violent, noisy, excited, destructive or obscene cases in the hospital.' Moreover, these were considered the types of patients 'who distress their relatives, upset the other patients and consume the time and energy which could be put in to so much better purpose by the staff.[109]

The selection of patients with the most troublesome behaviour was also illustrated in a Board of Control report on Gateshead Mental Hospital. Following an inspection, commissioners made a secret 'not for copy' note, shown only to Board members, in which they expressed 'concern' at the rationale behind the selection of patients for prefrontal leucotomies. The Board claimed Medical Superintendent, Dr. Banford, had selected patients for the surgery to make life more convenient for staff, and he had referred to leucotomies as being of 'economic value in these days of depleted and nervous staff.'[110] It seems unlikely that this attitude was a one-off example of malpractice, but illustrated prevalent attitudes in psychiatry at this time, whereby the surgery was seen as worth risking if it produced patient compliance and the cessation of disruptive behaviour. Indeed, in his report for the year 1945, the London County Council Medical Officer, wrote of how brain surgery offered something for staff, patients and their relatives. Even if no patient was actually cured of their mental disorder, he considered that the transformation from

[109] Cunningham Dax and Radley Smith, 'The Early Effects of Prefrontal Leucotomy on Disturbed Patients with Mental Illness of Long Duration', p. 182; See also T. Percy Rees, 'Symposium on Pre-Frontal Leucotomy. The Indications for Pre-Frontal Leucotomy', *Journal for Mental Science*, Volume 89, (April, 1943), pp. 161-164.
[110] TNA MH 100/5, Board of Control Monthly Conference No. 103, October, 1943.

'noisy, violent and destructive behaviour' to that of 'orderly habits and of cheerful compliance with hospital routine' made the operation worthwhile.[111]

It was not until near the end of the war, in March 1945, that the Board of Control sought to collate statistics on the extent which prefrontal leucotomies were being practiced.[112] One year later, the Board of Control reported that physical treatments had been used 'extensively' for a number of years, and declared that it was 'glad to note that some form of physical treatment is used in every mental hospital to supplement psycho-therapy and other methods of approach.'[113] In a small-scale survey of 16 British mental hospitals two years after the war, American writer Dallas Pratt found that one-quarter were using prolonged narcosis to treat patients, induced by injections of paraldehyde or sodium amytal for ten to 13 days in a row. Some 14 of the 16 hospitals studied used insulin-coma therapy, and ten of the hospitals had each carried out over a hundred prefrontal leucotomy operations. All 16 hospitals used ECT on a weekly basis, some so extensively that Pratt commented that 'electroshock was being used as a substitute for psychotherapy'.[114]

The widespread use of physical procedures during the war did not, of course, mean that all other treatments were abandoned. Mental hospital doctors continued to pursue an eclectic mix of treatments, including crude palliative drugs,

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[111] Anon, *Interim Report of the County Medical Officer of Health and School Medical Officer for the year 1945*, p. 63; See also the interviews with nursing staff cited in Cunningham Dax and Radley Smith, 'The Early Effects of Prefrontal Leucotomy on Disturbed Patients with Mental Illness of Long Duration', p. 185.
[112] MH 51/242, Board of Control Circular No. 958, March, 1945.
[113] Anon, *The Thirty-Third Annual Report of the Board of Control (for the year 1946)*, p. 3.
[114] Wellcome Collection, GC/135/B.3/4, Dallas Pratt, 'Public Mental Hospitals in England: A Survey', (London: National Mental Health Foundation, 1948), pp. 23-26, p. 24.

such as paraldehyde, bromides and other sedatives.[115] At Bristol Mental Hospital where as well as the extensive use of prefrontal leucotomies and ECT, medical records for 11 male wards in 1942 reveal extensive use of 'sedatives' (although which ones are not stated) and injections of cortico tropic hormone.[116] At Gateshead Mental Hospital, the Board of Control noted that 'excessive' doses of the drugs paraldehyde, potassium bromide and chloral hydrate were regularly given to patients, sometimes as often as three times a day, well in excess of what was considered the usual dosage.[117]

Some mental hospital Medical Superintendents favoured a mix of psychotherapeutic and somatic treatments for patients, although it is noticeable in Board of Control reports from the war period that inspectors were more likely to highlight what one inspector described as 'heroic' physical methods.[118] The use of psychotherapeutic treatment was very limited during the war. Even prior to 1939, psychotherapy was not widely practiced in public mental hospitals, and wartime conditions curtailed its use even further, especially because of staff shortages and the lack of adequate spaces in which such therapy could be conducted.[119] Many Medical Superintendents remained sceptical of psychotherapeutic methods, however. J. Bierer, a psychotherapist employed by Runwell Mental Hospital, for example, wrote of how psychiatrists appeared 'nihilistic' and 'defeatist' about the

[115] Moncrieff, 'An Investigation into the Precedents of Modern Drug Treatment in Psychiatry', pp. 481-482.
[116] BRO 40513/C/12/22, 'Male Hospital Day Journal, 1942-43.
[117] MH 100/5, Board of Control Monthly Conference No. 103, October, 1943.
[118] TNA MH 95/11, Report of the Commissioners of the Board of Control Reports, Staffordshire County Mental Hospital, Burntwood, 3 October, 1944.
[119] A similar point is made by McCrae, '"A Violent Thunderstorm"', p. 69.

prospects for psychotherapeutic methods.[120] One of the reasons for this sceptical attitude was expressed by the Medical Superintendent of Friern Mental Hospital on the eve of the war, when he declared that, 'the majority of the patients admitted to this hospital are of a low intellectual standard and not susceptible of benefit by psychological treatment.'[121] Bierer did set up group therapy sessions and a social club at the Runwell Hospital, but such examples were exceptional.[122] One doctor, in a letter to the *BMJ*, even felt moved to ask, 'Is psychological treatment ever really consciously carried out in the present-day mental hospital?' He reported that he worked in a mental hospital with 370 patients, many of whom were considered suitable for psychotherapy, but with only two psychiatrists at the hospital, one of whom was the Medical Superintendent, it had been impossible to run any therapy sessions. 'No wonder the electric button is popular,' he remarked.[123]

The adoption of physical treatments during the war helped to bolster the biological orientation of psychiatric practice in mental hospitals, despite the contemporaneous growth in influence of psychologically-based ideas and treatments in psychiatric sites outside the mental hospital.[124] Such physical treatments also reinforced the idea, embedded in the 1930 Mental Treatment Act, that mental hospitals should be medical sites of treatment and cure, rather than places of detention and custody. This view of mental hospitals as places of medical

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[120] J. Bierer, 'Psychotherapy in Mental Hospital Practice', *Journal of Mental Science*, Volume 86, (September, 1940), p. 928.
[121] LMA H12/CH/A/08/010, Reports to Friern Hospital Sub Committee (ACC/2897) Jan 1937-Nov 1946, Report by the Medical Superintendent, 12 May, 1939.
[122] J. Bierer and F.P. Haldane, 'A Self-Governed Patients' Social Club in a Public Mental Hospital', *Journal of Mental Science*, Volume 87, (July, 1941), pp. 419-426.
[123] T. H. B. Gladstone, 'Physical Therapy in Mental Disorder', Letter, *British Medical Journal*, 1, (2 February, 1946), p. 180.
[124] McCrae, '"A Violent Thunderstorm"', p. 82.

treatment encouraged psychiatrists' ambitions to achieve equal prestige with medical doctors and for psychiatry to be aligned more closely with general medicine, even if such treatments had failed to produce a 'cure' for mental illness.[125] As an editorial in the *BMJ* in 1942 put it:

> The usefulness of these physical methods of treatment emphasizes the kinship of psychotic with general medical illness. We are not deterred by fear of relapses from treating tuberculosis, diabetes, and cardiac disorder by the best methods we know, and the same attitude should be more general in psychiatry.[126]

After the war, the Board of Control put forward a positive view of physical treatments suggesting that they provided evidence that mental hospitals could become modern institutions, at the forefront of psychiatric expertise.[127] But a rather different interpretation can also be put on the overall effect of the extensive use of such treatments. As Andrew Scull has pointed out, the crude application and failure of physical treatments worked to further marginalise mental hospitals as places to house those considered incurably insane. Rather than help to place mental hospitals on an equal footing with general hospitals, psychiatrists increasingly preferred to apply their expertise at sites beyond the hospital walls. In this way, the inpatient population of mental hospitals was increasingly stigmatised in the years following the war. Indeed, the failure of what Scull calls the 'paroxysm of experimentation' on long-term mental hospital patients in the 1930s and 1940s, 'may well have contributed its quota to the dilapidated denizens of the back

[125] Moncrieff, 'An Investigation into the Precedents of Modern Drug Treatment in Psychiatry', pp. 481-482, p.484.
[126] Anon, 'Shock Treatment in Psychiatry', *British Medical Journal*, 2, (3 October, 1942), p. 398.
[127] Salusbury McNalty (ed.), *The Civilian Health and Medical Services*, p. 185; Anon, *The Thirty-Second Annual Report of the Board of Control for the year 1945*, p. 12.

wards.'[128] Similarly, Nikolas Rose has suggested that the Second World War decisively shifted the balance of power in psychiatry away from the psychiatrists who dominated the Board of Control, and who favoured mental hospitals as the main site of psychiatric expertise, towards those who wanted to align psychiatry more closely with general medicine through practice outside the mental hospitals.[129] In the next section of the chapter, I explore these issues by asking whether the war played a part in cementing the divisions between those considered to be neurotic/curable and those seen as psychotic/incurable.

Abnormalisation of the psychotic?

In the years prior to the war, especially following the 1930 Mental Treatment Act, there had been various moves to divide and sub-divide the mental hospital population along an acute/chronic dichotomy. This marked the acceleration of a process that had begun in some hospitals in the early years of the twentieth century, and included the development of more clearly defined demarcations within the hospital, such as the development of separate admission blocks and the provision of acute wards. There had also been a limited development of a villa system in some hospitals, entailing the construction of separate blocks and which divided the patient population into smaller units. Patients deemed to need less supervision were given more freedom of movement.[130]

[128] Andrew Scull, 'Psychiatry and Social Control in the Nineteenth and Twentieth Centuries', *History of Psychiatry*, Volume 2, (1991), p. 165.
[129] Rose, 'Psychiatry: the Discipline of Mental Health', p. 60.
[130] Armstrong, 'Madness and Coping', p. 305; Jones, *Mental Health and Social Policy*, p. 261.

In many ways, wartime overcrowding, bomb damage and the subsequent reconfiguring of hospital spaces put a brake on many of these changes. All new hospital building projects ceased for the duration of the war, for example, and planned repairs and refurbishment of the old asylum buildings were also strictly limited. The spaces into which patients could be divided, segregated and treated within the hospital were severely curtailed by overcrowding. As has been illustrated earlier in this chapter, such conditions sometimes dramatically affected the quality of life and the physical and mental health of patients. In other ways, however, pre-war developments that aimed to divide and sub-divide patients according to diagnosis and the manageability of symptoms continued despite wartime overcrowding. All mental hospitals continued to operate strict segregation according to gender, even when groups of male or female wards were destroyed due to bombing, for example. The development of the asylum as a medical space, with its regimes of physical treatments, meant that even when psychiatrists could not physically divide patients in separate wards, categorisation could still take place according to who was judged to be amenable to treatment, and ultimately, viewed as curable.[131]

There was also a rise in voluntary patients in mental hospitals during the war. In its post-war report for 1946, the Board of Control trumpeted this rise, and its figures showed that voluntary admissions now accounted for half of all admissions – 18,059 out of 35,585 total admissions for that year, compared to 9,651 in 1938, the last full peacetime year. Although, as noted earlier in this

[131] Armstrong makes this point about the continued sub-division of patients in the 1930s and 1940s. See Armstrong, 'Madness and Coping', p. 306.

chapter, the number of discharges fell in the first two years of the war, overall the rate of discharges increased from an average yearly total of 14,892 discharges between 1934 and 1938, to 17,378 per year between 1939 and 1945.[132] For the Board, these changes signified a greater awareness among the public for the need for early treatment, and a sign that patients were willing to admit themselves to mental hospitals, despite the associated stigma. The Board surmised that the public were 'beginning to appreciate that a mental hospital is a place where effective treatment is possible and where conditions are in a great many instances fully acceptable to those seeking treatment.[133]

Despite this increase in voluntary patients, towards the end of the war there was a growing view in mainstream psychiatric circles that the division between psychotic/long-term patients and neurotic/short-term patients should be extended beyond the sub-division and segregation *within* mental hospitals. There were frequent calls for the construction of new institutions that would cater for the needs of psychotic and neurotic patients separately. This view was expressed by the President of the Royal Medico-Psychological Association, A. A. W. Petrie, who argued that the construction of separate facilities for long-term patients was the only way to overcome the 'terror' patients felt that they would be incarcerated in a mental hospital for life and that deterred many from seeking treatment at an early stage of their illness. Although admission to a chronic unit 'will excite even more antagonism than is earned at present on admission to a mental hospital', he

[132] Anon, *The Thirty-Second Annual Report of the Board of Control (for the year 1945)*, pp. 12-13. This figure excludes those discharged on admission and 'not now insane' and those patients transferred between institutions.
[133] Anon, *The Thirty-Third Annual Report of the Board of Control for the Year 1946*, *Part 1,* (London: HMSO, 1947), p. 1.

argued, it would also help to 'lessen the resistance to early treatment.'[134] Speaking at meeting of the Mental Hospitals Association in August 1945, J. Iverson Russell, the Medical Superintendent at the North Riding of Yorkshire Mental Hospital, similarly claimed that the public's main objection to mental hospitals was the presence of the 'settlers', as he termed long-term patients. The 'settlers' made up over two-thirds of the mental hospital population, argued Iverson Russell, and included mainly 'chronic psychotics'. His solution was to re-house these patients in 'subsidiary' or 'after-care' homes, or in separate annexes of the mental hospital grounds, with the main sites of mental hospitals devoted to 'administrative offices, progress wards, special treatment rooms, out-patient consultation rooms, occupational centres, operating theatres and laboratories, and sick-rooms for bodily illness'.[135] For psychiatrists like Iverson Russell, the vision of a closer alignment of psychiatry with general medicine thus involved the treatment of more transient, usually neurotic, mental disorders in separate premises.

Louis Minski, a psychiatrist working with neurotic patients at Sutton Emergency Hospital, also favoured the separation of chronic and short-term patients. In a letter to the *BMJ,* Minski expressed fears that potential voluntary patients would be put off seeking help because of the fear of being placed in institutions in close proximity to long term patients. Although Minski insisted that he would be, 'the first to deprecate the fact that mental hospitals should be used

[134] A. A. W. Petrie, 'Psychiatric Developments', *Journal of Mental Science*, Volume 91, (July, 1945), p. 278,
p. 279; See also A. A. W. Petrie, 'Reconstruction in Psychiatry (Abridged)', *Proceedings of the Royal Society of Medicine*, Volume 35, (July, 1942), pp. 569-576.
[135] Cited in Anon, 'Mental Hospital Population: Proposal for Dispersion', *British Medical Journal*, 2, (25 August, 1945), p. 265.

solely as dumping grounds for the chronic, incurable patient', he nevertheless wrote that

> Many of those suffering from neuroses and early psychoses (socially well conducted) resent going into mental hospitals, as even though they are housed in separate villas or admission units in the mental hospital, they of necessity meet the chronic patients on common ground, viz., at occupation, recreation, in the grounds, etc.[136]

These fears reaffirmed the notion, advocated by many psychiatrists influenced by the ideas of mental hygiene, that chronic patients could 'contaminate' those with less serious conditions. The problem was located not so much in the dilapidated infrastructure or the nature of the regimes of care and control in the hospital, but by chronic patients infecting those with more minor conditions. Such views in many ways reinforced the stigma attached to the long-term patients and, despite Minki's wishes to the contrary, the view of mental hospitals as 'dumping grounds' for those with chronic mental disorders.

These demands to separate chronic and acute patients were in part influenced by the changing nature of the inpatient population of mental hospitals during the war, which seemed to confirm mental hospitals as places of neglect. In particular, there was a significant rise in the elderly population through the war years. Some psychiatrists speculated that part of the reason for this rise was that the conditions of wartime life, such as the blackout, made it harder for elderly and

[136] Louis Minski, 'Psychotherapy in General Hospitals', Letter, *British Medical Journal*, 1, (26 June, 1943), p. 800.

infirm relatives to be cared for at home. Dr. Brian Kirman from St. Mary Cray in Kent, suggested in a letter to the *BMJ* that

> a patient with early senile dementia who might well have been cared for at home in peacetime may now be impossible to cope with owing to a risk of offences against blackout regulations or because all the female relations are now at work and there is nobody at home to be responsible for the patient.[137]

Similarly, psychiatrist Frederick Hopkins, from Smithdown Road Mental Hospital in Liverpool, argued that families in wartime found it harder to care for those with mental disorders. The increase in new patients largely consisted of 'patients coming into hospital who show disabilities of long standing but who previously had been cared for in their own home,' he claimed.[138] In his case study of the Royal Edinburgh Hospital for Mental and Nervous Diseases, Felix Post noted that the rise in the elderly population rose exponentially during the first three years of the war – from 25.1 per cent of the hospital's inpatient population between 1935 and 1938 to 32 per cent between 1939 and 1942. Although he emphasised hereditary and 'predisposing constitutional factors' in the aetiology of mental disorders in elderly people, Post regarded social factors, including the war and the consequent lack of domestic help as playing an important part in the onset of the disorders.[139] This longer-term trend of a rise in the elderly population of mental hospitals was accelerated by the war. Changing family relationships, including the call-up of men

[137] Brian H. Kirman, 'Admissions in Mental Wards in Wartime', Letter, *British Medical Journal*, 1, (15 May, 1943). p. 614.
[138] Frederick Hopkins, 'Decrease in Admissions to Mental Observation Wards During War', *British Medical Journal*, 1, (20 March, 1943), p.358.
[139] Felix Post, 'Some Problems Arising from a Study of Mental Patients over the Age of Sixty Years', *Journal of Mental Science*, Volume 90, (April, 1944), p. 556, pp. 558-559.

into military service and the move of many women into paid employment, often meant that families could no longer provide the care elderly people suffering from dementia and other mental health conditions needed. As an editorial in the *BMJ* put it, there was a 'general belief that persons of 65 and over no longer find the comfortable place in the family circle which they enjoyed in the Victorian era.'[140]

The changing mental hospital population during the war years thus exacerbated fears that mental hospitals had become 'dumping grounds' for patients in need of long-term institutional care. These concerns were encapsulated in the parliamentary debate quoted at the beginning of this chapter, initiated by the Labour Party MP for Bolton, John Lewis. Lewis made the case that mental hospitals had become merely containers for those with incurable mental disorders. He argued that mental hospital wards were used for the 'chronically infirm', who, he claimed, 'are often noisy, excited, wet or dirty'. Lewis described these patients in rather derogatory language as 'sub-human wrecks', who were 'devoid of human faculties' and claimed that they 'cannot benefit in any way from any form of treatment of any kind.' Furthermore, these chronic cases took up the bulk of the time of the medical and other hospital staff and would deter others from admitting themselves on a voluntary basis. Lewis's proposed solution was for the authorities to build two types of mental hospitals, which separated the 'curable' and 'incurable' patients. In this scheme, chronic cases would be 'left to end their days' in mental hospitals, while 'all the most modern scientific methods' would be

[140] Anon, 'Mental Hospitals in Wartime', *British Medical Journal*, 2, (1 December, 1945), p. 778; See also Claire Hilton, 'The Origins of Old Age Psychiatry in Britain in the 1940s', *History of Psychiatry*, Volume 16, (2005), pp. 267-289.

deployed for those cases judged as amenable to treatment.[141] Whatever the hyperbole in these statements, and his very disparaging view of long-term patients, Lewis was reiterating mainstream psychiatric thought about the future direction of mental health services. Indeed, the joint recommendations of the Royal College of Physicians, the British Medical Association and the Royal Medico-Psychological Association in the run-up to the creation of the National Health Service included a call for the provision of new facilities within mental hospitals, whereby patients could be graded and housed separately according to the severity of their disorder.[142]

Conclusion

This chapter has shown how from its outset the war affected every aspect of life within wartime mental hospitals. Psychiatric patients did not escape air-raids, bomb damage, rationing, fuel shortages and all the other deprivations of war suffered by civilians on the home front. As for civilians outside the hospital, life entailed extremes of fear and anxiety and long spells of discomfort, inactivity and boredom. Such wartime hardships were exacerbated by life inside an institution where personal space and autonomy was already severely compromised. Although the war touched the life of every mental patient, how patients felt about and reacted to the war varied depending on the area of the hospital, whether the hospital suffered

[141] Hansard, House of Commons Debates, Tuesday 6 November, 1945, Volume 415, Columns 1188-1204.
[142] Anon, 'The Psychiatric Services: Joint Recommendation', *The Lancet*, Volume 1 (16 June, 1945), p. 764.

bombing raids, the type of regime and treatments favoured by the Medical Superintendent, and also the relationships patients had with relatives, staff and fellow patients.

Although some aspects of treatment, such as Occupational Therapy, were severely curtailed during the war, psychiatrists continued to research and implement new physical therapies, such as insulin coma treatment, prefrontal leucotomies and ECT. Indeed, the development of these treatments was sometimes prioritised over and above the amelioration of other hardships and deprivations of the war. This helped to confirm the hold of biologically-based psychiatry within the British mental hospital system. Of course, this may have proved to be the trajectory of British psychiatry if there had not been a war, and prior to the war somatic ideas and practice were dominant in mental hospitals. But as this chapter has shown, wartime shortages, especially of psychiatrists and other hospital staff, hastened the uptake of treatments which, unlike psychotherapy, minimised the amount of time staff spent with patients.

The war period thus saw both the curtailment and the continuation of some of the developments in mental hospital care initiated and envisaged in the 1930 Mental Treatment Act. These developments were not incidental to the changes taking place in psychiatric provision outside of mental hospitals. Rather they were a crucial part of what Scull has described as a 'symbiotic' process, whereby at the same time as services were developed in clinics outside the hospitals, normalising the occurrence of more minor psychiatric conditions, the long-term patients within

the hospitals were increasingly marginalised as objects of psychiatric scrutiny.[143] In the next chapters of the thesis, I will examine the effects of the war on this process of the 'normalisation' of more minor mental disorders by examining psychiatric practice at sites outside of the mental hospitals.

[143] Scull, 'Psychiatry and Social Control in the Nineteenth and Twentieth Centuries', p. 165.

Chapter Five: Outpatient clinics: between hospital and community

> The building is somewhat ramshackle – a skin-clinic meets at the same time and all the patients use the same waiting hall. No nurse is on duty for the Psychiatry Clinic but one is available if required. The doctor has a buzzer in his room to summon the next patient and the patients sit on a bench outside.[1]

This account by an inspector of the Board of Control of her visit to a crowded South London psychiatric outpatient clinic in March 1943 describes a wartime site of psychiatric practice that has rarely been glimpsed in histories of the Second World War. There have been remarkably few historical accounts of the material conditions of the clinics or of the diagnoses and treatments dispensed within them.[2] Titmuss's history of social policy during the war, for example, made only a brief mention of the clinics, concluding that there was a decrease in attendance at the clinics during the Blitz period of 1940-41.[3] In subsequent historical accounts, the wartime clinics have most frequently been examined in the context of a broader framework of changes in psychiatric treatment. In more traditional medical histories, the development of the clinics has been viewed as part of the progressive trajectory of psychiatry through the twentieth-century. In this view, the clinics can be seen as a positive step in the move away from a focus on the custodial confines of the asylum

[1] TNA MH 51/663, Report from St. John's Hospital Psychiatric Clinic, Lewisham.
[2] The exception to this are historical studies of the development of Child Guidance Clinics and the work of psychoanalysts with children, such as the Hampstead Nurseries run by Anna Freud and Dorothy Burlingham. See, for example, Shapira, *The War Inside*; Anna Freud and Dorothy Burlingham, *Infants Without Families and Report on the Hampstead Nurseries, 1939-1945*, (London: Hogarth Press, 1974). As explained in Chapter One, children's clinics do not form part of this research.
[3] Titmuss, *Problems of Social Policy*, p. 340; p. 341 footnote. Titmuss's conclusions have tended to be adopted uncritically in some historical accounts. See, for example, Rose, *Governing the Soul*, p. 24; Gardiner, *The Blitz*, p.179.

towards more community-based provision for the early treatment of minor nervous disorders.[4] A more critical assessment has been provided by Foucauldian scholars, in particular David Armstrong and Nikolas Rose, who have analysed this shift as part of medicine's increasing encroachment into, and surveillance of, the lives of the general population.[5] As Armstrong has persuasively argued, this 'medicalisation of the mind' involved a process whereby psychiatrists began to shift their gaze away from the 'deviant body' of asylum patients and on to the minds of the 'normal' population.[6] There has, therefore, been a tendency in both traditional histories of psychiatry and in poststructuralist accounts for the details of psychiatric practice at the clinics during the war to get submerged in a broader analysis of wider changes in psychiatric theory and practice.

The most comprehensive account of the clinics was provided by the survey conducted on behalf of the government by the wartime military psychiatrist and eugenicist Carlos Blacker, which was published in 1946.[7] Blacker's survey was initially prompted by concerns that Aubrey Lewis brought to the government's attention in 1942. Lewis believed that existing outpatient provision was inadequate to deal with a growing number of civilian neurotic cases. Official attention had been so focused on 'the lack of evidence that air-raids led to any notable increase in neurotic illness,' Lewis contended, 'it is inferred all is well.' All was far from well, according to Lewis, and, in particular, he highlighted the severe shortage of civilian

[4] See, in particular, Jones, *A History of the Mental Health Services*, pp. 226-261.
[5] Armstrong, *Political Anatomy of the Body*; Rose, *Governing the Soul*. Other more recent critical accounts of the development of the clinics include Joan Busfield, 'Restructuring Mental Health Services in Twentieth Century Britain', in Gijswijt-Hofstra and Porter (eds.), *Cultures of Psychiatry*, pp. 9-28; Hayward, *The Transformation of the Psyche in British Primary Care*.
[6] Armstrong, 'Madness and Coping', p. 297; Armstrong, *Political Anatomy of the Body*, pp. 21- 31.
[7] C. P. Blacker, *Neurosis and the Mental Health Services*, (Oxford: Oxford University Press, 1946).

psychiatrists, due to their secondment into military service and the EMS.[8] Four conferences were held between Lewis and various representatives of the Ministry of Health and the military services between March and November 1942, in which government officials made it clear that additional resources would not be available to fund an extension of psychiatric facilities. Indeed, the government failed to guarantee that it would even be able to provide a more efficient allocation and coordination of existing staff and resources if the war continued, opting instead to conduct a survey of the facilities available.[9] The final survey was not published until 1946, even though it included research from the early years of the war, and this delay meant that the results were mainly viewed as a contribution to discussions about the future of mental health services under the auspices of the NHS.[10]

By drawing on Blacker's survey, and the unpublished reports of two of the inspectors who helped him compile it, in this chapter I have provided a hitherto unexplored account of psychiatric practice at the clinics. In the first section, I look at material conditions inside the clinics, and the ways in which the clinics reinforced as well as challenged the stigma attached to having a psychiatric diagnosis during this

[8] TNA MH 76/115, Letter from Aubrey Lewis, Mill Hill Emergency Hospital to Professor F. R. Fraser, Ministry of Health, 4 March, 1942. Lewis's primary concern in the letter was reports about the high levels of neurosis among factory workers, especially women, and its effects on productivity and morale, which will be considered in detail in Chapter Seven. Lewis also insisted that medically trained psychiatrists should run psychiatric services, and was very dismissive of the idea of the Mental Health Emergency Committee running some psychiatric services. Indeed, he likened the idea of members of the Committee treating neurotic ex-servicemen to 'entrusting orthopaedics to masseuses' or 'obstetrics to midwives'. Nor did he favour the adoption of psychotherapeutic methods of treatment, calling psychotherapy 'too expensive a luxury and too feeble a remedy for these times'.

[9] Ibid. Conference on psychiatric services held on 14 August, 1942. There was some discussion at this, and at a later conference in November 1942, as to whether Blacker was the most suitable person to head up the survey. See also Thomson, *Psychological Subjects*, p. 241.

[10] I have not ascertained the reason for the delay in publication, although it might be speculated that part of the reason may have been due to reluctance to publish a report during the war that showed the mental health services were over-subscribed.

period. I then analyse Blacker's contention that the overcrowded conditions of the clinics did not signify a rise in neuroses in the civilian population, and explore the effects of increasing numbers of patients, combined with shortages of staff and resources, on the psychiatric services offered. I also explore why one group of civilians, those discharged from military service, were viewed as being problematic and a drain on the resources of the clinics. In the final section of the chapter, I unpick some of the assumptions embedded in Blacker's report about which patients should be defined, classified and counted as psychiatric casualties of war, and examine psychiatrists' concerns about the longer-term psychological effects of the war.

Blacked-out, cramped and crowded

By the time Blacker's survey was conducted in 1943, there were 216 public psychiatric clinics open in England and Wales, although a handful would close down in the course of the survey.[11] There is very little description of the material conditions inside the clinics in the final published report, apart from passing references to overcrowding and inadequate facilities, and a description of an imaginary scenario of a patient 'kept waiting for two hours in a draughty, ill-lit and forbidding room.'[12] For the following analysis, I have drawn on the unpublished reports by two inspectors of the Board of Control, Catherine Gavin and Isobel Laird,

[11] Blacker, *Neurosis and the Mental Health Services*, p. 7. Blacker's survey did not include clinics in Scotland.
[12] Ibid, p. 14.

who were seconded to work on Blacker's survey.[13] Gavin and Laird visited every psychiatric clinic in London and the North-West region respectively from February to April 1943, interviewing the psychiatrists, social workers and almoners who staffed them and reporting on the facilities and conditions they encountered.[14] None of this reportage by the inspectors was included in the final report, nor has it been alluded to in the subsequent historiography. These reports are important, however, because they are the only surviving sources that record in detail both the material state of the clinics during this period, and the attitudes and opinions of the psychiatrists and social workers who worked within them.[15] The reports may offer what Gavin admitted was 'nothing more than a bird's eye picture',[16] but they nevertheless provide hitherto unexplored accounts of the 'lived materiality of the space and resources' of the wartime clinics.[17]

Although the two inspectors found that buildings and facilities varied from clinic to clinic, and from area to area, the overall picture that emerges from their accounts is of spaces which were run-down, blacked-out and cramped, and which were discouraging for those seeking psychiatric help. Isobel Laird described the 23 outpatient clinics in the North West region, for example, as being overwhelmed by the numbers of waiting patients. 'In almost every clinic,' she wrote, 'a long wait is inevitable', and 'during the waiting time there is seldom comfortable warmth, very

[13] Ibid, p. 2.
[14] TNA MH 51/663. These reports are not catalogued in the main file, but are unsorted in an envelope at the back of the file.
[15] Unfortunately, I have not been able to locate copies of reports from the other nine regions.
[16] TNA MH 51/663, C. M. Gavin, 'Confidential Report to Triumvirate on Out Patient Clinics in the London Area', p. 5.
[17] This phrase is from Volker Hess and Benoit Majerus, 'Writing the History of Psychiatry in the 20th Century', *History of Psychiatry*, Volume 22, (2011), p. 142.

seldom light for reading or sewing, nothing to read, no hope of a hot drink or snack.'[18] Psychiatric patients often had to share waiting room facilities with patients from other clinics. At the clinic in Barrow, for example, patients could not fit in to the tiny, blacked out and airless waiting room and had to queue in a cold corridor with no seats. 'On certain days the neurotic patients wait among children in various noisy and gory stages of recovery from operations for the removal of tonsils,' Laird reported.[19] At the clinic based in the Warrington Infirmary conditions were particularly 'deplorable', according to Laird, especially as the 'the dingy waiting hall' was 'filled with fumes from the boilerhouse.'[20] Patients at the clinic based at the Blackburn and East Lancashire Royal Infirmary had to navigate their way along a route used to transport accident and emergency patients to a surgery ward to reach the interview room. During the interview, Laird described how the patient and psychiatrist 'face each other across a table arranged with a large bowl of disinfectant, a pile of hand-towels, and a tray of instruments very occasionally used in physical examinations.'[21]

In Preston, although Laird described the doctor's consulting room in the hospital as 'a pleasant comfortable place', she also noted how the psychiatric patients were forced to wait 'in a very narrow corridor totally blacked-out, poorly-lit, and ventilated mainly from the large waiting room where about fifty patients with an assortment of skin affections await their clinic.'[22] There are similar

[18] TNA MH 51/663, Isobel Laird, 'N.W. Region. Report on Fieldwork,' p. 12.
[19] Ibid, p. 5.
[20] Ibid, p. 7.
[21] Ibid, p. 5.
[22] Ibid, p. 7.

descriptions in the reports of the 44 clinics in the London area visited by Gavin.[23] She described makeshift and inadequate buildings, with crowded waiting rooms, sometimes overflowing into nearby corridors. At the Royal Northern Hospital Neurological clinic in North London, one of the biggest outpatient clinics in London, staff told Gavin that at one afternoon session some 300 surgical and psychiatric patients had been packed into the waiting room. Gavin described that on the day of her visit, 'the small waiting hall for the various out-patients clinics was crowded with all the benches filled and a few people standing round the walls.'[24] The clinic run by the West End hospital had to borrow two rooms from the Debenhams department store after the clinic was gutted in an air-raid.[25] Such conditions did not provide a propitious atmosphere for those seeking psychiatric help. As Blacker commented in his report, 'good psychiatric work cannot be done in an atmosphere of hurry, when visions of long queues of waiting patients are disclosed every time the door opens.'[26]

Perhaps most pertinently, Gavin and Laird found that patients often faced a complete lack of privacy due to the inadequate design and set-up of the rooms allocated to the clinics, resulting in patients having to reveal the details of their nervous complaints to everyone else in the waiting room. At the Warrington psychiatric clinic, for example, Laird reported that the 'waiting hall is not large, and the hatch at which new patients ask for cards is in one wall. New patients therefore give all the necessary particulars about themselves in full hearing of all waiting

[23] While Laird's report is written up as a single document, Gavin collected individual reports from each clinic.
[24] TNA MH 51/663, Report from the Royal Northern Hospital Neurological Clinic, Holloway Road.
[25] Ibid, Report from West End Hospital for Nervous Diseases Out-Patient Department.
[26] Blacker, *Neurosis and the Mental Health Services*, p. 72.

patients.'[27] The absence of privacy sometimes extended beyond the waiting room to the patient's consultation with the psychiatrist or social worker. At the clinic based at the Royal Northern Hospital, for example, there were no private rooms available for patients to have a one-to-one interview with the psychiatrist. Two psychiatrists had to share a small room during the interviews, and these sessions were constantly interrupted. 'The two nurses were moving in and out the room and there seemed to be one or two people (relatives?) sitting inside the room waiting for interviews in addition to those being seen by doctors,' Gavin reported.[28] Similarly, in the North West region Laird wrote of how talks between patients and psychiatrists were sometimes conducted in the presence of six people, and often within earshot of the other waiting patients.[29] In Chester, the half-hour sessions between doctor and patients were 'continually interrupted by nurses and clerks bursting in to see whether the rooms are vacant yet', and at the Warrington clinic the psychiatrist's consultations were regularly interrupted by patients from the adjacent VD clinic, asking their way for treatment.[30]

The conditions Gavin and Laird described were perhaps not surprising in the context of the scarcity of resources in wartime Britain. The observation that patients were prepared to queue for hours in cramped waiting halls and cold corridors indicates, however, that there was an often unacknowledged level of demand for psychiatric help during the war. This is especially the case considering both the physical obstacles patients had to surmount to get to the clinics, such as

[27] TNA MH 51/663, Isobel Laird, 'N.W. Region. Report on Fieldwork', p. 7.
[28] Ibid, Report from Royal Northern Hospital Neurological Clinic, Holloway Road.
[29] Ibid, Isobel Laird, 'N.W. Region. Report on Fieldwork', p. 6.
[30] Ibid, p. 6, p. 7.

traversing bomb-damaged areas and lack of transport, and the stigma still attached to having a mental illness during this period. Moreover, the absence of privacy afforded to patients was also indicative of how the outpatient clinics still retained a strong connection with the large mental hospitals. For working-class patients, lack of privacy in mental institutions was not new, of course. In public asylums working-class patients were seldom offered individual, private consultations, and were subject to compulsory psychiatric scrutiny on large dormitories, often crowded with other patients. Unlike the asylum, where the majority of patients were still detained under certification, the clinics were voluntary institutions where the patient could choose whether to attend or not. Yet, despite marking a move away from the institutionalisation and containment of the mentally ill, the new clinics still retained the ethos of the mental hospital and the stigma attached to being identified as a mental patient. Although only 15 of the 210 clinics that responded to the survey were situated in the grounds and buildings of mental hospitals, 150 clinics (just over 70 per cent of the total) were staffed by psychiatrists and social workers who were based in mental hospitals.[31] These asylum-based psychiatrists were not necessarily interested in investigating more minor neurotic disorders. The government's psychiatric advisor Bernard Hart pointed out that many of the clinics were staffed by

> medical officers of mental hospitals whose interest and training is mainly with psychoses and not psycho-neuroses, and who tend to consider cases chiefly from

[31] Blacker, *Neurosis and the Mental Health Services*, p. 55.

the angle of their suitability to be admitted to mental hospitals as voluntary patients.[32]

Hart's view was confirmed in Blacker's final report, which found that the clinics staffed by mental hospital psychiatrists were more likely to diagnose disorders as a psychosis, particularly in clinics located in small towns, and to send clinic patients to be admitted to mental hospitals as certified patients, or, most often, as voluntary patients.[33] Blacker noted that in the small town clinics, GPs were more likely to utilise the clinics 'for the disposal of severe cases who need hospital treatment', rather than for the early treatment of neurotic ailments.[34] He warned that there was a danger that the fear of mental hospitals could be extended to the clinics.[35] The association of clinics with mental hospitals was also made by members of the public, according to Laird.[36] From her observation of the patients in the waiting queues, Laird considered that there was a danger of the clinics being regarded 'as a recruiting centre for a mental hospital.'[37] It is unclear, however, whether she was making a disparaging remark about the patients' appearance, or whether she was referring to the fears of the patients. Although there are no records of how the patients viewed the prospect of being referred to a psychiatric clinic, we can surmise that some patients may have feared that attending the clinic might confirm an unwanted identity as a mental patient.

[32] TNA MH 76/115, Letter from Bernard Hart to Prof. F. R. Fraser following the Conference on Civilian Neuroses. Undated.
[33] Blacker, *Neurosis and the Mental Health Services*, p. 58.
[34] Ibid, p. 158.
[35] Ibid, pp. 18-19.
[36] TNA MH 51/663, Isobel Laird, 'N.W. Region. Report on Fieldwork,' p. 11.
[37] Ibid, p. 12.

A rise in neurosis?

The upheavals, overcrowding and depletion of staff in the public mental hospitals, discussed in Chapter Four, initially had a detrimental effect on services at outpatient clinics, particularly those staffed by psychiatrists and social workers based in the hospitals. Some clinics immediately closed when war broke out, while others drastically reduced the amount of psychiatric sessions offered.[38] Such was the level of 'reduction or even complete suspension' of outpatient services less than two months after the outbreak of the war that the Board of Control wrote to the Medical Superintendent of every mental hospital in England and Wales urging them to reinstate outpatient services in the interests of 'efficiency and economy'.[39] The commissioners of the Board of Control feared the curtailment of outpatient services would result in more admissions to the overfull hospitals and in the failure of mental health services to cope with the still expected rush of psychiatric casualties once the bombing started. The 'lessening of out-patient treatment cannot fail to aggravate a situation which was already grave,' the Board warned.[40]

By the time Blacker's survey was conducted in 1943 attendance at the clinics had been steadily rising. Although there had been a drop in the numbers of new patients attending the clinics in the first year of the war, by 1942 some clinics were seeing double the numbers of new patients who had attended in the last full

[38] TNA MH 51/252, Minutes of Board of Control, 19 September, 1939.
[39] TNA 51/241, Board of Control Circular No. 869, October, 1939.
[40] Ibid. In the confusion of the early months of the war, some patients stopped attending clinics which remained open or felt 'anxiety so acute that they could not leave home', according to one small study of clinics in East London. Elizabeth H. Rosenberg and E. Guttmann, 'Chronic Neurotics and the Outbreak of War', *The Lancet*, 2, (27 July, 1940), p. 95. For a brief account of the clinics in the first weeks of the war, see George Pegge, 'Notes on Psychiatric Casualties of the First Days of the War', *British Medical Journal*, 2, (14 October, 1939), pp. 764-765; W.H. Whiles, 'Psychiatric Casualties of War', Letter, *British Medical Journal*, 2, (28 October, 1939), p. 881.

peacetime year of 1938.[41] In London, attendance at many of the clinics began to pick up after the end of the bombing raids of the Blitz, and Gavin reported that out of all 44 London clinics there was only one clinic, based in central London, 'where mention was made of any lack of work.'[42] At St. George's Hospital Psychiatric Clinic in central London, staff reported that 'there were very few patients for a time after the outbreak of war and for a period it was just kept alive.' Yet by 1942, the numbers had picked up to 210 new patients, with over 700 patients attending the clinic in total, approximately the same numbers as before the war in 1938.[43] A similar picture was found at other London clinics, such as at the British Hospital for Functional Mental and Nervous Disorders. At this clinic in Camden in North London, patient numbers fell during the Blitz period, despite the clinic being situated in a heavily bombed area. Staff at the clinic believed this was mainly due to the more vulnerable sections of the London population being evacuated, the effects of the black-out, which meant evening sessions at the clinic were no longer possible, and because they thought that the war gave those with neurotic tendencies 'something else to think about.'[44] At the time of their interview with Gavin in 1943, staff reported that patients were steadily returning, and put this down to the lull in air-raids and because people were adapting to moving around in black-out conditions.[45]

[41] The overall figures and comparison with the peacetime year of 1938 are complicated by the fact that the 44 London clinics only returned data from 1942. Blacker, *Neurosis and the Mental Health Services*, pp. 146-148.
[42] TNA MH 51/663, Report from St. Marylebone and Western General Dispensary Psychiatric Clinic.
[43] Ibid, Report from St. George's Hospital Psychiatric Clinic, Hyde Park Corner.
[44] Ibid, Report from The British Hospital for Functional Mental and Nervous Disorders, Camden Road.
[45] Ibid. Psychiatrist Ian Skottowe also noted a pattern of rising admissions in a report from his Buckinghamshire region, which found that by 1942 the number of new outpatients had 'multiplied

Of course, this steady rise in patients attending the clinics was not necessarily a measure of a wider rise in neurosis in the general population. There were multiple reasons for the increase in the numbers of patients attending the clinics – including patients finding it easier to traverse previously bomb-damaged areas to get to the clinics, the re-establishment of transport links in many areas, and the return of some families and individuals from evacuation. Dr. Slater, from the St. George's Hospital psychiatric clinic in London, commented that the 'wartime population of London has altered so much... it is difficult to judge if there is any increase in the incidence of neurosis.'[46] According to Blacker, an assessment of the 'real' trends in neurosis was impossible due to poor record-keeping and the movement and dispersal of local populations. Patients in psychiatric clinics were also rarely followed up after their discharge or if they stopped attending.[47]

Due to confusion over diagnostic categories, Blacker insisted that it was impossible to accurately define 'neurosis', let alone to conclude whether neurotic disorders were connected to the events of the war or were indicative of a greater incidence of neurosis in the general population.[48] Rather, he argued, the 'main

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by about 4 times.' Cited in Anon, 'Conference on Mental Health', *The Lancet*, 2, (6 November, 1943), p. 582.

[46] TNA MH 51/663, Report from St. George's Hospital Psychiatric Clinic. This is the renowned psychiatrist Eliot Slater, who was Clinical Director of the Sutton Emergency Hospital and who wrote, with William Sargant, *Physical Methods of Treatment in Psychiatry*, based on their treatment of mainly military psychiatric casualties. Slater was a strong advocate of somatic theories and physical treatments for war neurosis. See, for example, Eliot Slater, 'The Neurotic Constitution: A Statistical Study of Two Thousand Neurotic Soldiers', *Journal of Neurology and Psychiatry*, Volume 6, (January-April, 1943), pp. 1-16. See also Anon, 'Obituary: Eliot Trevor Oakeshott Slater', *The Lancet*, 1, (28 May, 1983), pp. 1231-1232.

[47] Blacker, *Neurosis and the Mental Health Services*, p. 16. On the lack of follow-up of patients in psychiatric clinics see James Flind, 'Some Practical Considerations in Relation to In-Patient and Out-Patient Treatment in the Psychoneuroses', *Journal of Mental Science*, Volume 85, (September, 1939), p. 890-891.

[48] Blacker, *Neurosis and the Mental Health Services*, p. 16.

cause' of the rise in admissions was 'the attitude towards the clinic of the general practitioners working in the area served by the clinic.'[49] Attendances at the London clinics in particular had risen because of a high level of 'psychiatric awareness', suggested Blacker. Both GPs and the general population were becoming 'alive to the nature of psychiatric problems', he insisted, and were 'gaining confidence in the services provided by psychiatric clinics.'[50]

The rise in the numbers attending the clinics cannot entirely be attributed to whether GPs were aware of the clinics and their services, however. As one retired psychiatrist pointed out in a letter to the *BMJ*, GPs varied in their attitudes towards the clinics. Some GPs boasted that they had never referred patients to a psychiatrist or a psychiatric clinic, while others seeking specialist psychiatric treatment for their patients found that there was no clinic in their neighbourhood. Those who did refer patients to the clinics were often met with complaints that there were inadequate numbers of staff and resources available to meet patients' needs.[51] The most prevalent problem many psychiatrists reported was not that GPs refused to refer patients to the clinics, but that they were forced to send patients *back* to their GPs, due to the shortage of staff and the restriction of the number of clinic sessions, even though this was not necessarily considered the best psychiatric outcome for the patient.

Some psychiatrists worried about what happened to patients dispatched back home due to lack of facilities and staff. The psychiatric clinic at the Central

[49] Ibid, p. 14.
[50] Ibid, p. 15, p. 70.
[51] C. Lodge Patch, 'Planning for Mental Health', Letter, *British Medical Journal*, 2, (27 September, 1941), p. 458.

Middlesex County Hospital in West London, for example, was staffed by just one psychiatrist, Dr. Fitzgerald, who was also the medical superintendent at the large Shenley Mental Hospital in Hertfordshire. He could only attend the clinic on one afternoon per week and the clinic did not offer any treatments. Fitzgerald complained that 90 per cent of the patients had to be 'disposed of at the first interview', and the only patients who returned were cases where there was 'some social difficulty.' Moreover, because there were no facilities for treating patients at the clinic, those patients he thought needed treatment, such as ECT, had to travel over 20 miles from Willesden in West London to Shenley Mental Hospital in Hertfordshire.[52] At the Queen Mary Hospital psychiatric clinic in East London, Dr. Ffoulkes Edwards described how although the clinic offered several sessions of psychotherapy and ECT resources were so limited that 'a number of patients have had to be referred back sooner than desirable and when they are in need of specialised treatment.'[53]

ECT was used much more sparingly as a method of treatment in the psychiatric clinics than it was in mental hospitals. This seemed to be largely due to the wartime staff shortages, and lack of space in the premises used for the clinics, rather than a rejection by medics, or patients, of such physical methods of treatment. At the clinic at the London Hospital, psychiatrist Henry Wilson and social worker Miss Phelps told Gavin that patients and their relatives often asked for ECT treatment, 'possibly because of its tangible, physical character and its mystery.'[54]

[52] TNA MH 51/663, Report from Central Middlesex County Hospital Psychiatric Clinic.
[53] Ibid, Report from Queen Mary's Hospital Psychiatric Clinic, Stratford.
[54] Ibid, Report from London Hospital Psychiatric Clinic, Whitechapel.

Overall, Gavin reported that ECT was carried out at just seven of the 44 London psychiatric clinics, with two other clinics waiting for the machines to arrive.[55] According to William Sargant, who was a great advocate of physical methods of treatment, the low take up of ECT at psychiatric clinics in the early 1940s was due to the caution of health and local authority officials who had, he claimed, 'set their faces at first against the use of electrical shock machines.'[56] Sargant even claimed that outpatients travelled to his London clinics from as far away as Dorset, Bedford and Birmingham in order to receive treatment and so prevent hospital admission.[57] Sargant introduced ECT at St. George's Hospital psychiatric clinic in 1941 and the following year at the outpatient clinic at the West End Hospital for Nervous Diseases, where he conducted a 'trial' of ECT on selected patients. Out of a total of 735 patients who visited the clinic in 1943, 53 patients were selected for ECT. Sargant claimed this experimental treatment had been an overwhelming success, with over two-thirds of patients showing improved mental states after the treatment.[58] For Sargant, ECT had even greater benefits for outpatients than for mental hospital patients. In particular, Sargant suggested that ECT could be a means whereby patients could avoid admission to mental hospitals. This 'advantage' would, he maintained, outweigh any dangers of injuries of the back and limbs that might be caused to patients in its administration.[59]

[55] Ibid, C. M. Gavin, 'Confidential Report to Triumvirate on Out Patient Clinics in the London Area'.
[56] Sargant, *The Unquiet Mind*, p. 108.
[57] Wellcome Collection, PP/WWS/F/5/2/Box 15, William Sargant, 'Draft Paper on Out-Patient ECT Treatment', pp. 1-12, p. 1.
[58] Wellcome Collection, PP/WWS/F/5/1/Box 15. William Sargant, 'Draft Letter Reporting on Work of the Out-Patient Department, 9 March, 1944.
[59] Wellcome Collection, PP/WWS/F/5/2/Box 15, William Sargant, 'Draft Paper on Out-Patient ECT Treatment', p. 12. For the increasing use of ECT during and after war at the St. George's Psychiatric

Many clinics used various forms of drug therapy, such as bromide and evipan, as the main method of treatment for patients. Psychiatrists at the clinics had mixed views on the benefits of such drug use. Psychiatrist Ian Skottowe, who worked at an outpatient clinic in Buckinghamshire, expressed concern about the harmful effects of the use of bromide.[60] Bromide was one of the most commonly used drugs in psychiatric treatment during this period, and, as noted in Chapter Three, it was referred to in the government's wartime directives to medics as a suitable treatment for those suffering from air-raid shock. Skottowe believed that the over-use of this drug, however, could cause dependency and he referred to patients who repeatedly visited outpatient clinics as 'the weekly bromide-toppers'.[61]

The most common treatment mentioned in Gavin and Laird's reports, however, was various limited forms of psychotherapy – although it is not always clear whether this amounted to much more than a brief talk between psychiatrist and patient. The high ratio of patients to staff led to psychiatrists at clinics in West London and Southend introducing forms of group psychotherapy, most renowned for being practiced by psychoanalysts at Northfield military hospital.[62] In the civilian outpatient clinics, such group therapies were introduced largely due to financial pressures and the lack of adequate numbers of psychiatrists. 'Mass' psychotherapy

Clinic see also W.P. Mallinson, 'Outpatient Electric Convulsion Treatment', *British Medical Journal*, 2, (2 October, 1948), pp. 641-645.

[60] Ian Skottowe, 'Psychological Medicine: Current Methods of Treatment', *The Lancet*, 1, (11 March, 1944), p. 331.

[61] Ibid. For an interesting account of the use of the drug evipan as an aid to diagnosis in the clinics, see Ellis Stungo, 'Evipan Hypnosis in Psychiatric Outpatients', *The Lancet*, 1, (19 April, 1941), pp. 507-509.

[62] See Thalassis, 'Soldiers in Psychiatric Therapy', pp. 351-368.

was introduced 'as an experimental method of dealing with the large numbers now attending,' reported Dr. Snowdon at the clinic at Maida Vale Hospital for Nervous Diseases.[63] Patients in groups of 30 or more were given eight weekly lectures on various aspects of their neuroses, followed by a short individual consultation with the psychiatrists, lasting between three to eight minutes. According to Dr. Snowdon, 'the patient is asked whether he or she has understood the lecture, any difficult point is cleared up and if the subject was particularly applicable to that patient's case, the matter is driven home.'[64] How the patients felt about the way information about their diagnosed disorder was 'driven home' is not expanded on in the interview, although Snowden reports that there was a 'high degree of co-operation' between the patients and the psychiatrist, with only two patients considered to be 'not on the right lines.'[65]

As well as the rationing of treatment, psychiatrists also frequently complained about the lack of available inpatient beds for those patients whose condition warranted further observation, but who were not thought to be suitable for admission to a mental hospital. As highlighted in Chapter Four, demands for more inpatient provision for neurotic patients were frequently raised by psychiatrists during this period, and were partly linked to psychiatrists' hope that more psychiatric units could be located in general hospitals.[66] In 1941, for example,

[63] TNA MH 51/663, Report from Maida Vale Hospital for Nervous Diseases Psychological Clinic.
[64] Ibid. See also, E. N. Snowden, 'Mass Psychotherapy', *The Lancet*, 2, (21 December, 1940), pp. 769-770; J. Bierer, 'Group Psychotherapy', *British Medical Journal*, 1, (14 February, 1942), pp. 214-217.
[65] TNA MH 51/663, Report from Maida Vale Hospital for Nervous Diseases Psychological Clinic.
[66] Blacker's report has a section on the establishment of closer links between general and mental hospitals, and recommends the setting up of psychiatric units separate from mental hospitals for 'early and remedial' cases. Blacker, *Neurosis and the Mental Health Services*, pp. 55-56; pp. 62-69;

a British Medical Association (BMA) Committee, as part of discussions about future mental health services, advocated the setting up of 'special psychiatric hospitals' to receive and treat those diagnosed with neuroses or minor psychoses who were judged as having 'acute' and 'recoverable' conditions.[67]

The psychiatrists interviewed by Gavin and Laird reiterated these demands for inpatient treatment separate from the mental hospitals. These practitioners claimed that without the provision of such beds they risked sending patients back to family doctors who were often not professionally trained in psychological medicine. At the St. John's Hospital psychiatric clinic in South-East London, for example, Gavin reported that, 'the complaint is that such patients are pushed home after a very short time and alleged to have been given no definite treatment.'[68] In the North West region, Laird bemoaned that 'there are at present no facilities for inpatient treatment of civilian neurosis.'[69] The Neurosis Centre at an EMS Hospital in Southport, for instance, only admitted current and former service patients, and 'Ministry of Pensions' cases.[70] Laird highlighted how 'feeling runs high' in the community about 'empty beds at Southport'. There were 'numbers of people, especially of men discharged from the Forces', she maintained, who were 'in urgent need of treatment', but who could not be treated due to the demand on the

p. 63; See also, Flind, 'Some Practical Considerations in Relation to In-Patient and Out-Patient Treatment in the Psychoneuroses', p. 886-891; Dalton E. Sands, 'Treatment of Psychiatric Patients in General Hospitals', *British Medical Journal*, 1, (22 May, 1943), pp. 628-630.

[67] Anon, 'Planning for Mental Health: Report of B.M.A. Committee', *British Medical Journal*, 2, (23 August, 1941), p. 277.

[68] TNA MH 51/663, Report from St. John's Hospital Psychiatric Clinic, Morden Hill, Lewisham.

[69] Ibid, Isobel Laird, 'N.W. Region. Report on Fieldwork,' p. 32.

[70] Ibid. The admittance of civilian patients to the neurosis centres was to some degree dependent on the requirement of the Ministry of Pensions from 1941 that any civilian claiming compensation for psychological injuries due to the war must be admitted to a neurosis centre in order to qualify for compensation. See Chapter Three.

overcrowded clinics.[71] The neurosis centres were thus viewed as prioritising military patients, and civilians claiming compensation for war injuries, at the expense of those civilians who were in acute need of psychiatric treatment, but who were forced to rely on inadequate and overcrowded outpatient facilities.

Staff shortages and rising numbers of attendances also resulted in some clinics introducing a rigorous selection of patients. The Tavistock Clinic, for example, lost two-thirds of its doctors when the clinic relocated to Hampstead, as male staff were called up for military service or sent to EMS hospitals.[72] This resulted in some 400 people being stuck on the waiting list for over one year, although that number had been reduced to 50 by the time of the inspector's visit in 1943. As Dr. Maberley reported, the waiting list was reduced 'by a greater degree of selectiveness in patients and by shortening the length and type of treatment available.'[73] In the London region, half of the 44 clinics held only one half-day session per week at the time of Gavin's visit, and five clinics had suspended their services, due to lack of staff and bomb damage.[74] Dr. Grey Clark from West London was one of several psychiatrists interviewed by Gavin who bemoaned that too many patients and too few staff resulted, 'in a high degree of selection to cope with the pressure of work.'[75] As Dr. Slater at St. George's Hospital psychiatric clinic pointed out, the number of patients tended to increase in line with the number of services that were

[71] Ibid.
[72] J. R. Rees, 'The Tavistock Clinic', Letter, *American Journal of Psychiatry*, Volume 97, (September, 1940), p.482.
[73] TNA MH 51/663, Report from the Tavistock Clinic.
[74] Ibid, C. M. Gavin, 'Confidential Report to Triumvirate on Out Patient Clinics in the London Area', p. 1.
[75] Ibid, Report from West End Hospital for Nervous Diseases Outpatient Department.

offered. If his clinic were to meet daily instead of weekly, Slater speculated, 'it would probably be full every day.'[76]

The long waits and the introduction of appointment systems often deterred patients from attending the clinics altogether. This was the view expressed by Miss Morris, the almoner at the psychiatric clinic based in St. Thomas's Hospital in London. She worried that when patients had to wait for appointments 'there was a real risk of missing the right moment.' 'Patients coming to see the psychiatrist for the first time frequently had to screw up the courage,' she believed, and 'if an appointment were not immediately available, their courage would ebb and they might refuse to go at a later date.'[77] Patients with neurosis could also be misdiagnosed as having a physical disorder. According to Morris, many neurotic patients were not seen by the psychiatric clinic but treated in the Casualty department, and ended up being diagnosed with various physical illnesses.[78] Morris's observation highlighted the difficulties that doctors and social workers faced in making distinctions between the underlying aetiology of illnesses that were manifested in physical symptoms but that were believed to have a psychological aetiology. In his report, Blacker referred to these difficulties in diagnosis as an 'almost uncharted no-man's land between psychological and physical illness,' which had made it almost impossible for medics to define what symptoms constituted a diagnosable neurotic condition.[79]

[76] Ibid, Report from St. George's Hospital Psychiatric Clinic.
[77] Ibid, Report from St. Thomas' Hospital Department of Psychological Medicine.
[78] Ibid. Psychosomatic manifestations of neurosis will be considered further in Chapter Six.
[79] Blacker, *Neurosis and the Mental Health Services*, p. 16.

These reports illustrate the difficulties psychiatrists and clinic staff experienced in attempting to classify the types of nervous disorders they encountered and treated at the clinics. As will also be shown in my examination of non-institutional sites of psychiatric practice during the war, there was no agreement among doctors about how neurosis should be defined, the boundaries between organic and functional disorders, and what symptoms could be viewed as part of the 'normal' spectrum of behaviour and emotions. The boundaries between different nervous conditions seemed ever more permeable as doctors focused on civilians whose behaviour and symptoms were not considered disabling enough to warrant hospitalisation.

Whether psychiatrists' decisions about which patients should be hospitalised were influenced by the lack of available beds and shortages of staff in the overcrowded mental hospitals is difficult to ascertain. Many of the psychiatrists Gavin interviewed articulated the view that mental hospitals were not the most suitable places for patients with neurotic conditions. These doctors insisted that there was an urgent need for inpatient provision that was separate from the mental hospitals with their large numbers of long-term patients with psychotic conditions and seriously disturbed behaviour. Psychiatrists thereby made a distinction between psychotic patients in mental hospitals and neurotic patients visiting the clinics. Despite the close association between mental hospitals and clinics, psychiatric opinion increasingly favoured treating patients with minor conditions outside of mental hospitals, even if they were thought to be disturbed enough to need inpatient treatment.

Ex-service patients

The investigations in the London and North West of England areas gave only a glimpse of the lives of the people who made up the patient population at the clinics. To a large extent, the backgrounds of the clinic patients varied according to the wider population in the area in which the clinic was situated. In Gavin's interviews with psychiatrists from the East End and central London, for example, there are several references to the working-class backgrounds, and the Jewish ethnicity, of some of the patients.[80] There is little explicit commentary on these references to class and race in Gavin's reports from the London clinics, apart from her note that this patient population merely reflected the make-up of the surrounding area.

There was one group of patients who were more frequently referred to in the reports, and who seemed to cause particular concern – former military servicemen who had been discharged from the forces on the grounds of neurosis. In his letter to the Ministry of Health, Lewis noted that in 1941 alone there had been 12,000 discharges from the services due to neurosis, a figure which Lewis believed was likely to grow as the war continued.[81] In Gavin's interviews, psychiatrists frequently raised the problem of ex-servicemen overwhelming the clinics. According to Dr. Strauss from St. Bartholomew's Hospital, which held one of the larger outpatient psychiatric clinics in London, neurotic and psychopathic cases

[80] Ibid, Report from London Hospital Psychiatric Clinic, Whitechapel; Report from Queen Mary Hospital Psychiatric Clinic, Stratford; Report from St. Bartholomew's Hospital Department of Psychological Medicine.
[81] TNA MH 76/115, Letter from Aubrey Lewis, Mill Hill Emergency Hospital to Professor F. R. Fraser, Ministry of Health, 4 March, 1942.

discharged from the forces had come to 'swell the numbers attending the civilian out-patient clinics where there are insufficient staff to cope with them.'[82]

This language of ex-service patients 'swelling' the numbers of patients visiting the clinics is repeated in several reports from the London clinics, which had double the number of ex-service patients than the rest of England and Wales.[83] Blacker surmised this was largely due to the reputation of London clinic's for treating minor disorders, along with better transport links and accessibility.[84] One psychiatrist, Dr. Ewen at the West Middlesex County Hospital Psychiatric Clinic, told Gavin that he believed the increase in neurosis in the general population had 'chiefly occurred among patients who have been actually called up and then discharged from the Services.'[85] For Ewan, some of these men broke down because they had been uprooted from their families and usual environment, and may not have suffered a nervous breakdown if they had continued in civilian life. 'These patients are chiefly psychoneurotics suffering from a feeling of failure and shame,' Ewen asserted.[86] After discharge from military hospitals or neurosis centres, ex-service patients were allowed to drift in the community before eventually ending up at a psychiatric clinic, suggested the staff from St. John's psychiatric clinic in Lewisham. According to Gavin, 'mention was made of the bad time-lag (which may be anything up to two years between the date of their discharge from the Army and the date of their coming to the clinic.'[87] However, the notion that the clinics were

[82] TNA MH 51/663, Report from St. Bartholomew's Hospital Department of Psychological Medicine.
[83] Ibid, Report from University College Hospital. Interview with Dr. Dillon and psychiatric social worker Miss Pratt Yule.
[84] Blacker, *Neurosis and the Mental Health Services*, p. 171.
[85] TNA MH 51/663, Report from West Middlesex County Hospital Psychiatric Clinic.
[86] Ibid.
[87] Ibid, Report from St. John's Hospital Psychiatric Clinic, Morden Hill, Lewisham.

'swamped' by ex-military patients was not borne out by the overall figures for clinics in England and Wales, which showed that of 41,982 new cases attending the clinics, just 1,056 had been discharged from the forces, with ex-service patients making up just 2.5 per cent of the total number of patients at the clinics.[88] The interviews with London psychiatrists nevertheless reflected a much wider concern about the lack of after-care and subsequent psychiatric problems experienced by former servicemen, which would increasingly come to the fore as a political issue through the course of the war.[89]

The psychiatrists interviewed by Gavin rarely depicted former servicemen as men whose psychological problems had been caused by traumatic military experiences during the war. Rather they viewed such men as part of a group psychiatrist Louis Minski characterised as 'the chronic neurotics of peace-time, who should never have been enlisted into the services.'[90] Minski distinguished between those whose mental disorder had been caused by the severity of their wartime experiences, such as among the soldiers who had fought at Dunkirk, and men whose mental problems existed prior to their military service, and who had a history of poor work records.[91] Reiterating the division between acute and

[88] Blacker, *Neurosis and the Mental Health Services*, pp. 170-171.
[89] Anon, *Report of Inter-Departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*; TNA MH 100/5, Board of Control Monthly Conference No. 104, 8 December, 1943. There were also a host of reports in psychiatric journals from 1943 onwards about the psychiatric problems of ex-service personnel. See, for example, Aubrey Lewis, 'Social Effects of Neurosis', *The Lancet*, 1, (6 February, 1943), pp. 168-169; Harry Stalker, 'Psychiatric States in 130 ex-service Patients', *Journal of Mental Science*, Volume 90, (January, 1944), pp. 727-738; Aubrey Lewis and K. Goodyear, 'Vocational Aspects of Neurosis in Soldiers', *The Lancet*, 2, (22 July, 1944); pp.105-109; For the psychiatric problems of women discharged from the auxiliary services, see S.J. Ballard and H.C. Miller, 'Psychiatric Casualties in a Women's Service', *British Medical Journal*, 1, (3 March, 1945), pp. 293-295.
[90] Louis Minski, 'Rehabilitation of the Neurotic', *Journal of Mental Science*, Volume 89, (July, 1943), p.391.
[91] Ibid, p. 392.

intractable psychiatric conditions, Minski considered soldiers returning from the front-line as mainly having temporary, and curable, conditions, whereas 'chronic neurotics' were harder to rehabilitate. He even suggested the majority of former servicemen had only been able to hold down jobs after discharge from the services because of 'indulgent employers' who allowed them to take time off to attend psychiatric clinics. They were, he argued, 'kept going by means of short psychological talks and a bottle of medicine.'[92]

This view of ex-service patients as being a drain on psychiatric services is replicated in Blacker's survey, with such patients being viewed as part of a 'residuum' or 'reservoir' of untreatable cases 'upon whom all efforts are wasted.'[93] Indeed, the survey is permeated with the language of Blacker's eugenicist beliefs, with patients with long-term conditions described as descending 'in vast multitudes upon the psychiatric clinics of this country'.[94] Similar views were expressed by some of the psychiatrists interviewed by Gavin. She reports that Henry Wilson, the main psychiatrist working at the psychiatric clinic based at the London Hospital in Whitechapel, believed that the war had brought to the fore 'a horrifying number of psychopathic personalities', who had 'lived the life of a parasite and who have never done anything in their lives, being either supported by allowances or content to remain on the dole.'[95] In this view, the clinics had provided a space for an existing pool of 'problem' civilians, including ex-service personnel, who had a tendency to malinger and to misuse the services provided. Their nervous

[92] Ibid, p. 392.
[93] Blacker, *Neurosis and the Mental Health Services*, p. 107.
[94] Ibid, p. 107, p. 15.
[95] TNA MH 51/663, Report from London Hospital Psychiatric Clinic, Whitechapel.

complaints were embedded in their pre-war personalities and psyches rather than being a direct result of traumatic experiences or the longer-term effects of the war.

Not due to the war?

Whether or not the rise in outpatient numbers represented a 'real' increase or underestimated the incidence of neurosis in the population, Blacker was adamant in his conclusion that any rise in attendances was not due to the effects of air-raids. Blacker stated in his report that

> In view of the total physical casualties caused by air-raids and of the stresses which they caused, it is remarkable that, in only about one case in thirty was the patient's disability connected by the psychiatrist with air-raid experiences.[96]

How did Blacker reach this conclusion? Firstly, it is worth emphasising that the results were based on psychiatrists' subjective judgement at the time of the questionnaire that the neurotic cases they treated in 1940-42 were not due to air-raids. This captured psychiatric views of a particular phase of the war rather than its entire duration. Secondly, the psychiatrists completing the survey were directed in their answer by the way that Blacker constructed the questions. In order to ensure that incidences of psychological breakdown could definitely be attributed to the war, Blacker asked psychiatrists to state whether the patient had suffered from a psychiatric condition before 1940, and also to state if the patient had been the victim of a direct physical injury. Blacker thus followed the Ministry of Pensions'

[96] Blacker, *Neurosis and the Mental Health Services*, p. 12.

strict definition of what cases could be defined as psychiatric casualties. The wording of the questionnaire was predicated on the assumption that air-raids would *not* be the primary causal factor in the development of neurosis for the majority of patients. As Blacker wrote when preparing the questionnaire, 'The phrase "associated with air-raids" is designedly used in preference to "caused by air-raids" because, in many cases, it is doubtful the air-raids are the real cause of the disability.'[97] Similarly, an assumption was embedded in questions about whether a patient's neurosis could be verified as being caused by air-raids by whether or not they also had a physical injury. As the guidance notes issued to psychiatrists stated, this question was aimed at

> separating persons who are involved in the experience of a direct physical character such as blast or falling masonry from those who were merely exposed to fears or to indirect stresses as are involved in life in shelters or through evacuation.[98]

The responses to this question in the survey showed that just over one-fifth of those categorised as having a psychological injury due to the effect of air-raids had also sustained a physical injury, with a lower proportion of patients with a physical wound presenting at the clinics in small towns. Psychiatrists thus believed that a large majority (four-fifths) of patients whose disorders were classified as being 'associated' with air-raids had not been physically injured.[99] However, in his assessment of these results Blacker emphasised that he believed these patients had

[97] Wellcome Collection, PP/CPB/D.5/1 'C. P. Blacker. Ministry of Health: Neurosis Survey: Report, analysis sheets, 1942-1944 and 1943 Letters from Ministry of Health'. 'Notes on the Questionnaire', p. 5.
[98] Blacker, *Neurosis and the Mental Health Services*, p. 165.
[99] Ibid, p. 168.

suffered less stress and trauma than those who had also suffered physical wounds. These patients included, he argued, 'timid and excitable people who left the scene of danger quickly, and complained of symptoms later, without having experienced stress which would be accounted severe by objective standards'.[100] Blacker also adopts a rather sceptical tone to the idea that his investigations could rely on subjective accounts from patients. 'The sound of a siren constitutes a shock to some people,' wrote Blacker in a rather dismissive way, especially in light of psychiatric reports that emphasised how the sounds of the war could induce terror.[101] On top of this, Blacker claimed that 'air-raid stories have been known to undergo a measurable distortion or secondary elaboration in a very short time.'[102] Like many medics at the time, he expressed scepticism about the accuracy of the accounts patients themselves gave about how their traumatic experiences in air-raids were the cause of their neurotic symptoms.

Blacker not only made huge assumptions as to what could be considered an 'objective' level of stress, but he also contradicted much psychoanalytical theorising about war neurosis which maintained that physical injuries mitigated against the development of neurosis.[103] Blacker's construction and interpretation of the questions, and the assumptions embedded in them, in many ways prefigured the survey's main conclusion that air-raids had not led to a significant rise in neuroses. This is not to suggest that Blacker's conclusion was in some way mistaken. Rather it is to indicate that the prior assumptions about the causes and manifestations of

[100] Ibid, p. 169.
[101] See Chapter Six for psychiatrists' views on how the sounds of the war produced feelings of fear and anxiety.
[102] Ibid, p. 165.
[103] See Freud, *Beyond the Pleasure Principle*, p. 6, p. 27.

neurosis shaped the results of the survey and the subsequent narrative about how the war had not resulted in significant numbers of psychiatric casualties.

The question of what psychiatrists actually meant by being caused by 'the war' also warrants further interrogation. In Blacker's report, as in nearly all wartime reports about civilian neurosis, being caused by 'the war' was seen as synonymous as being caused by air-raids. Although nearly all of the psychiatrists interviewed for Blacker's survey maintained that the experience of air-raids had not led to the development of neurotic disorders, they nevertheless often attributed the onset of neurosis to the wider and longer-term effects of the war, citing factors such as the disruption to routine, the dislocations of social life, homelessness, lack of services, transport disruption, black-outs and the effects of fatigue and loneliness following separation from or the death of loved ones. As Gavin reports from St. Thomas's Hospital clinic, 'In Miss Morris' opinion, the main contributory causes of nervous breakdown at present were: short holidays, long hours and bad travelling conditions, resulting in cumulative fatigue even among the normal population.'[104] Other psychiatrists reported seeing cases showing 'the after-results of war conditions – e.g. shock of loss of business, home or relatives, loneliness due to separation, etc.'[105] Noel Harris, psychiatrist at the Middlesex Hospital psychiatric clinic, thought people had 'stood up well to the acute distress of the war and the air-raids' and had 'not cracked when the Blitz was on.'[106] But in the lull in bombing raids after 1941, Harris identified how the relentless social conditions of war were

[104] MH 51/663, Report from St. Thomas's Hospital Department of Psychological Medicine.
[105] Ibid, Report from Croydon General Hospital Psychological Department.
[106] Ibid, Report from Middlesex Hospital Psychiatric Clinic, Mortimer Street, London.

resulting in the manifestation of nervous conditions. What upset his patients, he remarked, was the

> complete disturbance of normal life, particularly women separated from their husbands and if pregnant having to face child-birth alone, or those who had to leave their homes and are in unfamiliar surroundings, or those whose children have been evacuated – and this situation is becoming worse.[107]

The disruption to family life, and the absence of men, was frequently referred to by psychiatrists as an example of how the 'abnormality' of war conditions created psychological problems. As Gavin remarked in her report on the clinics, the absence of men caused an 'absence of disciplinary control' in family life, which had implications for the mental health of the woman left behind to cope with bringing up a family alone and taking on new tasks. The war was seen, suggested Gavin, 'as ushering in loneliness for the wife parted from her husband.' She had 'no one to talk over her troubles', or faced living with strangers, and having her daily routines disrupted.[108] These worries about the effects of the war on women, and on relationships within the family, were often couched in rather gendered language, which presumed that women would not be able to cope, practically or emotionally, without men. These fears of the destabilising effect of the changes to gender roles and responsibilities were often remarked upon in psychiatric reports during the war period, and will be examined in more detail in Chapter Seven.

[107] Ibid.
[108] Ibid, C. M. Gavin, 'Confidential Report to Triumvirate on Out Patient Clinics in the London Area', p. 5.

Psychiatrists also articulated a more general concern about nervous destabilisation, which psychiatrist Ian Skottowe described as a 'long wearing process of maintaining abnormal ways of life.'[109] Even if air-raids had directly produced few cases of hysteria, the war was imposing, in Skottowe's view, 'abnormal ways of living', which emphasised the close connection between social conditions and mental health. What was crucial was the way in which the individual adapted to the new social conditions in which they lived, and the 'prolonged series of stresses' brought on by war conditions.[110] As an editorial writer in the *BMJ* commented at the end of the war, in a war where civilians were involved as never before, the clinical work at psychiatric clinics would reflect the wartime experiences of the population. 'States of anxiety associated with bombing, with casualties or possible casualties among relatives at home and over-seas, and with strange work and conditions of work, including direction away from home, are all reflected in the problems to be dealt with', remarked the author.[111]

Many psychiatrists believed that long-term, chronic neurotic conditions could develop in response to the more relentless, day-to-day pressures of life induced by the war. Many psychiatrists in Blacker's survey worried about the possibility of cases of latent neurosis developing, especially after the war. Over a half of those psychiatrists responding to Blacker's question stated they feared that

[109] Ian Skottowe's reported speech at a one day conference of the Provisional National Council for Mental Health on 29 October, 1942. Anon, 'Conference on Mental Health', *The Lancet*, 2, (6 November, 1942), p. 582. A similar view is put by the psychologist P. E. Vernon, 'Psychological Effects of Air-Raids', *Journal of Abnormal and Social Psychology*, Volume 36, (October, 1941), p. 462; p. 466.
[110] Ian Skottowe, 'Psychological Medicine: Current Methods of Treatment', p. 329; The quote is from Dorothy Odlum, cited in Anon, 'Effect of War Conditions on Mental Health', *British Medical Journal*, 2, (13 November, 1943), p. 618.
[111] Anon, 'Wartime Work of Psychiatric Clinics', *British Medical Journal*, 2, (6 October, 1945), p. 467.

high levels of neurosis were likely to manifest after the war.[112] The fear that the war was harbouring future psychiatric problems was even remarked upon by inspectors of the Board of Control who contemplated that the low level of psychiatric casualties may be 'a postponement of a liability'.[113] The worry about the development of future psychiatric problems once the hostilities were over was also a recurring theme in Lewis's writings. The manifestation of mental illness during the war itself was far from being a 'safe index' of 'what is really happening to the mental health of the community,' Lewis suggested. 'The evil harvest may be reaped afterwards,' he wrote.[114] Concerns about the development of chronic mental conditions after the war was, of course, speculative. It was often based, however, on psychiatrists' analyses of the current conditions of their own patients, and was in contrast to many published psychiatric reports which emphasised how well the civilian population had stood up to the war. As Henry Wilson wrote in the *BMJ*, 'despite the optimistic tone of some writings, my own experience is that even with enthusiasm and evipan narcosis chronic conditions are developing.'[115]

Psychiatrists' views on the psychological effects of the war on the civilian population were more complex than has often been portrayed in histories of psychiatry during the war. Although many psychiatrists emphasised that air-raids had not led to the astronomical numbers of psychiatric cases feared before the war, the cases seen in the psychiatric clinics led psychiatrists to be concerned about the

[112] Blacker, *Neurosis and the Mental Health Services*, p. 13.
[113] TNA MH 51/663, 'Board's Annual Report for 1941', Board of Control Monthly Conference No.98, Wednesday 2 December, 1942. The report's circulation was restricted to Board of Control Commissioners and Inspectors.
[114] Aubrey Lewis, 'Mental Health in War-Time', *Public Health*, Volume 57, (December, 1943), p. 27.
[115] Henry Wilson, 'Mental Reactions to Air Raids', *British Medical Journal*, 1, (7 March, 1942), p. 286.

effects of years of wartime conditions and to worry about the development of chronic neurosis after the war.

Conclusion

This chapter has provided an account of the material facilities and psychiatric practice at a selection of outpatient clinics during the war, highlighting an often unacknowledged growth in demand for civilian psychiatric services. Clinic patients traversed war-damaged areas, and queued in dilapidated, cold, blacked-out and crowded rooms and corridors in order to seek psychiatric help. The reports examined here have shown that, despite the stigma attached to mental illness in this period, patients were also prepared to forego privacy as well as comfort when they visited the clinics.

Whether the rise in the numbers visiting the clinics was a sign of an increasing incidence of neurosis in the civilian population was a matter of debate among psychiatrists, government inspectors and social workers, many of whom admitted they found it impossible to assess wider trends. Historians Marijke Gijswijt-Hofstra and Harry Oosterhuis have noted that in twentieth-century psychiatry 'to some extent supply increasingly created demand.'[116] In some ways, the wartime conditions and lack of staff showed the obverse – that the severe limitations of the availability of clinic sessions and staff determined the numbers of patients who visited the clinics. As the Chair of the Board of Control, Sir Laurence

[116] Gijswijt-Hofstra and Oosterhuis, 'Introduction: Comparing National Cultures of Psychiatry', in Gijswijt-Hofstra, Oosterhuis, Vijselaar and Freeman (eds.), *Psychiatric Cultures Compared*, p. 15.

Brock, put it in his speech at the annual Maudsley Lecture in 1946, the needs of patients had been conditioned by the availability of staff rather the numbers of staff determined by the needs of the community.[117]

Blacker admitted in his report that the extent of neurosis in the wider population was open to dispute, but he was unequivocal in his conclusion that air-raids had not led to a significant increase in psychological disorders, a conclusion which has formed the basis for many subsequent historical accounts. In this chapter, I have examined the assumptions which underpinned this conclusion, and which led to a downplaying of the traumatic effects of air-raids. In this, Blacker's report reiterated and reinforced the restricted definition of what constituted a psychiatric casualty contained in documents and directives issued by the Ministry of Health and the Ministry of Pensions.[118] Moreover, if the numbers of patients at the clinics could not be viewed as an indicator of the real level of neurosis in the population, then neither could the numbers defined as psychiatric casualties be an accurate reflection of psychological suffering due to the war. The complexity of civilians' psychological responses to the war is indicated by the number of psychiatrists cited in this chapter who feared the longer-term consequences for civilians who had lived through years of wartime hardships and stresses.

There were a range of patients at the public psychiatric clinics, including some who had been long-term mental hospital patients and others who had been discharged from the armed forces, as well as those referred by family doctors. Not

[117] Sir Laurence G. Brock, 'The Twentieth Maudsley Lecture: Psychiatry and the Public Health Service', *Journal of Mental Science*, Volume 92, (April, 1946), p.291.
[118] See Chapter Three.

all of these patients had experienced bombing-raids first hand, and it can be assumed that many would have been referred to the clinics even if there had not been a war. In the next chapter, I explore the psychiatric judgement and treatment of those civilians who had been the victims of air-raids, and who received psychiatric attention on the 'front lines' of the home front, including at First Aid Posts, Rest Centres, GP surgeries and at public air-raid shelters.

Chapter 6: Psychiatric first aid

> After the May blitz, when she was imprisoned, she was in bed for a fortnight. She dreamt of raids and used to lie awake imagining horrors. She could not forget the death of her sister's children and used to cry all day. She had headaches and fits of dizziness and was terrified of the siren.

Mrs. C was a housewife living in a heavily raided working-class area in Hull. She was married to a worker at the port and looking after their four children, including a two-year old baby. She had previously been bombed-out of two homes but the May blitz, to which this quote refers, was a devastating raid, which demolished Mrs C.'s home altogether. During it she was trapped in the rubble for three-quarters of an hour before being rescued. Her sister, along with her five nieces and nephews, were all killed in a raid in the same year.[1] Mrs. C's heart-breaking story was not unusual among those civilians who lived in the most heavily bombed cities, ports and towns during the Blitz period of 1940-41, and their story has been told in many subsequent histories of the Blitz. Less explored by historians has been the way in which the types of nervous symptoms experienced by civilians like Mrs. C, who had directly experienced bombing raids, were conceptualised, explained and diagnosed by the psychiatric and medical profession during the war.

The government's directives to psychiatrists, social workers, civil defence workers and medics working with air-raid victims at First Aid Posts, Rest Centres and other sites in the vicinity of air-raids insisted that 'emotional shock' would be temporary, and such civilians should be treated swiftly, with firm reassurance,

[1] The Zuckerman Archive, SZ/OEMU/57/5/4, Appendix 2, 'Some Illustrative Case Histories', Case 37.

appeals to patriotism, cups of sweet tea, and dosages of bromide or other barbiturate-type drugs.[2] As noted in Chapter Three, some psychiatrists seemed to dissent from this view of temporary emotional shock, based on the patients they observed in the aftermath of raids. In this chapter, I also suggest that civilians' psychological reactions to bombing were much more multifaceted and diverse than encompassed by the notion of a collective psychological resilience.[3]

I begin the chapter by examining psychiatric practice at three major areas of 'front line' treatment – First Aid Posts, Rest Centres and at GP surgeries. I explore how psychiatrists, doctors and social workers conceptualised and treated the symptoms of those civilians whose lives had been devastated by the material destruction and social hardships wreaked by the bombing. I follow this with a detailed analysis of a major study conducted among the working-class population of the port city of Hull, where people like Mrs. C experienced and coped with some of the most relentless raids of the war without receiving psychiatric attention. As part of this analysis, I also look at official attitudes to those in Hull, and in Bristol, who nightly trekked out of the vicinity of the night-time Blitz, and who were often singled out by official government and medical authorities as forming part of a mentally unstable section of the population. In the final section of the chapter, I focus on the concerns of some social observers who speculated that the official emphasis on civilian stoicism had resulted in a host of individual psychological

[2] Anon, 'Neuroses in Wartime: Memorandum for the Medical Profession', p. 1201. For more details see Chapter Three.
[3] For this chapter, I have found Mark Honigsbaum's exploration of the cultivation of stoicism at the end of the First World War and during the 1918-19 Spanish influenza pandemic particularly helpful. Mark Honigsbaum, 'Regulating the 1918-19 Pandemic: Flu, Stoicism and the Northcliffe Press', *Medical History*, Volume 57, (2013), pp. 165-185.

problems remaining undiagnosed and untreated, and possibly shoring up psychological problems for the future.

First Aid Posts

The government, with the aid of local authorities, established a network of hundreds of First Aid Posts at the start of war. These were designed to provide prompt treatment for the expected mass physical and psychiatric casualties resulting from bombing attacks.[4] The First Aid Posts were established in makeshift accommodation, such as requisitioned school buildings, Church halls or rooms in hospitals and other local authority buildings. They were staffed mainly by ARP wardens and other civil defence workers, along with volunteers from the Red Cross and St. John's Ambulance and other voluntary organisations.[5] In government planning, it had been envisioned that the primary work of the posts would be to treat minor physical injuries to prevent hospitals being swamped with patients.[6] Nevertheless, many of the posts had a psychiatrist, usually from the nearest mental hospital, attached to them. In addition, psychiatric social workers from the Mental Health Emergency Committee were loaned to the First Aid Posts to provide

[4] By mid-1940 there were 2,000 equipped and staffed First Aid Posts and 880 mobile aid units. Titmuss, *Problems of Social Policy*, p. 188

[5] TNA MH 76/355, First Aid Posts 1940-41; MOA File Report 271, 'Notes on Air-Raids in Portsmouth', June 1940, p. 2.

[6] Anon, *Statement Relating to the Emergency Hospital Organisation, First Aid Posts and Ambulances*, pp. 19-20; Calder, *The People's War*, p. 188.

emergency psychiatric assistance and practical help with finding suitable billets for those suffering nervous problems.[7]

The posts were organised along military lines, with a reception area for admitting casualties, a treatment area and a rest area, although conditions were often chaotic, especially in the immediate aftermath of air-raids.[8] Priority was given to treating those with physical injuries. Medical staff, civil defence workers and volunteers were 'concerned almost exclusively with organic conditions,' according to Glover, with few measures in place to deal with the psychological effects of people's injuries and experience.[9] Immediate social needs were also prioritised over the treatment of psychological disorders. Bombed-out victims needed food and shelter, clothing and temporary accommodation. Their possessions had to be salvaged from wrecked homes and they required immediate financial assistance to help them survive the disaster.[10] According to one psychiatric social worker, Miss R. Thomas, so much practical help was needed, that only those with serious mental disturbances were identified. At a post she was attached to in Southampton she reported that

> Everyone is occupied with supplying the material needs of the population, and there is so much uncertainty, anxiety and excitement amongst those who have

[7] TNA CAB 102/719, Annual Reports of the Mental Health Emergency Committee; CMAC Wellcome Collection SA/MAC/E.5/6. See Chapter Three for the setting up of the Mental Health Emergency Committee.
[8] TNA MH 76/354, First Aid Posts, 1939-41; TNA MH 76/355, First Aid Posts, 1940-41.
[9] Glover, 'Notes of the Psychological Effects of War Conditions on the Civilian Population, (III)', p. 17, p. 20.
[10] Juliet Gardiner, War*time Britain 1939-1945*, (London: Headline Books, 2004), p. 391.

been rendered homeless that only the more severe forms of psychosis, mental deficiency and epilepsy show themselves.[11]

Despite the priority given to treating physical injuries and providing material support for the dispossessed and homeless, there were significant cases of 'emotional shock', the conceptualisation of nervous reactions to bombing that had been highlighted in the government's instructions to medics early in the war.[12] Government figures showed that in 1941 some 700 new cases of emotional shock were treated every week at First Aid Posts, amounting to nearly one-fifth of all casualties. Yet the government's strict rules on claiming compensation, discussed in Chapter Three, meant that emotional shock was given as the reason for making the claim in just five per cent of all cases which came to the attention of the Ministry of Pensions.[13] Many shocked bomb victims did not see a psychiatrist, but were treated by ARP wardens, volunteer first aiders, and psychiatric social workers in attendance at the First Aid Posts.

The psychiatric treatment offered to victims of emotional shock was swift and often rudimentary – a kind of 'mental health first aid,' as one social worker described it.[14] The immediate effect of an air-raid, wrote the author of a Mass Observation report about a First Aid Post in Portsmouth was 'tremendous psychological shock'. But this was 'not shock in the nervous sense', but rather a 'mental blackout'. A distinction was thus made between immediate, and

[11] TNA CAB 102/719, Mental Health Emergency Committee: Summary of Workers' Reports 1.1.41, p.3.
[12] Anon, 'Neuroses in Wartime: Memorandum for the Medical Profession', p. 1201. For more details see Chapter Three.
[13] TNA PIN 15/2208, Civilian Neurosis. First Aid Posts.
[14] Pricilla Norman, 'Some Preliminary Notes on Mental Health Work for Air Raid Victims', *Mental Health*, Volume 1, (January, 1941), p. 4.

presumably temporary, reactions to raids and diagnosable neuroses, which were seen to have more deeply-rooted causes.[15] According to social worker Doris Odlum, most cases of shock were treated with 'a cup of hot tea with plenty of sugar, or failing that, sal volatile and hot water followed by a lump of sugar.'[16] Another social worker, Mildred Scoville, suggested that relief from the emotional tension induced by the raids could be provided by 'such simple things as an attentive ear, a little hand holding and suggestion.'[17]

Many of the social workers and civil defence volunteers at First Aid Posts were trained to encourage air-raid victims to accept their feelings as a 'normal' reaction to the raids, and not as a sign or cowardice or weakness, or an indication of a more serious mental illness. The National Council for Mental Hygiene, one of the organisations that formed the Emergency Mental Health Committee, organised well-attended public lectures, with between 400 and 1,000 people in attendance, to deliver this message.[18] The idea that civilians needed to admit to and embrace their fears was also encapsulated in a film made by the Council entitled *Fear and Peter Brown*, which was screened at selected West End cinemas in London. Its main message was the need for individuals to admit their fears and to not feel ashamed if they were frightened, a point explicitly made in the original title of the film, *Make Friends with Fear*.[19]

[15] MOA File Report 271, 'Notes on Air-Raids in Portsmouth', June 1940, p. 2.
[16] Doris M. Odlum, 'Some Wartime Problems of Mental Health', *Mental Health*, Volume 2, (April, 1941), p. 35; Norman, 'Some Preliminary Notes on Mental Health Work for Air Raid Victims', p.2.
[17] Mildred C. Scoville, 'Wartime Tasks of Psychiatric Social Workers in Great Britain', *American Journal of Psychiatry*, Volume 99, (November, 1942), p. 360.
[18] Anon, 'News and Notes', *Mental Health*, Volume 1, (July, 1940), p. 82.
[19] Ibid, p. 51, p. 82.

In his account of the psychiatric ailments of 134 civilians suffering from emotional shock at the First Aid Post he was attached to, psychiatrist Henry Wilson, based at the London Hospital in the East End, also emphasised that civilians needed to admit their fears.[20] Although Wilson admitted that it was difficult to define a 'normal' response to war, he posited that the admittance of some fear, along with somatic responses, such as trembling, sweating, palpitations and loose bowels, were all part of a normal response to air-raids, unless they were experienced in excess. If anything, Wilson argued, it was 'abnormal' for a civilian not to feel fear in the face of air-raids, and 'abnormal' responses were encountered in those civilians who only reluctantly admitted to feeling fear and, especially, in those who denied any feelings of fear at all.[21] The examples he gave of those who experienced 'abnormal' responses included a lorry driver, who admitted he was 'shaky', but denied any feelings of fear because he did not shake as much as his wife did after a bomb had fallen. Although civil defence duties were often seen as a means of providing civilians with a sense of purpose, which was understood to mitigate against the development of neurosis, Wilson noted several cases of breakdowns in civil defence workers. It is 'natural' that civil defence workers 'hesitate to admit their anxieties,' he argued, but 'unnatural' if they denied them altogether. For Wilson, the main problem for civil defence workers arose when they were 'afraid of their fear', echoing the concerns of the film referred to above. 'Sometimes this was fear of social ostracism,' Wilson wrote, 'but, as one expressed it: "if I was to be afraid I don't know what could happen. I might burst."'[22] Wilson also claimed that

[20] Wilson, 'Mental Reactions to Air-Raids', pp. 284-287.
[21] Ibid, p. 284.
[22] Ibid, p. 287.

some of those who denied fear were suffering from 'shelter-phobia', and included those who claimed they stayed outdoors during raids. Their 'real' reason, Wilson surmised, was that their houses or the shelter had produced 'acute claustrophobia' at the time of bombing.[23]

Cases of 'emotional shock' thus contributed to how 'normality' was reconceptualised, and which emotional reactions were understood to be on a 'normal' spectrum of psychological responses to the war. This reconceptualisation was closely connected to the political priorities of the government and medical authorities in their handling of the psychiatric cases. This was apparent when Wilson reported that the majority of patients diagnosed with emotional shock were not referred on for further psychiatric treatment and were dispatched home within 24 hours. 'They were all told that their reaction was due to fear,' Wilson claimed, which was an emotion they 'shared with all other patients and with the first-aid workers and that it was important that they should return to their normal work and resist the temptation to exaggerate the experiences through which they'd passed.'[24] Wilson's description encapsulated the government's preferred approach to deal with cases of 'emotional shock' swiftly and brusquely, sending patients home as soon as possible, getting them back to productive work, and instructing them not to exaggerate their air-raid experiences.

In the chaotic conditions of war little was known about what happened to civilians discharged from First Aid Posts.[25] Wilson admitted that in 'the rush of

[23] Ibid, p. 285.
[24] Ibid, p. 284.
[25] There was also a lack of after-care for physical casualties discharged from First Aid Posts. Titmuss, *Problems of Social Policy*, p. 188.

work', no adequate notes or follow-up of cases of emotional shock was possible, but he nevertheless assumed that the majority of shock victims continued with their lives and returned to work without further nervous problems. Only six cases out of the 134 he studied returning for subsequent treatment.[26] One study that did trace and follow up what happened to 127 civilians who had been treated for emotional shock at a First Aid Post in an unnamed city found that over half had suffered subsequent nervous ailments.[27] All of the patients traced and interviewed were aged between 18 and 65 years, all had experienced heavy air-raids, but none had been recorded as having sustained a physical illness or injury at the time of their treatment. Although records were not made of these patients' psychological states when they were treated at the post, the authors deduced that they had suffered from 'various degrees of emotional excitement, acute restless anxiety or depression, often with tremors, in "dazed" states or as "shock".'[28]

Ten months later, the investigators found that over half of those interviewed had subsequently experienced 'abnormal anxiety' during the continued raiding of the town, while nearly one-third had trekked out of the city at night to escape the raids. Just over one-third had evacuated from the area altogether.[29] Of those buried alive under debris for more than one hour during the original heavy raid, some 65 per cent had suffered from either a temporary neurosis or persistent neurosis, verified by medical certificates or absence from work.[30] Cases of

[26] Wilson, 'Mental Reactions to Air-Raids', p. 284.
[27] Russell Fraser, I. M. Leslie and D. Phelps, 'Psychiatric Effects of Severe Personal Experiences During Bombing', *Proceedings of the Royal Society of Medicine*, Volume 36, (January, 1943), pp. 119-123.
[28] Ibid, p. 120.
[29] Ibid, p. 120, p. 123.
[30] Ibid, pp. 119-120.

temporary neurosis included a married woman in her mid-forties, who had been covered with debris and buried in a gas cupboard for over an hour after her home had been hit. Her son had been injured beside her. She could 'scarcely sleep for weeks: "one worry after another" had come upon her after this – her son's injury, her husband became ill and her daughter died with TB, arranging a new house, etc.' The woman was said to have remained well, although the admittance that she spent a few weeks in bed because she felt 'run-down' indicates otherwise. A more persistent neurosis was suffered by a man of 51, who had been covered up to his chest with debris for over two and a half hours. His business of a small shop was destroyed in the raid, and he experienced six months of 'bad nerves', lack of sleep, feelings of depression and pain in his back, even though there was nothing physically wrong with it, before he returned to good health.[31]

The study established that the high incidence of persistent neurosis was 'clear evidence' of the importance of severe personal experiences of bombing in the development of nervous disorders. Moreover, it also directly contradicted the prevalent view that neurosis would only take hold in those who were predisposed. Some three-quarters of the cases studied could not be categorised as having a pre-war 'personality abnormality' or faulty constitution. Rather, the authors identified social factors, such as dealing with broken homes, financial strains, long working and travelling hours, and being forced to remain living in bomb-damaged

[31] Ibid, p. 121.

accommodation and subject to continuing raids, as the main reasons for the persistence of neurotic symptoms.[32] As the authors concluded:

> It appears that neurosis is likely to follow severe personal air-raid experiences, which at the time upset the individual emotionally, or produced a serious upset in the pattern of his living by destroying a much-esteemed home or a close friend, especially, but not only, if he is of unstable personality and was at the time living under some other strain.[33]

By focusing on participants' own descriptions of the bombing, the findings also contradicted many of the assumptions about neurosis contained in the official advice to workers at First Aid Posts, which assumed emotional shock would be short-lived, followed by complete recovery and a return to 'normal' life. The study found that neuroses could develop in civilians who had been through severe raid experiences, whether or not they had previously suffered from a nervous disorder, and their symptoms were likely to persist not only due to inherent factors within the psyche or personality of the individual but also because of social factors incurred by the bombing, such as bomb damage and financial difficulties.

As W. H. Gillespie, a psychiatrist working with emergency psychiatric cases at Mill Hill Emergency Hospital, would later remark, the study showed how neurosis could develop in those with no prior history of nervous disorders. According to Gillespie, the most interesting factor established by the study was that, 'the majority of the population is liable to develop a neurosis under certain conditions, and as often as not a persistent one.' Moreover, he concluded, 'the question

[32] Ibid, p. 122.
[33] Ibid, p. 123.

whether it is possible to develop a neurosis without a predisposition is thus answered very definitely, unless the concept of predisposition is to be stretched to the point at which it becomes meaningless.'[34]

The prevalent psychiatric view that neurosis would only take hold in those who were predisposed was thereby countered by some of the reports of psychiatrists working directly with raid victims. The scepticism about reports that denied those who had pre-war mental disorder were psychiatric casualties was also voiced by EMS psychiatrist George Pegge, as was noted in Chapter Three.[35] For Pegge, psychiatric casualties seen directly after bombing raids may have been on a smaller-scale than anticipated, but this did not mean the symptoms of patients who had previously had a mental illness should be viewed as having nothing to do with the war. In a later letter to the *BMJ*, Pegge claimed the 'unwonted intensity and suddenness' of the raids resulted in a symptomology that was 'more florid, more extreme, and more essentially abnormal' than the neuroses of peacetime. In wartime, Pegge suggested that

> a class of neurosis can be recognized in which the person was previously of good personality and quite without neurotic illness or even (discoverable) neurotic predisposition. These men and women under sufficient strain will break down, and often the symptoms then produced will be of this florid type.[36]

[34] W. H. Gillespie, 'The Psychoneuroses', *Journal of Mental Science*, Volume 90, (January, 1944), p. 303.
[35] Pegge, 'Psychiatric Casualties in London, September, 1940', pp. 553-555; See Chapter Three.
[36] George Pegge, 'War Neuroses', Letter, *British Medical Journal*, 1, (13 March, 1943), p. 333. See also the cases recounted by Felix Brown at Guy's Hospital, who included those considered to have 'previously normal' personalities, but who had been 'acutely exhausted emotionally by their terrifying experience'. Brown, 'Civilian Psychiatric Air-Raid Casualties', pp. 686-691, p. 687.

After such severe experiences during raids, a return to 'normal' life was impossible for some civilians, practically as well as emotionally, because their homes had been made inhabitable or because they had no relatives or friends in the vicinity to turn to. Some of these air-raid victims were referred to Rest Centres, which had been established by the government and local authorities to provide bombed-out civilians with a space to recuperate, obtain advice, and help with repairs, re-housing, finding hostels or temporary billets or to await evacuation. The Rest Centres, as will be shown in the next section, also became sites of psychiatric practice during the war, with advice and support provided in the main by psychiatric social workers, either based at local mental hospitals or supplied by the Mental Health Emergency Committee.

Rest Centres

Rest Centres provided very basic facilities for those who had been bombed-out, with sometimes hundreds of homeless people crowded into school buildings and church halls, and having to sleep on unwashed floors, without proper bedding and blankets, and inadequate toilet and washing facilities.[37] There was often a lack of basic information about the whereabouts of the centres, or the facilities provided, and eyewitnesses spoke movingly of dishevelled and disorientated people, wandering aimlessly in cities and towns following bombing raids not knowing where they could seek help.[38] In Southampton, for example, one observer described how

[37] Titmuss, *Problems of Social Policy*, pp. 333-340.
[38] See, for example, TNA INF 1/292, Home Intelligence Weekly Reports, Monday 30 September – Monday 9 October, 1940, p. 5; 9 April – 16 April, 1941, p. 1.

'homeless, old, pregnant, ill and anxious-to-be evacuated people' spent hours wandering around lost after raids.[39] In Bristol, psychiatric social worker Miss Wigan reported that many 'tired and shaken victims' were still wandering the streets 24-hours after a heavy raid, facing 'fatigue, cold and uncertainty', which was, she argued, 'bound to impair the morale of the homeless.' The lack of information, she reported, only caused 'additional' and 'unnecessary' strains on those who had already experienced the traumas of being bombed.[40]

Although conditions at the Rest Centres varied in different parts of the country, and improved through the course of the war, the spaces provided for civilians were often far from conducive for rest and recuperation following raids. According to one Mass Observation report from Manchester, bomb victims at one of the city's Rest Centres were 'bundled off in a highly nervous state, and dumped into empty rooms, where they have to spend the night, cold and overcrowded, and where little preparation is made to receive them.'[41] Even in centres where conditions were better, air-raid victims found themselves having to grieve and recover in unfamiliar surroundings, living with strangers, lacking privacy and facing an uncertain future. 'Much of the psychological suffering was often due to the loneliness of unfamiliar surroundings,' suggested psychiatric social worker, Priscilla

[39] MOA File Report 516, 'Southampton', December 1940, p. 7.
[40] TNA CAB 102/719, Mental Health Emergency Committee: Summary of Workers' Reports 1.1.41, p. 4.
[41] TNA INF 1/292, Home Intelligence Weekly Reports, 1 January – 8 January, 1941, p. 3; MOA File Report 538, 'Liverpool and Manchester – the Effect of the Blitz', December 1940. Officials in the Home Office were appalled by Mass Observation's report from Manchester, describing it as 'mischievous and extremely dangerous'. TNA HO 199/442, Reports by the 'Mass Observation' groups – attached to the Admiralty. There are, however, frequent references to overcrowded Rest Centres in many of the intelligence reports for the Ministry of Information. See, for example, TNA INF 1/264 and TNA INF 1/292.

Norman.[42] Similarly, social worker Miss Dyson, working at a rest centre in Barnet, North London, remarked that the strangeness of new surroundings greatly intensified the psychological problems of individuals, which led to a 'more than usually great tendency to talk only of war horrors, and to sit doing nothing but dreading the night or waiting to hear the next bomb fall.'[43] Norman saw it as crucial that psychiatric social workers at the centres offered families practical help with accommodation, bills and pensions, and made themselves available to help people get through subsequent crises.[44] Such support was not always possible in the chaotic conditions of the Rest Centres, and social workers often lacked the space, time and resources to assist bomb victims.

The Rest Centres were originally designed and planned to provide temporary, overnight accommodation for bombed-out residents, but many people ended up living in the centres for weeks, and sometimes months, due to the lack of available billets and alternative accommodation.[45] Many social workers worried that extended stays in the centres could exacerbate nervous tension and lead to the onset of more serious nervous disorders. The care and 'mothering' provided by social workers had the effect of 'dulling anxiety, allaying fear, and producing a sense of security', according to social worker Norman. But this sense of security was often 'illusory' and short-lived, she claimed, and signs of strain began to reappear after a few days of living in the rest centre. 'The neurotic, after a week or so, often begin to

[42] Norman, 'Some Preliminary Notes on Mental Health Work for Air Raid Victims', p. 4.
[43] TNA CAB 102/719, Mental Health Emergency Committee. Summary of Workers' Reports 1.1.41, p. 2.
[44] Norman, 'Some Preliminary Notes on Mental Health Work for Air Raid Victims', p. 6.
[45] Calder, *The People's War*, p. 191.

lapse into a depression,' Norman reported, adding that 'personal antagonism and resentments flare up and increase, and some of the men take to drinking.'[46]

Life at the Rest Centres could thus exacerbate nervous problems, which were not always apparent in the immediate aftermath of the raids. M. Dunsdon, a psychologist who worked with air-raid victims, believed that for many people the shock of the bombing was initially 'registered by apathy', followed by 'anxiety and irritability' over dealing with practical matters such as organising rehousing, or fixing repairs and visiting relief agencies. It was only after three to four weeks, after all the practical issues had been dealt with, that 'reactive depression' was likely to set in, she suggested.[47]

Cases of severe psychological disturbance were reported to be rare and exceptional in Rest Centres, and social workers frequently expressed surprise that there were not more cases of hysteria and panic.[48] According to Norman, there was just 'a small group of individuals' who needed definite psychiatric help. One of the cases she recounted was that of the Ms, a family of a grandfather, middle-aged parents and a 13 year-old daughter from the East End of London who were in a particularly distressed state when they were first seen by the social worker. All were anxious and panic-stricken, and the mother feared she was 'going mad'. The father, a dock worker, had been injured in the street during a raid, and three days

[46] Norman, 'Some Preliminary Notes on Mental Health Work for Air Raid Victims', p. 2; M. I. Dunsdon, 'A Psychologist's Contribution to Air Raid Problems', *Mental Health*, Volume 2, (April, 1941), p. 41.
[47] Dunsdon, 'A Psychologist's Contribution to Air Raid Problems', p. 41.
[48] See TNA CAB 102/719, Mental Health Emergency Committee: Summary of Workers' Reports 1.1.41. See also the account in R. D. Gillespie, *Psychological Effects of War on Citizen and Soldier*, (London: W. W. Norton and Company, 1942), p. 108.

later the hospital he was recovering in was hit by a bomb. The other members of the family, she writes, 'were in a shelter where four neighbours were killed, and then themselves received injuries. Moreover, the girl ('G') 'had on her knees a baby who was killed and (according to her story) when she put out her hand to stroke its head in the dark she found to her horror that the head had been blown off.'[49] Although the story of the girl in the 'M' family story may have been apocryphal, the social worker's note of scepticism reflected more widely articulated doubts about the veracity of the air-raid stories and the motivations of those who stayed in Rest Centres.

Many of the social and welfare workers at Rest Centres assumed that some civilians were exaggerating their air-raid experiences, and believed that if more serious neurotic disorders began to develop in patients then factors other than the experiences of bombing were equally if not more important. Norman, for example, wrote of how a 'cross-section' of the public could 'drift in and out', with no questions asked about whether they were entitled to the facilities. It was commonplace, she wrote, for a neurotic to appear in Rest Centres, and who 'happily adapts himself to an environment in which he receives food, shelter and protection without the need for personal effort' and 'with no desire ever to leave it'. These people 'inevitably' included 'the neurotic and unstable, the epileptic, the mentally defective, the senile,' who she described as a 'residuum' of the population who needed to be dispatched to evacuation areas as soon as possible.[50] Thus many of those in the Rest Centres were viewed as malingerers, who had not necessarily

[49] Norman, 'Some Preliminary Notes on Mental Health Work for Air Raid Victims', pp. 4-5, p. 5.
[50] Ibid, p. 3, p. 4.

experienced raids and who were viewed as forming a pool of mentally unstable or abnormal individuals or families. It was assumed that such people would have experienced mental problems regardless of the effects of the war.

The fear that disordered or hysterical behaviour in one or two people could spread and 'infect' others was also a dominant motif in many psychiatric social workers' reports about air-raid victims. Odlum, for example, described three types of neurotics who appeared at Rest Centres: 'people of over-sensitive type', 'the so-called hysterical type prone to excitability and loss of emotional control', and the 'chronic-anxious' types, 'who take themselves and life much too seriously...' These people could even be frightening, asserted Odlum, and unless such cases were handled correctly 'the condition becomes worse and is catching. Thus one unstable emotional person may infect a crowd with hysteria or even panic.'[51]

These ideas to some extent were influenced by the 'mental hygiene' approach dominant in the Mental Health Emergency Committee, which supplied many of the social workers posted at the Rest Centres and which issued instructions to social and voluntary workers at the start of the war. The Committee listed six types of people it considered to be vulnerable to nervous troubles during the war, only one of which was 'cases of nervous breakdown arising out of war conditions.' The other types listed were unstable mental defectives, those already suffering from nervous disorders, unbalanced individuals 'including young girls, often of subnormal mentality, who flock to munition [sic] works and haunt military camps',

[51] Odlum, 'Some Wartime Problems of Mental Health', p. 33.

'problem children' and epileptic children.[52] It was those who had already been identified as constitutionally 'abnormal', unbalanced or mentally deficient who became the major focus of concern.

In recounting a serious of case studies, largely provided to him by psychiatric social workers working at Rest Centres, Edward Glover provided a rather different interpretation to the variety of nervous conditions and behaviours that presented at the centres. For Glover, the assessment of psychological disorders following air-raids depended on an analysis of a complex set of inter-related social, environmental and psychological factors. These included the intensity and duration of the bombing, whether the person was seen immediately after their raid experiences, family relationships, and particular superficial and deep-rooted psychological factors in each individual.[53] In several cases where the individual had a history of mental instability and had also experienced 'raid-shock', Glover noted that it was 'social attributes and strains' that predisposed the person to breakdown.[54] Glover included in this category cases, provided to him by psychiatric social worker Dorothy Hardcastle. In one instance, a woman of 65, who lived alone and had no relatives was bombed out and sent to a billet to live with a family. 'She was unable to adjust in the new neighbourhood,' he wrote. 'She became depressed, confused and unable to look after herself.'[55] For Glover, social problems, rather than innate characteristics or constitution were seen as predisposing factors. Although the experience of bombing contributed to this woman's nervous

[52] TNA CAB 102/719, Mental Health Emergency Committee Leaflet, September, 1939.
[53] Glover, 'Notes on the Psychological Effects of War Conditions on the Civilian Population. (III)', pp. 19-27.
[54] Ibid, p. 26.
[55] Ibid, p. 27.

breakdown, it was the changes in her domestic and social environment that was seen as the major factor.

Although such cases were observed and assessed at Rest Centres, Glover asserted that it was impossible to calculate the psychological effects of the war on the vast majority of the population. Most people, he claimed, were 'never observed at any of the various centres', and, due to the shortages of psychiatric social workers and welfare workers, the majority of shock victims discharged from First Aid Posts and Rest Centres 'filtered back into the general population, where they were dealt with, if at all, by local practitioners having no specialist psychological training.'[56] In the next section, I explore the ways in which GPs handled victims of air-raid shock who were referred from the emergency or Rest Centres, or who called on their doctor to help with nervous symptoms due to the raids.

GPs: a dose of patriotism?

Glover's scepticism about the ability of general practitioners to understand and treat the minor psychological disorders of civilians who had experienced air-raids was well-founded. Although general practice was in a process of change during this period, with practitioners becoming more accustomed to treating patients experiencing various form of neurosis, many GPs remained rather dismissive about the psychological problems reported by patients.[57] Moreover, the organisation of

[56] Ibid, p. 17, p. 29.

[57] For a good account of the development of a more holistic and biographical approach among GPs, see Hayward, *The Transformation of the Psyche in British Primary Care*, pp. 61-89. See chapters Two and Five for examples of the dismissive attitudes of some GPs towards patients with neurosis.

general practice in this period often provided an unconducive atmosphere for patients to admit to certain emotional or psychological problems to their family doctor. Not only was the doctor sometimes a friend of the family, but the doctors' surgery itself was usually a domestic space, situated within the doctor's home. The relationship between doctor and patient was either personalised or it could be 'authoritarian', whereby the patient viewed the doctor as an esteemed figure to look up to.[58] As psychiatrist R. D. Gillespie put it, the doctor was viewed 'like a priest', invested with 'mysterious power' that could allay patients' anxieties.[59] This domesticised context could make it difficult for patients to admit to what might be seen as a personal failing. Doctors themselves often took on the role of acting as what psychoanalyst John Rickman called 'moral reinforcement', rather like a 'kindly parent figure' exerting authoritative reassurance over the patient.[60] There was also the very practical matter of the cost of seeing the doctor, which, except for those receiving National Assistance, might be financially prohibitive, or, at least, not considered for anything but severe physical and organic complaints. As psychoanalyst Melitta Schmideberg observed, 'To many of those who were upset or bereaved through bombing it did not even occur that medical help might be desirable.'[61]

Moreover, in the atmosphere of the war, when the image of the 'ideal' stoical citizen dominated press reports and government propaganda, nervous

[58] Armstrong, *Political Anatomy of the Body*, p. 21.
[59] Gillespie, 'Psychological Medicine and the Family Doctor' *British Medical Journal*, 2, (26 August, 1944), p. 265.
[60] Rickman, 'The Mental Aspects of A.R.P', p. 458.
[61] Melitta Schmideberg, 'Some Observations on Individual Reactions to Air Raids', *International Journal of Psychoanalysis*, Volume 23, (1942), p.171.

problems could be interpreted by both patient and practitioner as being unpatriotic or defeatist. Doctors often seemed to insist that their patients adopt a stoical attitude to the war. In Aubrey Lewis's study of the psychological effects of the Blitz, for example, GPs repeatedly used the language of courage and stoicism when describing the attitudes of their patients.[62] According to Dr. Geoffrey Evans, writing to the *BMJ*, doctors had a duty to 'take pains to determine that our thoughts are those of courage, confidence, faith and hope.' Doctors must, he insisted, 'sedulously refuse every thought of fear, regret, resentment, and the like, because these thoughts have a weakening effect.' [63] Practitioner Ellis Sturgo, for example, argued the war merely provided patients with convenient language for explaining or justifying a pre-existing disorder, claiming it gave neurotics 'a superb scapegoat' to account for their 'abnormal personalities'.[64] This led some doctors to be dismissive of patients' feelings, and also seemed to affect what symptoms patients were willing to admit to if they did not want to be viewed as unpatriotic or defeatist. As one GP put it, 'my people are ashamed to complain of their symptoms.'[65] Another GP from Kent wryly noted that a large number of cases remain 'unrecognised and untreated (unless one describes as treatment an assurance by their private doctor that there is "nothing wrong" with them).'[66]

[62] Lewis, 'Incidence of Neurosis in England Under War Conditions', pp. 175-183; See also Caspar, 'The Origins of the Anglo-American Research Alliance', pp. 327-346.
[63] Geoffrey Evans, 'Doctor and Patient in War Time', Letter, *British Medical Journal*, 2, (7 October, 1939), p. 742.
[64] Ellis Stungo, 'Psychiatric Casualties in London', Letter, *British Medical Journal*, 2, (9 November, 1940), p. 646.
[65] Cited in Lewis, 'Incidence of Neurosis in England Under War Conditions', p. 178.
[66] Kirman, 'Psychiatric Casualties', p. 761.

The reluctance of patients to report nervous problems to their family doctor was also noted by J. Whitby in his small-scale study of 275 patients with neurotic symptoms at his general practice in an unnamed suburb of London during 1940 and 1941.[67] After discounting what he considered to be 'normal apprehension' during raids, Whitby concluded that in the first three months of the Blitz there had been 'a small but real increase in nervous symptoms', after which the number of patients reporting neurotic symptoms began to decline.[68] Whitby admitted he found it very difficult to disentangle the causes of the physical and mental symptoms presented by his patients. 'It is commonplace,' he wrote, 'to see in the same patient a mild anxiety or depression associated with an infection, at another time with psychological stress.' He identified that 'about half' of the patients included in his study had also complained of a physical ailment. This was not only because the patients were experiencing both physical and mental symptoms, he surmised, but also because they were unused to seeking help for minor nervous disorders and felt justified in visiting their doctor only when, 'some physical disorder gave them an excuse.'[69] As Whitby's research suggests, concerns about the misdiagnosis of patients presenting with physical symptoms were particularly prevalent in the context of general practice, where doctors faced patients with a range of minor physical and psychological complaints during the war.

[67] Whitby admitted that his patients were not necessarily typical, as the surgery was situated in a middle-class suburban area that was only lightly bombed. J. Whitby, 'Neurosis in a London General Practice During the Second and Third Years of War', *Proceedings of the Royal Society of Medicine*, Volume 36, (January, 1943), pp. 123-128, p. 123.
[68] Ibid, p. 126.
[69] Ibid, p. 124.

Other doctors seemed to suggest that patients were more likely to come forward to their family doctor with psychological problems than they had been in the 1920s and 1930s. This was the view of Gillespie, for example, who wrote a major article about the role of the family doctor, published in the *BMJ* in 1944.[70] Gillespie correlated this change in attitudes with a decline in the manifestation of hysterical symptoms and a rise in diagnoses of 'frank anxiety states', which was also noted in Chapter Two of this thesis. In Gillespie's estimation, by the mid-1940s patients were less likely to emphasise bodily symptoms and more likely to speak openly about their fears and worries. He considered that the increase in anxiety states was not due to differences in the conditions experienced in the two world wars, but could be explained by longer-term changes in psychiatry occurring during the interwar years.[71] It was, according to Gillespie, peacetime changes in the conceptualisation of the symptoms of minor neuroses, rather than the development of new psychological states engendered by the war, which accounted for the prevalence of anxiety in wartime diagnoses.

Moreover, Gillespie insisted that the lack of recognition of the psychological aetiology of the physical disorders presented at GP surgeries was not necessarily due to misdiagnosis by doctors who lacked training in psychological medicine, or because patients were too ashamed to admit to feelings of nervousness.[72] Rather, such symptoms were psychosomatic, the result of patients unconsciously converting their anxieties into somatic disorders. Diagnoses, such as debility,

[70] Gillespie, 'Psychological Medicine and the Family Doctor', pp. 263-268.
[71] Ibid, p. 263.
[72] Ibid, pp. 263-264.

anaemia, rheumatism and gastritis are, he wrote, 'apt to be labels for what is really a psychoneurosis.'[73] As highlighted in Chapter Two, psychosomatic theories, which emphasised the importance of psychological factors in the development of physical conditions had gained increasing credence among physicians and psychiatrists during the 1930s. In the war years, medics drew on these theories to conceptualise an increasing range of physical disorders, such as dyspepsia, stomach ulcers, gastroenteritis and rheumatism, as being a manifestation of psychological anxieties. This was seen, for example, in some of the explanations given for the rise in the numbers of civilians diagnosed with stomach complaints. Two wartime studies, conducted by doctors from Charing Cross Hospital, examined records from 18 other hospitals in the London region, and correlated a rise in the numbers diagnosed with peptic ulcers to periods of severe blitzing.[74] Although factors like dietary changes, as well as increases in the consumption of alcohol and tobacco, were seen as important, the authors considered these secondary to the role of rising levels of anxiety in causing stomach ulcers.[75] As historian Ian Miller has highlighted, the significant rise in the numbers of what became colloquially known as 'air-raid ulcers' encouraged interpretations that 'prioritised the role of wartime psychological stress as inducing gastric illness.'[76]

We do not know how many patients visited their family doctors suffering either overt anxiety symptoms, or physical ailments where there could have been a

[73] Ibid, p. 264.
[74] D. N. Stewart and D. M. de R. Winser, 'Incidence of Perforated Peptic Ulcer: Effect of Heavy Air-Raids', *The Lancet*, 1, (28 February, 1942), p. 261; C.C. Spicer, D. N. Stewart and D. M. de R. Winser, 'Perforated Peptic Ulcer during the Period of Heavy Air-Raids', *The Lancet*, 1, (1 January, 1944), p. 14.
[75] Stewart and de R. Winser, 'Incidence of Perforated Peptic Ulcer', p. 260.
[76] Miller, 'The Mind and Stomach at War', p. 101. See also Jones, 'The Gut War', pp. 30-48; Jones et al, 'Civilian Morale During the Second World War, p.746.

psychological element in their aetiology and manifestation. Neither do we know how many of these physical or psychological symptoms could have been related to the traumatic experiences of air-raids, or to the more everyday but longer-term stress of wartime life, such as the blackout, rationing and the pressures of long working hours. During the war very few studies were undertaken of patients' visits to family doctors, and those that were tended to be on a small-scale or based on anecdotal accounts.[77] Neither were any overall statistics gathered indicating how many patients reported to their GPs with symptoms of neurosis or a stress-related physical disorder. Moreover, as previous chapters of this thesis have highlighted, calculations of the extent of neurosis from figures of mental hospital admissions or attendances at psychiatric clinics were full of inconsistencies. The extent of neurotic conditions and diagnoses outside of psychiatric institutions was even harder to calculate. There was, however, one attempt to quantify the mental stability of a section of the civilian population during and after heavy bombardment in a major study conducted among workers and their families in the city of Hull, to which I now turn to examine in detail.

[77] The figures and quotes from the London GPs cited in Lewis's survey, for example, were all taken from Whitby before he wrote it up as a separate study. See Lewis, 'Incidence of Neurosis in England Under War Conditions', pp. 176-177; TNA FD 1/6580, Preliminary Draft of Aubrey Lewis's Report, 1942.

Neuroses in the working-class population of Hull

The Hull neurosis survey was the only study of significant size undertaken during the war investigating the psychological reactions of civilians to bombing-raids, although until recently its findings have been rather neglected by historians.[78] The investigation was initiated by the Ministry of Home Security as part of wider research into the physical and psychological effects of bombing in Birmingham and Hull, under the direction of prominent scientists, the zoologist Solly Zuckerman and the physicist J. D. Bernal.[79] Hull had been subject to some of the most intense bombardment outside of the London area during the Blitz period, with the most devastating raids taking place between March and the end of July 1941. Out of a population of 320,000 at the start of the war, in total 1,200 civilians were killed, 3,000 civilians seriously injured, and over 152,000 people made homeless.[80] Hull was picked as a site for the neurosis investigation not because of the intensity of the Blitz, however, but because government officials believed that civilians in Hull, particularly the working-class population, had much lower morale than in other areas badly hit by raids. One Ministry of Information report, for example, described the post-raid atmosphere in one working-class area of Hull as being 'one of

[78] Recent exceptions are the excellent short account provided by Overy in *The Bombing War*, pp. 169 -172; an analysis of the children's writings collated for the Hull survey in James Greenhalgh, '"Till We Hear the Last All Clear": Gender and the Presentation of Self in Young Girls' Writing about the Bombing of Hull during the Second World War', *Gender and History*, Volume 26, (April, 2014), pp, 167-183; and an examination of the scientific and political context of the study by Ian Burney in 'War on Fear: Solly Zuckerman and Civilian Nerve in the Second World War', *History of the Human Sciences*, Volume 25, (2012), pp. 49-72.

[79] TNA HO 199/453, Letter from Air Ministry to Ministry of Home Security, 11 October, 1941. Since the late 1930s Zuckerman had been researching the effects of blasts on the human body. See, for example, S. Zuckerman, 'Discussion on the Problem of Blast Injuries', *Proceedings of the Royal Society of Medicine*, Volume 34, (1941), pp. 171-188; Burney, *War on Fear*, pp. 53-60.

[80] Gardiner, *The Blitz*, pp. 321. See also, Harrisson, *Living Through the Blitz*, pp. 262-266.

complete helplessness and resignation.'[81] Government ministers were also concerned about the high numbers of people trekking, with up to 9,000 people leaving the city on a nightly basis during worst of the bombing-raids. That people were prepared to sleep in makeshift accommodation in barns, pigsties, schools and cinemas, was seen as indicative of low morale.[82]

In their final report, which was based on the wider investigations about the physical and psychological effects of the bombing in Birmingham and Hull, Zuckerman and Bernal concluded that there was no evidence of panic, hysteria or low morale. 'In both towns, actual raids were, of course, associated with a degree of alarm and anxiety, which cannot in the circumstances be regarded as abnormal, and which in no instance was sufficient to provoke mass anti-social behaviour,' the authors state.[83] These conclusions were based, however, on the authors' focus on whether bombing produced instances of mass panic and social disorder rather than a thorough analysis of the examination of the types of mental suffering experienced in the raids.[84] Moreover, this conceptualisation of civilians' fears and anxieties as a 'normal' response to raids has meant that there has been little examination of the results of the study. As Overy has pointed out, the 'bland' assertion that morale had

[81] TNA INF 1/292, Hull and East Riding Information Committee, Effects of Enemy Raid Action upon Hull, on the Nights of Thursday 13 March, Friday 14 March, and Tuesday 18 March, 1941, p. 1.
[82] Overy, *The Bombing War*, p. 144.
[83] The Zuckerman Archive, SZ/OEMU/57/3/4, J.D. Bernal and Solly Zuckerman, 'A quantitative Study of the Total Effects of Air Raids', 1942. Solly Zuckerman, *From Apes to Warlords: the Autobiography*, (London, Hamish Hamilton, 1978), p. 143.
[84] Ian Burney has provided a compelling account of how the political framework of the study shaped its outcome and dissemination. As Burney notes, on the one hand the government used the findings to reinforce the increasingly dominant narrative of civilian resilience, and, on the other, for the opposite purpose of justifying the later controversial carpet-bombing of German cities to try to break the morale of German civilians. Burney, 'War on Fear', pp. 49-72.

held up in Hull masked a much more complex social and psychological reality for the civilians who faced the relentless bombardment of the city.[85]

Based on a series of over 900 psychiatric interviews with port workers and their wives, which were carried out between November 1941 and January 1942, the study provides a rare view of the nervous reactions to raids experienced by a section of the working-class population, who had never previously come to psychiatric attention and whose stories were seldom told or remarked upon in the medical press. The interviews were conducted by a team of psychiatrists and social workers led by psychiatrist Russell Fraser, who was one of the authors of the follow-up study of shock victims at First Aid Posts discussed earlier in this chapter. The Hull study was similarly based on civilians' own assessments of their bombing experiences.[86] Zuckerman had insisted that Fraser construct the interviews to provide an 'objective' measurement of behavioural responses to the bombing, although whether such objectivity was possible could, of course, be contested.[87] This desire for objectivity imposed certain restraints on the types of questions posed, and the interviewees were asked identical questions about their past medical history, family situation, personal bombing experiences, changes in patterns of behaviour, and their physical and psychological responses during and after the raids.[88] The interviews were also carried out some six months after the

[85] Overy, *The Bombing War*, p. 170, p. 172.
[86] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, 'Disturbances in the Mental Stability of the Worker Population of Hull due to the Air-Raids of 1941', n.d., p.1.
[87] The Zuckerman Archive, SZ/OEMU/56/6/1 'First Note on Proposed Psychological Survey', 1941, p. 2.
[88] The Zuckerman Archive, SZ/OEMU/57/5/3 'Criteria for Diagnosis of Neurosis', n.d.

heaviest raids, when, as Fraser admitted, 'only very severe or persistent cases of neurosis would not have already recovered.'[89]

Fraser categorised those interviewed into four main groups: male workers from the port, housewives living in heavily bombed areas, housewives in lightly bombed areas and members of families who were still trekking out of town every night, six months after the end of the worse raids. The experiences of children were omitted from the survey, and it is perhaps noteworthy that the majority of those interviewed were over the age of 30, with many in their 50s and 60s. Overall, out of the 706 interviews assessed for the final study, 332 civilians, just under half of those interviewed, were considered to have some form of neurotic disorder connected to the raids.[90] The male workers, who formed the biggest group interviewed, were judged to be less affected by the raids than their wives, with 4.2 per cent of the men still experiencing seriously neurotic symptoms and 20 per cent judged to have moderate or slight neurosis at the time of the interviews.[91] Among the women, some 13.7 per cent in the heavily bombed area and were judged to suffering serious neurosis, with over half, 53 per cent, still experiencing moderate or slight neurotic symptoms six months after the heavy raids.[92]

In the illustrative case histories produced for the report, the workers and their wives reveal a range of mental and physical complaints, which were caused or

[89] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p.2.
[90] The Zuckerman Archive, SZ/OEMU/57/5/4, Tables 1-IIV.
[91] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p. 2.
[92] Ibid, p.3.

exacerbated by the raids.[93] Although the male workers were judged to be less psychologically affected by the raids, there were also cases recorded of depression, excessive anxiety, palpitations, insomnia, and feeling afraid of the blackout.[94] In one case, a 41 year-old dock worker, married with six children, suffered from depression after his mother and three of his nieces were killed in another shelter. 'He had to go round the mortuaries, and to identify them. His brother and sister were also involved and it took four days to dig them out,' recorded the interviewer. After the incident, the man lost 6lbs and became 'increasingly miserable and worried'. 'Sometimes I feel that life is not worth living,' he said.[95] In another case, the 56 year-old dock master of the port recounts the horror of when a landmine hit his house when he and his wife and their four children were still inside. The man recalls that he felt the explosion hit his stomach and tasted a burning odour in his mouth. 'On recovery, he saw the whole house in ruins except for the walls of the room where he was. He heard moaning, and set about digging for his children – this was the worst experience of all; he felt in a "mental frenzy".' Two of his family were killed in the explosion, and the man was hospitalised for several days. 'In hospital he felt terrible, collapsed upset with hearing his wife screaming; after being put to bed he vomited for two days, but could not sleep at all during this period.' Although the man returned to work two months after the incident, in December the

[93] The Zuckerman Archive, SZ/OEMU/57/5/4, Appendix 2. Forty case histories were prepared to accompany the Hull report. It should be noted that all of the case histories are of people judged to have either a serious, moderate or slight neurosis.
[94] Ibid, Cases 1 to 9.
[95] Ibid, Case 9.

interviewer noted that 'he still looks depressed and tends to talk a lot about his experiences.'[96]

The women interviewed in the survey were all housewives, and the interviewing team viewed them as being more mentally unstable than the male workers at the port and more liable to develop neurotic symptoms. The survey took place before the compulsory registration and call-up of women into the workforce, and no references were made to any of the women working outside of the home. Neither was there any attempt to explain why women may have been more prone to neurosis in the draft or final reports of the study, although there is reference to the men with neurotic symptoms being more likely to have 'timidity of personality.'[97] The gendered and class biases embedded in the psychiatric judgement of male and female factory workers during the war will be explored more fully in the following chapter of this thesis. It is worth noting here, however, that similar assumptions were made in the psychiatric assessment of this working-class community in their homes. The female case histories, for example, were replete with gender and class assumptions about what patterns of behaviour were considered to be 'normal' responses in working-class women. There were several references to the woman's lack of cleanliness and tidiness in the home being a sign of neurotic disturbance, for example. One middle-aged woman, who was grieving over the death of her sister in a raid and trying to cope with her own home being made uninhabitable by the bombing, was described as letting 'things slide in home', and feeling 'too dispirited to set to work to climb back to her former housekeeping

[96] Ibid, Case 1.
[97] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p.2.

standards.'[98] Similarly, a 28 year-old woman, who suffered palpitations, fainting fits and the feeling she was going to suffocate when she heard the alerts, was described as appearing 'retarded, depressed and anxious; her house is messy and untidy, and, one suspects, far below her usual standards of cleanliness and order.'[99]

Like the male workers, most of the female cases revealed a wide range of psychological and somatic reactions to the experience of the raids. The cases included a 62 year-old housewife with three sons in the Merchant Navy, who was hospitalised for shock after her house had been set ablaze by an incendiary bomb in February. She suffered two further raids causing damage to her home in May and July. In a few months the woman had lost two and a half stone in weight, 'felt disinclined to do anything', suffered pains in her head and back, worried about her sons, and suffered acute anxiety symptoms whenever she heard the air-raid siren. On several occasions she collapsed in the street.[100] Another woman, whose home was demolished in the May blitz, had been forced to move to a house on the same estate with her husband and seven children where only the living room was habitable. She lost two stone, felt run-down and miserable, and experienced anxiety attacks during the daytime. During the night raids, 'she feels dizzy and sick, has headaches, occasionally vomits. Her husband reports that she trembles all over and calls out in terror.'[101]

In his draft report, Fraser identified the 'continual emotional tension' of knowing that one's home was in a raid danger area as being the biggest cause of

[98] The Zuckerman Archive, SZ/OEMU/57/5/4, Appendix 2, Case 16.
[99] Ibid, Case 22.
[100] Ibid, Case 13.
[101] Ibid, Case 19.

stress, and a greater cause of neurosis than the physical and psychological effects of actually being bombed.[102] This reiterated the ideas of many the psychoanalytical thinkers discussed in Chapter Two, who believed that it was the anticipation of the attack that created the tensions that manifested in neurotic symptoms. In a majority of the case histories, however, the onset of symptoms followed personal experience of a raid. One 38 year-old woman of previously good health, for example, first experienced nervous symptoms after two nights of relentless raiding in May. She subsequently lost weight, and 'found herself unable to sleep for fear of the siren and was tired, easily startled, depressed and annoyed by noise of any sort.'[103] For others, previously mild nervous symptoms became worse after the raids. A 64 year-old married woman said she had been nervous as soon as the war started, but her symptoms greatly worsened after the May raids when the door of the family's Anderson shelter was blown-in. From that time, she could barely sleep because she was always listening for the 'buzzers' to sound. On hearing the alert, she 'becomes dizzy, feels near to collapse, her stomach turns over, she trembles from head to foot; on heavy bombing she has vomited.' Although her worst symptoms subsided after the All-Clear, the next day she would be 'depressed and afraid', and would sit 'brooding.'[104]

The symptoms described by those interviewed were not classified as being 'neurotic' unless they persisted for more than one week, and occurred at times when there were no raids, such as in the daytime or in lulls in the bombing. There

[102] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p. 7.
[103] The Zuckerman Archive, SZ/OEMU/57/5/4, Appendix 2, Case 10.
[104] Ibid, Case 11.

were very few cases of hysteria, with less than two per cent of cases showing 'hysterical features'. The most common symptoms experienced were of 'excessive anxiety' and depression', or a combination of the two.[105] Many of the symptoms the interviewees described were somatic, such as gastric problems, diarrhoea, vomiting, palpitations, backache, and leg pains. Other interviewees reported insomnia or persistent nightmares, and other symptoms that could not necessarily be classified as a diagnosable neurosis. One 31 year-old woman, who was grieving after the death of her father and a brother-in-law who was killed at sea, 'bit her nails until she had septic fingers' and would frequently get up during the night 'to look for searchlights'.[106]

Moreover, there were also aspects of the raids that Fraser found 'impossible' to assess, such as 'loss of sleep, enforced inactivity during raids, exhaustions due to various causes, horror from the sights seen, etc.'[107] It was often the seemingly more minor aspects of the raids that people could find most upsetting. There are frequent references in the interviews to anxiety at the sound of sirens and 'buzzers'. When asked what they found most disturbing about the raids, by far the most common response given by the interviewees was the sound associated with approaching bombing, such as the noise of whistling bombs, the flap of the parachute on parachute mines, and the sound of explosions and approaching planes.[108]

[105] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p. 5.
[106] The Zuckerman Archive, SZ/OEMU/57/5/4, Appendix 2, Case 24.
[107] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p. 7.
[108] Ibid.

Despite the debilitating symptoms suffered by those interviewed in the survey, the vast majority managed to continue with their usual routines, such as going to work or caring for children. Most of the male workers, for example, continued with their jobs in the port. Among a sample of 148 permanent workers in the docks, only seven per cent were absent between May and December, 1941, and on average only took 2.6 days off sick, due to neurotic symptoms.[109] Neither did the majority of people consult their family doctor about their nervous ailments. Among the housewives, for example, just ten per cent of those with neurotic symptoms in the area of light bombing-raids visited their doctors. In the heavily bombed area, just under one-third (32 per cent) of the women with neurotic symptoms went to their doctors with nervous symptoms. For both groups, however, it is not stated what treatment and advice was given.

Moreover, in both groups, the majority of those with neurotic symptoms did not visit their GPs, and as far as can be ascertained from the report and the interviews, did not receive any medical or psychiatric attention.[110] Although Zuckerman and Bernal interpreted these findings as being indicative of the failure of the bombing to break morale, they measured morale largely by the absence of panic, the lack of hysterical symptoms, and the low level of absenteeism from work. But as the case studies have shown, this focus on morale overlooked the types of psychological suffering experienced by civilians in raided areas, whose psychological symptoms, in most cases, went undiagnosed and untreated. The psychiatric interviewers in Hull assessed that many of the nervous symptoms experienced by

[109] Ibid, p.3.
[110] Ibid.

these working-class civilians constituted a form of neurosis, yet these cases were not counted in the overall reckoning of the psychiatric cost of the war, and remained unrecognised in psychiatric reports that lauded the way the civilian population had stood up to the bombing.

Trekkers and tunnel dwellers

As previously noted, one of the reasons Hull was chosen as the site for the neurosis survey was the high numbers of civilians who nightly trekked out of the city, often for several miles, returning to their jobs and homes the following day. Government officials had assumed that such trekking was indicative of low morale and mental instability in the city. Indeed, in the early years of the war, the government and local authorities actively tried to discourage trekking, They viewed it as a potential threat to social order and to industrial productivity if people failed to turn up to work on time the following day. Informants for the daily and weekly reports produced for the Ministry of Information often surmised that trekkers were overwhelmingly made up of the weakest and most vulnerable sections of the population. The trekkers were those people with 'weaker constitutional mental make-up,' wrote one writer about the trekkers from the heavily bombed south coast town of Plymouth. 'These people react to difficult situations in two ways – either as a cowardly retreat, or by a neurotic mental breakdown,' opined the informant.[111] These were people who either from age, fatigue or mental constitution felt they could no longer 'endure another night of it,' surmised another

[111] TNA INF 1/292, Home Intelligence Weekly Reports, 23 April – 30 April, 1941, p. 3.

report from Plymouth.[112] In one of his BBC radio broadcasts, Glover painted a similar picture of people being grabbed by an uncontrollable urge to escape cities and ports. He recounted knowing people whose response to the air-raids was to be 'seized with a powerful impulse to run as fast as they can from houses, seek the nearest open space, and then lie flat on their faces. If they did take shelter, it was only in some open archway or doorway.'[113]

The Hull study gave a much a much more complex picture of the motivations, behaviour and mental states of those who trekked. Rather than representing an urgent urge to take flight, trekking was, according to the preliminary report of the survey, 'an expression of lack of confidence in the safety of the home area more than nervous irritability', and related to a 'general appreciation of the risk from H.E. [High Explosive] bombs in the area of the home and to little else.'[114] In other words, it was a rational response to the danger these civilians faced under bombardment. Nearly all the civilians interviewed in the study trekked as a family unit, usually after the onset of a spell of the heaviest raids over the port and town. In the interviews, the overwhelming reason given by those who had trekked during the raids was safety.

Moreover, even though the lightly bombed area was only three miles in distance from the area of heaviest bombing in the study, 'practically no families trekked from the lightly bombed area.'[115] Mrs. R, for example, began trekking after

[112] Ibid, Appendix One, 'Report on Conditions in Plymouth following the Severe Raids', p. 2.
[113] Edward Glover, *The Psychology of Fear and Courage*, (Harmondsworth: Penguin Books, 1940), p. 28.
[114] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p. 8.
[115] Ibid.

her husband, son, mother-in-law, and two nephews were killed, and two of her other sons badly injured, when the communal shelter the family used was demolished by a bomb in the July raids. She had been buried in the rubble of the shelter, 'pinned with a beam across her back', and was only rescued after an hour. Some 45 of her neighbours were killed by the bomb attack, and she was one of only five survivors. Unsurprisingly, she suffered extensive symptoms of feeling 'dazed, run-down, irritable and worried', which began after her terrible experience. By the time of the interview in December, she was feeling better and felt she would keep well as long as 'she does not have to stay in Hull after dark.'[116]

The vast majority of those interviewed began trekking in response to such traumatic experiences of the raids, although not all experiences were as terrifying as those undergone by Mrs. R. The findings of the study showed that to categorise trekkers as pool of mentally unstable civilians introduced a false dichotomy between those civilians who trekked and those who did not. Many families trekked on an intermittent basis, depending on the severity of the raids, sometimes for just a few days and at other times for a few weeks, such as during the worst bombing attacks. Whether people trekked also depended on factors like work, family, mobility, physical health, or whether the family had a private shelter or a local communal shelter. In a few cases trekking was undertaken due to the encouragement of neighbours or friends. In contrast to the claims that trekkers were a permanent pool of the cowardly or mentally unfit, the study found that

[116] The Zuckerman Archive, SZ/OEMU/57/5/4, Appendix 2, Case 32.

trekking was more frequent among those people judged to be of 'normal stability'.[117]

By the time of the interviews, in December 1941, a more comprehensive system of communal shelters in schools and other public buildings on the periphery of Hull had been set up by the local authority.[118] At that time, only 23 per cent of the original trekkers were still making the journey out of the town each night. These trekkers included those who continued to experience nervous problems even though the heavy raids had subsided and also those whose mental health had improved, but who still couldn't bear the thought of staying in the city. There was a mix of reasons why people decided to carry on trekking. Among the December trekkers, for example, were Mrs H, who could not stand being in the communal shelters after her experience of being in her local shelter when it was bombed, killing 25 people. One young single man of previously nervous disposition had dreaded the night raids, but his mood and confidence improved when he made friends at the out of town shelter.[119]

The study found that nearly 80 per cent of those still trekking in December were those judged to be 'abnormally anxious' during raids – either due to their 'poor constitution' or because they had undergone severe raid experiences.[120] Just under one-quarter of the December trekkers were identified as having experienced a nervous illness prior to the start of the heavy raids in March, 1941.[121] Over two-

[117] The Zuckerman Archive, SZ/OEMU/57/5/5 Preliminary Draft of Report, p.9.
[118] Overy, *The Bombing War*, p. 144.
[119] The Zuckerman Archive, SZ/OEMU/57/5/4, Appendix 2, Case 34, Case 31.
[120] The Zuckerman Archive, SZ/OEMU/57/5/5, Preliminary Draft of Report, p. 9.
[121] Ibid, p.10.

thirds of all trekkers in survey reported improved mental health after trekking, including among those who continued to trek.[122] There was thus a much more diverse and complicated mix of emotional and psychological states among the civilians who decided to trek than indicated in the Ministry of Information reports.

The diversity of psychological states among trekkers was also shown in a separate study conducted by the Bristol Child Guidance clinic, which investigated 50 families, with a total of 172 men, women and children, who were chosen at random from the 3,000 or more people who nightly trekked four to five miles to the deep Portway Tunnel outside Bristol.[123] These trekkers spent twelve or more hours each night in the tunnel, and while some inhabitants had bunks others had 'staked a pitch' and 'like squatters' bedded down on damp, earth floors.[124] Discounting those who the investigators believed were experiencing a 'normal' fear of raids, the survey found that 82 per cent of the families investigated had one or more members experiencing 'well marked "nervous" symptoms, half of whom were receiving treatment for diagnosed conditions from family doctors, or in hospitals and psychiatric clinics.[125] Lewis concluded that the Bristol report showed that the shelter population contained 'an unusually high proportion of neurotic and otherwise unstable subjects'.[126] It is interesting to note, however, that (as in the Hull study) only a minority of the individuals studied had suffered a previous mental

[122] Ibid, p. 9.
[123] TNA CAB 102/719, Mental Health Emergency Committee. Summary of Workers' Reports, Tunnel Survey, 18 January, 1941, pp. 13-15; TNA INF 1/292 Home Intelligence Weekly Reports, 25 November-4 December, 1940, p. 1; 1 January-8 January, 1941, p. 4; the report is also briefly considered in Lewis, 'Incidence of Neurosis in England Under War Conditions', p. 178.
[124] TNA CAB 102/719, Tunnel Survey, p. 13. The lack of facilities in the tunnel is also described in MOA File Report 529, 'The Aftermath of Town-Blitzes', December 1940, p. 2.
[125] TNA CAB 102/719, Tunnel Survey, p. 14.
[126] Lewis, 'Incidence of Neurosis in England Under War Conditions', p. 178.

disorder and all had experienced traumatic events in the air-raids. Nearly all the families had had their homes totally or partially destroyed in the heavy air-raids, and usually the family only had recourse to public shelters. Of the 172 people whose case histories were recorded, only four of the women had experienced mental illness or suffered from 'nerves' before the start of the war, with another woman judged to be 'mentally defective' and another woman as 'feeble-minded'.[127]

The brief case notes for 50 families listed in the appendix that accompanied the report illustrate how most families, like the families in Hull, did so as a rational response to traumatic bombing experiences. In one case study, for example, family members trekked after they had been 'severely shaken' after their home and surface shelter had been wrecked by bombing. The father was said to be 'anxious about children; unfit for work unless able to sleep'. The older children in the family stayed at home and didn't come to the shelter. The younger five year-old child, who accompanied the parents to the shelter, was described as 'very frightened since seeing uncle killed in 1st December Blitz. Fear of noises. Clings to parents'. In another case, the husband of a couple from the Southville area said he left London after he got injured in a raid. The case notes record, 'Got a job at Distillery – distillery bombed, so now no job. Cries if spoken to. Can't eat – vomits. WIFE in very nervous state. Complains of gastric pains. HOUSE DEMOLISHED in Bristol.' Investigators recorded another woman as feeling surprised that she felt fearful during the raids. She described how she was 'nervy since near bombs in first blitz',

[127] TNA CAB 102/719, Tunnel Survey, Appendix, pp. 16-21.

but added that she was, 'never nervy before, surprised at feeling so disturbed by bombing.'[128] The Bristol tunnel-dwellers, like many of those interviewed in Hull, frequently cited the noise of the raids as exacerbating their fears. One mother described how her 'stomach turns over at the sound of planes'. Other inhabitants complained of severe stomach upsets or reported that they were unable to eat properly at home due to their nerves.[129]

Despite differences in the situation of Hull and Bristol, many of the interviewees recorded similar feelings about their experiences of raids, and their reasons for trying to escape the worst areas of raiding at night. In both studies, trekking was seen as a preferable and rational option, despite the hardships it entailed, to staying in wrecked and unsafe homes, where sleeping was difficult due to the noise of the raids and the fear of further bombing. Both reports noted that for most trekkers staying outside the city resulted in a lessening of their nervous feelings and an improvement in their mental health. The authors of the Bristol study concluded that 'the great majority of those nervous subjects have improved in health since they spent their nights in the tunnel. They sleep much better, eat more and put on weight.'[130] Above all, despite the limitations in their extent and scope, these studies showed that trekking could not only be explained by the notion that trekkers were those acting in a cowardly or irrational way, or who constituted a distinct mentally unstable section of the population.

[128] All quotes from TNA CAB 102/719, Tunnel Survey, Appendix, pp. 16-21. Emphasis in original.
[129] Ibid. Several Mass Observation reports also frequently linked fear with noise. See, for example, MOA File Report 150, 'Air-Raid Fear', May 1940; MOA File Report 371, 'Cars and Sirens', August 1940; MOA File Report 408, 'Human Adjustments in Raids', September 1940, p. 51.
[130] TNA CAB 102/719, Tunnel Survey, p. 15.

Undiagnosed and unrecognised?

Whether the Hull neurosis survey was indicative of more widespread psychological reactions to bombing-raids can only be speculated upon. It was impossible to calculate how many people in Britain overall suffered minor psychological problems, but never received any medical attention. There were no psychiatric studies of a comparable size and scope to the Hull investigation looking at the psychological reactions of bombed civilians during the Blitz period. One smaller-scale study, however, carried out by social workers for the Mental Health Emergency Committee, produced evidence of many similar psychological states to those described by the civilians of Hull.

The Bristol study also took place in December, 1941. Social workers conducted a house-to-house investigation, interviewing 119 people in living in two streets in Bristol, just one month after they had been subject to heavy raids. Most of those interviewed had not visited a First Aid Post or Rest Centre in the immediate aftermath of the attack, nor had they consulted their family doctor. Nearly 30 per cent of the people interviewed complained of symptoms 'which could be attributed directly to the effects of anxiety.' Half of those with anxiety-related disorders were experiencing somatic symptoms, identified as asthma, effort syndrome, gastric disorders, bladder dysfunction and problems with menstruation. Functional disorders included depression, anxiety and various eating disorders. The social workers who carried out the investigation believed that those who were 'suffering from anxiety and its physical equivalents are not being recognised.' There was a time-lag of two to four weeks in the development of such neurotic and/or

physical symptoms, according to the study. Such disorders did not usually develop until after the person had dealt with organising repairs, rescuing their possessions and visiting relief agencies to obtain financial help.[131] The 'longer term danger of breakdowns later is ignored, or not understood,' wrote the investigators. Bomb victims could 'live for weeks in almost impossible conditions', they noted, and thus 'allow illness and nervous symptoms to go untreated and generally plant the seeds of future troubles.'[132] Echoing the concerns of Glover that some civilians were slipping through the psychiatric net, the report concluded that

> those suffering from frank psychological illness are often ashamed to report their illness, and do not consult their doctor; this latter class stop working, send for a tonic from the chemist, and may stay at home for some weeks in an apathetic state.[133]

During and immediately after the Blitz, several social observers expressed similar concerns that there were substantial numbers of civilians experiencing symptoms of neurotic illness, but whose disorders were going unacknowledged in published psychiatric reports. Several investigators for the Mass Observation organisation, for example, referred to incidences of individual psychological turmoil that were being ignored. There was a danger of 'neglecting the private feelings' of those coping with the aftershock of air-raids, observed one writer, resulting in people internalising their fears and anxieties.[134] Another report for Mass Observation noted the emotional effects of fatigue and lack of sleep, suggesting

[131] Ibid, Report on Work done at Bristol, p. 7.
[132] Ibid, p. 5.
[133] Ibid, p. 7.
[134] MOA File Report 568, 'Morale in 1941', p. 61; MOA File Report 451, 'Reception Areas in Oxford, Windsor and Beaconsfield', October 1940, p. 17.

that lack of sleep was not only due to long working hours and night-time civil defence duties but was also 'intimately connected with fear', and may have been an indication of emotions that people felt unable to express openly.[135]

Such observations, along with the experience of his own visits to heavily bombed areas, prompted Tom Harrisson to write two letters to the *BMJ* that caused much discussion on the letters pages, one of which was highlighted at the beginning of this thesis.[136] According to Harrisson, the medical profession had failed to recognise the various ways in which the psychological effects of the bombing were manifesting in the minor ailments of civilians. People could 'cave in' after a heavy bombardment, he wrote, and in some cases 'they have simply taken to bed and stayed in bed for weeks at a time.' These individuals had 'not shown marked trembling or hysteria', as in the symptoms of shell-shock, but had exhibited 'an extreme desire to retreat into sleep and into being looked after as if chronically ill.'[137] Although Harrisson would later be highly critical of the Hull neurosis study, his examples of despondency, apathy and mild somatic symptoms were remarkably similar to the Hull case studies.[138] Harrisson considered that such cases were unlikely to have ever come to the attention of a psychiatrist or a family doctor because the individual's experiences did not conform to established neurotic symptoms, such as in hysteria. Rather, new types of psychological reactions had

[135] MOA File Report 408, 'Human Adjustments in Raids', September 1940, pp. 45-46.
[136] Tom Harrisson, 'Obscure Nervous Effects of Air Raids', Letter, *British Medical Journal*, 1, (12 April, 1941), p. 573; (31 May, 1941), p. 832.
[137] Harrisson, 'Obscure Nervous Effects of Air Raids', (12 April, 1941), p. 573.
[138] Harrisson later criticised the Hull study's quantitative approach and its 'war conditioned undertones' that enabled its use to justify the carpet bombing of Germany. See Harrisson, *Living Through the* Blitz, p. 301. For Zuckerman's response reiterating how the study had shown that civilians stood up to the bombing, see Zuckerman, *From Apes to Warlords*, pp. 146-147.

arisen, including intense depression and retreat, along with distress, shock, mild hysteria and personal panic.[139]

These concerns about the less severe psychological effects of war being overlooked were not surprising in a context where government propaganda and, in some cases, psychiatric reports, were infused with patriotic assertions about how well civilians were standing up to the bombing. This did not mean, however, that there was no recognition by psychiatrists that civilians under bombardment were experiencing an array of minor psychological symptoms, as illustrated by some of the case studies cited earlier in this chapter. Many psychiatrists and therapists did not think these symptoms could necessarily be classified as a neurotic illness or be viewed as an indicator of the onset of more serious mental illness. Later in the war, psychoanalyst Ernest Jones, for example, referred to such minor nervous symptoms as a 'diffuse anxiety'. He believed such symptoms were mainly experienced by those who suffered the cumulative effects of months without adequate sleep and, he asserted, 'could hardly be called neurotic.'[140] Similarly, the psychologist P. E. Vernon, referred to a range of minor emotional disturbances accompanying the experience of air-raids. The most frequent of these, he noted, was irritability, often due to lack of sleep, along with depression, and a lowering of confidence. He described, 'widespread lethargy and lack of energy, even after lost sleep has been made up, and pessimistic feelings about the future.' According to Vernon, civilians who experienced repeated raiding could suffer 'a slight dissociation of personality.'

[139] Harrisson, 'Obscure Nervous Effects of Air Raids', (12 April, 1941), p. 574 and (31 May, 1941), p.832.
[140] Ernest Jones, 'Psychology and War Conditions', *Psychoanalytic Quarterly*, Volume 14, (1945), p. 18.

'In the daytime the horrors of the night seem like a dream, which they view as spectators rather than sufferers,' he wrote, whereas at night, 'life seems to be all bombs and guns, and the safety of the day hundreds of years away.'[141]

One of the most frequent observations, as noted in the Hull psychiatric interviews, was the debilitating effects of the sounds of the raids, sirens and explosions. The bodily sensations that accompanied the vibrations of bombs became intertwined with feelings of fear and anxiety. 'It is the siren or the whistle or the explosion or the drone – these are the things that terrify. Fear seems to come to us most of all through our sense of hearing,' wrote the author of one Mass Observation report.[142] The anticipation of bombing was for many a 'realistic' fear that was realised in the 'shock' of the actual explosion, argued Schmideberg. This included not only the accompanying 'visual and acoustic stimuli', but also the vibrations and compressions of air, felt in the whole body, which forewarned of the intensity of the blast.[143]

The examples of minor neurotic cases highlighted by social workers and social observers offer a rather partial and impressionistic account of the psychological effects of bombing-raids. Indeed, as Jones remarked, such seemingly minor symptoms would not necessarily have been recognised as signs of the development of a diagnosable neurosis by most psychiatrists. Such examples could also be viewed as being consistent with the government's estimation that civilians' nervous reactions to being bombed would be transient, and would not require any

[141] Vernon, 'Psychological Effects of Air-Raids', p. 467.
[142] MOA File Report 408, 'Human Adjustments in Raids', September 1940, p. 51.
[143] Schmideberg, 'Some Observations on Individual Reactions to Air Raids', p. 150.

psychiatric treatment beyond reassurance and mild sedatives. The cases of undiagnosed neurotic-type symptoms also suggest, however, that the psychological effect of air-raids was much more multifaceted and diverse than conveyed by notions of collective, civilian resilience. Moreover, these examples illustrate that cases of fear and anxiety, although not necessarily conforming to expected hysterical reactions or matching textbook diagnoses of neurosis, were enough to cause many observers to worry that the medical profession was overlooking the psychological suffering of many civilians.

Conclusion

This chapter has examined psychiatric attitudes towards civilians who had directly experienced bombing-raids by exploring psychiatric practice on the 'front lines' of the air-war over Britain. In the context of rationed resources and facilities, psychiatrists encouraged their patients to understand their emotional reactions to raids not as a neurotic illness, but as 'normal' and temporary responses to bombing that would have few, if any, long-term effects. This focus on 'normal' reactions was made possible by the shift in psychiatric attention towards more minor neuroses during the interwar years, and also helped to further establish the idea that certain types of fear and emotion were part of the 'normal' spectrum of psychological reactions. Fear of raids was thus seen as 'normal', while denial of fear could be construed as 'abnormal', and a sign of more deeply rooted problems in the pre-war bodies, psyche or personality of the individual. This normalisation of some psychological reactions to air-raids also enabled psychiatrists to follow the

government's instructions to treat cases of air-raid shock as temporary, and not needing institutional, or even follow-up treatment. There was no agreement among psychiatrists, doctors and social observers about exactly what psychological reactions could be considered 'normal', or even how 'neurosis' itself should be defined.

This examination of psychiatric practice on the 'front line' has also illustrated how the narrative of 'few psychiatric casualties' was not settled at the start of the war, but was constantly being redefined, renegotiated and reiterated throughout the course of the war. Psychiatrists and other medics were not unanimous in their opinion on the aetiology of the mental disorders they encountered. Although few psychiatrists believed that air-raids were the sole cause of wartime mental illness, some feared that the nervous problems in the civilian population were being neglected. There was a tension between official discourses, which underplayed the effects of the war on civilians' mental health, and the lived experiences of air-raid victims in the aftermath of the shattering blitzes on their families, homes and neighbourhoods. As illustrated in my analysis of the Hull neurosis survey and the other case studies in this chapter, many civilians suffered a myriad minor psychological and physical complaints after their experiences during the raids, and yet never came under psychiatric attention, or even under the remit of their family doctor.

The majority of studies of the psychiatric effects of bombing between 1939 and 1945 centred on the period of the Blitz. As the raids of the Blitz subsided so too did the number of articles in psychiatric and medical journals about the effects of

bombing on civilians, although articles about military psychiatry continued to flourish in the psychiatric and medical press. There were no psychiatric studies published, for example, of the psychological effects of the V1 and V2 bomb attacks in 1944 and 1945, although anecdotal accounts suggest these 'silent' bombs could create more fear than the heavy explosives of the earlier bombing-raids. It would seem that by this point in the war, it had become established that bombing had had a negligible effect on civilians' mental health, and panic and hysteria among the civilian population was no longer feared. Psychiatric attention turned to the future provision of post-war services, and concern that the seemingly high incidence of neurosis in wartime factories could hamper productivity, which will be examined in the next chapter.

Chapter Seven: Neurosis in the wartime factory

In propaganda films and posters the wartime industrial factory was represented as a major site of the battle on the home front, with workers portrayed as heroically performing a crucial 'front-line' role in winning the war.[1] Yet despite such 'heroic' images, the wartime factory became a focus of government fears about the levels of neurotic illness in the civilian population. While 'resilience' was a dominant motif of the majority of wartime reports on the mental health of civilians, the government feared that incidences of neuroses were prevalent in industry. Pre-war fears of mass panic and social disorder had transmuted into fears that mass absenteeism would damage the war effort. Just as soldiers needed to be kept fit for duty, civilians needed to be kept fit for work. The mental health of the workforce thus became an issue of national concern.[2]

Much of this concern focused on the drafting of women workers into industry, with industrial health reports revealing that absenteeism due to neurosis was particularly high amongst female workers.[3] How did psychiatrists and industrial medical officers explain why women workers, so often praised for their courage in the face of bombing-raids, seemed to be particularly prone to neurosis when they were recruited into the workforce? We know from the work of gender historians that the construction of the woman worker as a heroic figure was far from a simple reflection of female workers' experiences during the war.[4] Work could provide

[1] Jennie Hartley, *Millions like Us: British Women's Fiction of the Second World War*, (London, Virago, 1997), p. 2.
[2] Mathew Thomson makes this point about the wider adoption of psychological expertise in industry. Thomson, *Psychological Subjects*, p. 141.
[3] Blacker, *Neurosis and the Mental Health Services*, p. 1.
[4] Summerfield, *Reconstructing Women's Wartime Lives*, pp. 80-81.

personal fulfilment but also exploitation; it could be exciting but also marred by boredom and fatigue; it could bring new friendships and sexual relationships but also loneliness and harassment. There has been little historical investigation, however, of the emotional and psychological response to the gender instabilities created by the wartime entry of women into the workforce.

In this chapter, I explore the reasons why the factory became the focus for government fears about civilian neurosis through an examination of government-sponsored reports and psychiatric case studies. In the first section, I focus on the political context in which government concerns over high levels of industrial neurosis first arose during the war, and how that concern was connected to government anxieties to keep up high productivity levels and yet at the same time preserve civilian morale. I follow this by asking why the psychological effects of air-raids on factory workers received scant attention in reports about factory neurosis, which was viewed as having little to do with the effects of the raids. I go on to analyse why the neurosis of women workers elicited particular concern, exploring the gendered ways in which the government and medical establishment explained the emotional states of women workers. Psychiatric judgements were also proffered on the mental fitness of male workers, and in the next section I examine how assumptions about both femininity and masculinity infused one of the major studies conducted during the war about the mental health of factory workers. I then consider how psychiatrists and industrial medical officers defined what symptoms and disorders were counted as a 'neurosis' and discuss how the concepts of 'normal' and 'abnormal' were applied to workers' emotional and psychological states. I conclude the chapter by looking at how government concerns about

industrial neurosis were connected to a wider trend, whereby the government and employers increasingly encouraged both male and female workers to take responsibility for their own mental health. In the context of the wartime drive to increase productivity, I suggest that this was primarily a means by which employers attempted to get workers to discipline their emotions in order to bolster wartime military ambitions, the national economy and social cohesion.

Fatigue, productivity and morale

The government's concerns about levels of industrial neurosis were articulated within a discourse of productivity, national stability and morale. The government's main priority was not the well-being of the worker for her own sake, but fears that absenteeism due to neurotic illness would be detrimental to industrial output.[5] During the early years of the war, the government pursued a relentless productivity drive, particularly in the wake of the military defeat at Dunkirk in June 1940 as the government sought to replenish military losses and prepare for future battles.[6] This productivity drive included instructing factories to keep up production 24 hours a day, seven days a week, and a concerted campaign to encourage workers to carry on working through air-raid sirens, risking their lives for national duty.[7] In the

[5] See, for example, Anon, 'Absent from Work', *The Lancet*, 2, (8 November, 1941), p. 566; Anon, 'Hours of Work and Lost Time', *British Medical Journal*, 1, (28 February, 1942), pp. 298-299; Wilson Jameson, 'War and Health in Britain', *American Journal of Public Health*, Volume 31, (December, 1941), p. 1258.
[6] Anon, *Medical Research in War. Report of the Medical Research Council for the years 1939-45*, Cmd. 7335, (London: HMSO, 1948), p. 153.
[7] Anon, 'Overtime and Overtiring', *The Lancet*. 1, (8 February, 1941), p. 181; Anon, *Annual Report of the Chief Inspector of Factories for the Year 1940*, Cmd. 6316, (London: HMSO, 1941), p. 10; Jones, *British Civilians on the Front Line*, p. 10, pp. 27-55.

months following Dunkirk, for example, it was not unusual for male workers to do shifts of over 70 hours per week, and for women to regularly work between 60 and 69 hours a week.[8] In an address to Ernest Bevin, the Minister of Labour and National Service, the Chief Inspector of Factories referred to how this relentless drive to keep up industrial productivity illustrated that the lessons of the First World War, when excessive working hours in the wartime munitions industry resulted in a decline in productivity, had been 'widely forgotten', or, at least, 'not yet fully appreciated.'[9]

As the war progressed, however, many psychiatrists and other medics became increasingly concerned that the intensive industrial practices of wartime would in the long-term prove counter-productive, damaging both workers' health and productivity levels. Moreover, this concern increasingly focused not only on workers' physical injuries and ailments, but also on the deleterious effects of overwork and fatigue on workers' mental health.[10] As the *Lancet* noted, within two months of Dunkirk 'the effects of strain appeared in the workers, shown by increased sickness and absenteeism.'[11] In his report for 1940, a senior government medical inspector, John Bridge, wrote that factory workers were not only suffering physically from working long hours, but were also experiencing, 'black-out

[8] H. M. Vernon, 'Industrial Health in Wartime', *British Medical Journal*, 2, (6 July, 1940), p. 25; Anon, 'Hours of Work in Wartime', *British Medical Journal*, 2, (19 October, 1940), p. 527; Anon, 'Hours of Work and Lost Time', p. 298; Anon, 'Hours of Employment and Health', *British Medical Journal*, 2, (26 December, 1942), p. 756.
[9] Anon, *Annual Report of the Chief Inspector of Factories for the Year 1940*, p. 3. See also Anon, *Medical Research in War*, p. 153.
[10] A. H. Waldron, 'Occupational Health During the Second World War': Hope Deferred or Hope Abandoned?', *Medical* History, Volume 41, (1997), p. 201.
[11] Anon, 'Overtime and Overtiring', p. 181.

anaemia', 'black-out blues' and 'war nerves'.[12] Complaints about 'nervous debility', 'edginess' and 'war strain' among women workers also became increasingly prevalent in the weekly reports by the Home Intelligence department of the Ministry of Information between 1940 and 1943.[13]

During the interwar years, psychiatrists, industrial medics and trade unionists had begun to focus on the damage that work could inflict on workers' psychological well-being. In some ways, however, this focus on the harm work could cause to workers' mental health ran counter to the main thrust of psychiatric investigations about work and mental health in the 1930s.[14] These investigations were largely focused on the positive aspects of work and the harmful psychological effects of unemployment, particularly during the Great Depression.[15] Moreover, as illustrated throughout this thesis, the view that the availability of work offset mass neurosis and improved individuals' mental health remained potent throughout the war. This message would be reiterated in post-war reports of wartime civilian health and in the subsequent historiography of the home front.[16] Many reports conducted during the war suggested that the boost to employment provided by the wartime economy had helped to prevent mass psychiatric casualties and ameliorated the onset of neurosis in individuals by providing civilians with a new

[12] John C. Bridge, 'Health in Factories in 1940', in Garrett, *Annual Report*, p.22.
[13] TNA INF 1/292, 'Home Intelligence, Weekly Reports'. No. 142 15th June-22nd June, 1943.
[14] This point is made by Vicky Long, *The Rise and Fall of the Healthy Factory: the Politics of Industrial Health in Britain*, (Basingstoke: Palgrave Macmillan, 2011), p. 13, pp. 136-143. The work of neurologist and former shell-shock doctor, Millais Culpin, was important in advocating a psychological approach to workers' illnesses. See, for example Millais Culpin, 'Nervous Disease and its Significance in Industry', *The Lancet*, 2, (27 October, 1928), pp. 899-902; Millais Culpin, 'A Study of the Incidence of the Minor Psychoses: their Clinical and Industrial Importance', *The Lancet*, 1, (4 February, 1928), pp. 220-224.
[15] See Chapter Two.
[16] See, for example, Lewis, 'The Social Effects of Neurosis', pp. 167-170; Titmuss, *Problems of Social Policy*, p. 347.

sense of purpose in their lives, and relieving boredom and financial worries [17] Psychiatrist D. Ewen Cameron, for example, boasted to an American audience that one of the British medical profession's main achievements was their realisation early in the war that 'one of the chief protections which could be given to the civilian population against war fears and against panic attacks was to assign them a job.'[18] Interestingly, in light of the concerns about the levels of female neurosis that arose during the war, Gillespie claimed that employment was more important for women's psychological well-being than it was for men's.[19] Nevertheless, despite this emphasis on work as warding off neuroses, the ways in which wartime work was directed frequently became the subject of articles in medical journals through the war. These articles pointed to excessive working hours, frequent shift changes, speed-ups on the production line, night-time work and its disruption to sleep and eating patterns, poor supervision, and the absence of recreational and other facilities as being contributory factors to the onset of neurotic symptoms and conditions.[20]

The aspect of these reports that most concerned the government was not workers' mental health *per se*, but the impact on levels of absenteeism, industrial

[17] Dr. Joan Harwood cited in Anon, 'Discussion on Effects of War-time Industrial Conditions on Mental Health', *Proceedings of the Royal Society of Medicine*, Volume 35, (April, 1942), p. 695; Schmideberg, 'Some Observations of Individual Reactions to Air Raids', p. 175.
[18] D. Ewen Cameron, 'War-time Pressure and its Effects', in D. Ewen Cameron and H. Graham Ross (eds.), *Human Behaviour and its Relation to Industry*, (Montreal: McGill University Press, 1944), p. 170.
[19] Gillespie, *Psychological Effects of the War on Citizen and Soldier*, p. 81.
[20] See, for example, Anon, 'Psychiatric Advice in Industry', *The Lancet*, 2, (25 November, 1944), p. 695; E. H. Capel, 'Psychiatric Advice in Industry: II', *British Journal of Industrial Medicine*, Volume 2, (January, 1945), p. 43; Anon, 'Discussion on Effects of War-time Industrial Conditions on Mental Health', pp. 693-698; Anon, 'Discussion on the Effect of Wartime Conditions on the Health of the Factory Worker', *Proceedings of the Royal Society of Medicine*, Volume 36, (April, 1943), pp. 275-280.

productivity and efficiency. The government commissioned a number of reports in the early 1940s that indicated that a significant proportion of workers who took time off sick were being diagnosed with neurotic conditions. One of the most influential of these reports was published in 1942 by the Industrial Health Research Board, a government appointed committee originally set up to investigate industrial fatigue following the First World War.[21] The report found that between two and seven male workers per thousand were absent due to neurosis every week. It was significantly higher for female workers, with between eight and 24 women per thousand off work each week because of neurotic illness.[22]

As discussed in Chapter Five, psychiatrist and trusted government advisor Aubrey Lewis had highlighted the problem of 'loss of productivity due to neurosis' when he wrote to the Ministry of Health in March 1942, initiating discussions that would lead to the setting up of Blacker's survey of psychiatric clinics.[23] Lewis estimated that nervous conditions were responsible for 'half the total sickness absenteeism among the women workers.' He cited a report of factory and transport workers, shop assistants and clerks where the proportion of sickness absence due to neurosis had trebled. According to Lewis, in one cigarette firm in a bombed area the percentage of days lost because of nervous illness had more than doubled.[24] Lewis concluded that there were 'psychiatric problems among civilians which are at

[21] Until 1928 the Board was called The Industrial Fatigue Research Board. See R. S. F. Schilling, 'Industrial Health Research: The Work of the Industrial Health Research Board, 1918-44', *British Journal of Industrial Medicine*, Volume 3, (July, 1944), pp. 145-152, p. 146.
[22] Anon, *Hours of Work, Lost Time and Labour Wastage*, Medical Research Council, Industrial Health Research Board, Emergency Report No. 2, (London: HMSO, 1942).
[23] TNA MH 76/115, Letter from Aubrey Lewis, Mill Hill Emergency Hospital, to Professor F. R. Fraser, Ministry of Health, 4 March, 1942, p. 6. See Chapter Five.
[24] Ibid, p. 6. Unfortunately, Lewis does not name the area or the source for these figures.

least as large and exacting as before the war, and are now considerably more important because of the effect on production.'[25]

Following Lewis's intervention, a series of private meetings were held in which government officials expressed their fears that high levels of neurosis could lead to a 'loss of productive capacity' and how they could tackle the problem of absenteeism in order 'to prevent wastage'.[26] In response to Lewis's concerns, the Ministry of Health and the Industrial Health Research Board commissioned two major surveys to chart and monitor levels of neurosis.[27] The Ministry of Health considered that 'it would be better not to try to build up a network of psychiatric clinics throughout the country for service cases and civilians of all kinds including industrial workers,' according to a memo from F. R. Fraser, the director of the EMS.[28] Fraser claimed the government would try to utilise existing psychiatric staff and clinics more efficiently, with a view to such services being offered to industry in the future.[29] The results of the reports are discussed later in the chapter, but it is worth noting here that neither of the reports, even though they were conducted between 1942 and 1944, were published until after the end of the war.[30] As noted about Blacker's report in Chapter Five, the delay in publication was perhaps an indicator of the government's concern not to publish information during the war that could be construed as being harmful to the war effort. The level of

[25] Ibid, p.4.
[26] Ibid, Conferences held on 17 April 1942 and 6 May 1942 to consider Dr. Aubrey Lewis' letter.
[27] Ibid, Conference on psychiatric services held on 14 August 1942; Blacker, *Neurosis and the Mental Health* Services; Russell Fraser, *The Incidence of Neurosis among Factory Workers*, Medical Research Council, Industrial Health Research Board, Report No. 90, (London: HMSO, 1947).
[28] For details of the organisation of the EMS, see Chapter Three.
[29] TNA MH 76/115, Memo from F. R. Fraser to Mr. Hawton, 6 July, 1942.
[30] Blacker's survey was conducted during 1943, and Russell Fraser's between 1942 and 1944.

absenteeism was held up as a marker of the morale of the wider civilian population, and the government faced a dilemma about how to maintain industrial productivity and at the same time uphold workers' morale in the factories. This dilemma shaped how the government, and much of the psychiatric establishment, approached the problem of industrial neurosis during the war.

'An air-raid or two would provide a stimulus'

As the site of wartime production, many factories were on the 'front-line' in the German air-war above Britain. Moreover, as noted above, workers were expected to take the risk of working through air-raid sirens, until raid spotters warmed of 'imminent danger'.[31] Yet the reports by psychiatrists and industrial medical officers were remarkably silent on the psychological strains this might impose on workers. Few psychiatrists or medical officers explicitly connected neurosis to the impact of air-raids and bomb damage to factories, or to the dangers incurred by workers continuing to work through the alert. In part, this may have been because most of the studies on factory neurosis were conducted after the Blitz period, when the worst of the air-raids had subsided. It may have also be due to psychiatrists viewing the workforce, in general, as being the most resilient section of the civilian population, and able to withstand the stress of the raids. Yet, even in psychiatric and industrial reports about why so many workers, particularly women, were suffering from neurosis only rarely was a connection made between neurosis and the stress incurred by the raids on factories. Rather, as has been highlighted

[31] Garrett, *Factories Annual Report of the Chief Inspector of Factories for the Year 1940*, p. 10.

throughout this thesis, the emphasis of psychiatrists was on the underlying factors that caused neurosis, located in the workers' body, psyche or personality rather than in the external events of the war.

According to Blacker, there was 'near unanimity' among the Industrial Medical Officers he interviewed that air-raids had not caused any rise in the incidence of neurosis in the workplace. Indeed, he claimed that some factory doctors believed it would be beneficial for their workers to experience *more* air-raids, as this would help to stimulate production and relieve workers' boredom. One medical officer interviewed in March 1943, for example, was quoted as saying that 'People here seem to regard the war as won. An air-raid or two would provide a stimulus and bring home to people that there was still a war on.'[32] Of course, most psychiatrists and medics did not advocate more bombing as a psychological boost to the workforce, but the comment reflected a wider view that the raids were not a factor in the onset of neurotic conditions.

Perhaps more surprisingly, few medics explicitly connected the neurotic symptoms of workers to general wartime conditions. As has been shown in Chapter Five, although medics were often dismissive about the psychological effects of air-raids, they worried about the longer-term effects of wartime conditions. Yet some of the authors of industrial reports minimised the impact not only of raids, but also of hardships such as the blackout, food and fuel shortages, or even the excessive working hours of wartime, suggesting these were negligible factors in the onset of neurosis. Russell Fraser, whose study of factory workers will be discussed in more

[32] Blacker, *Neurosis and the Mental Health Services*, p. 30.

detail below, maintained that there was no connection between air-raids and the onset of neurosis, although he did point out that the study took place at a time of few raids. More than this, Fraser insisted that wartime measures both inside and outside the factory were 'not closely associated' with the levels of neurosis.[33]

Despite psychiatrists' and industrial medics' reluctance to explicitly link workers' nervous disorders to air-raids or to wartime dislocation, many psychiatric accounts of industrial neuroses were permeated with references to the psychological effects of wartime life.[34] It seemed 'obvious', stated one psychiatrist, that sleeplessness incurred from regular bombing-raids, the strain of dealing with the wreckage of bombed-out homes and drastically altered domestic arrangements meant 'that some absenteeism must be due to mental ill-health or maladjustment or fatigue, often not recognized as such by the absentee.'[35] Although some workers mentioned the anxieties and sleeplessness incurred by bombing-raids in several psychiatric reports, some investigators noted that workers themselves rarely related their nervous troubles directly to the war. It is of course difficult to ascertain how much this reflected the bias of the interviewer or the writer of the report, or how much the worker him or herself believed that their nervous problems were not closely connected to the war. As will be shown in my analysis of Fraser's report, some interviewers imposed their own narrative as to the cause of a worker's

[33] Fraser, 'The Incidence of Neurosis among Factory Workers', p. 5.
[34] See for example some of the interviewees quoted in S. Wyatt, *A Study of Women on War Work in Four Factories*, (London: HMSO, 1945), Medical Research Council Industrial Health Research Board, Report No. 88, p. 38.
[35] Dr. W. Blood cited in Various, 'Discussion on Effects of War-time Industrial Conditions on Mental Health', p. 693; See also May Smith, 'Fatigue and Boredom', in Humphry Rolleston and Alan A. Moncrieff (eds.), *Industrial Medicine*, (London: Eyre and Spottiswoode, 1944), p. 130; Lewis, 'Incidence of Neurosis in England Under War Conditions', p. 181; H. H. Bashford, 'Some Aspects of Sick Absence in Industry', *British Journal of Industrial Medicine*, Volume 1, (January, 1944), p. 9.

neurosis, even if the worker themselves believed that bombing-raids were partly to blame for their nervousness. It is not clear why workers chose to articulate a particular narrative about his or her experiences. As wartime psychologist P. E. Vernon observed, 'psychological inquiries meet with a good deal of suspicion during war-time.' While some people over-dramatised the events of the war, other people 'are apt to minimize the effects of raids on themselves, both because they do not wish to be regarded as frightened, and perhaps because they are unwilling to admit their fear to themselves.'[36]

The emphasis of many industrial reports, however, was not so much on workers' feelings about air-raids, but on psychological weaknesses in the wartime workforce. The psychological impact of the war was thus construed not as a problem of how air-raids or wartime conditions might affect the psychology of individual workers, but on how war-time exigencies had changed the make-up of the workforce, leading to a greater proportion of workers perceived as being psychologically weak and unable to adapt to factory life. In the following sections of the chapter, I look at how these arguments about the psychological weakness of the workforce dominated psychiatric explanations of increased levels of neurosis, and the gendered and class assumptions embedded within them.

[36] Vernon, 'Psychological Effects of Air-Raids', pp. 457-458.

Gender and class prejudices

Although numerous government and psychiatric reports praised women workers' courage, many psychiatric and industrial health reports assumed that female neurosis was caused by the individual woman's inability to adapt to the discipline and environment of previously male dominated sites of production.[37] Drawing on gendered discourses first developed in the nineteenth century, some wartime psychiatrists emphasised women's physical inferiority, the nervous strains that heavy work inflicted on female reproductive systems, and women's unsuitability for performing jobs usually carried out by, as psychiatrist J. M. Davidson put it, 'the husky type of male'. Women now worked, he wrote, 'side by side with men in hot foundries and loading bays.'[38] Despite such images of women doing heavy 'male' work, it is important to note that the vast majority of female recruits into the factories during the war carried out basic, routine work, often because factory managers considered these tasks more suitable for women.[39] Industrial officers and psychiatrists thus also explained the higher levels of women developing neurotic conditions to the concentration of women in, as the *Lancet* put it, 'the dullest and most monotonous jobs', rather than women's inability to perform heavy industrial work.[40] The authors of a report of sickness absence among munitions workers in

[37] See, for example, Anon, *Annual Report of the Chief Inspector of Factories for the Year 1941,* p. 18; Lady Isobel Cripps, 'Foreword', in Amabel Williams-Ellis, *Women in War Factories*, (London: Victor Gollancz, 1943), pp. 7-8.
[38] J. M. Davidson, cited in Anon, 'Discussion on the Effect of Wartime Conditions on the Health of the Factory Worker', p. 275.
[39] Field, *Blood, Sweat and Toil*, p. 140.
[40] Anon, 'The Happy Worker', *The Lancet*, 2, (29 September, 1945), p. 407. Geoffrey Field has also noted how a large proportion of the paid jobs carried out by women during the war involved the performance of basic, repetitive tasks that many employers deemed to be more suitable for women. Field, *Blood, Sweat and Toil*, p. 140.

engineering firms, for example, remarked on 'the greater liability of females to nervous disabilities connected with the repetitive work allotted to them.'[41] Similarly, Fraser's study identified neurosis with the jobs most frequently carried out by women workers, such as light sedentary jobs in the factory, which produced 'a trying monotony'.[42] Industrial medical officer Elizabeth Bunbury reported a 'small epidemic' of neurosis among a group of young women whose work involved adjusting electrical keys, which was only solved when the job became mechanised.[43]

Despite this concern about the detrimental psychological effects of tedious and repetitive work, government reports tended to downplay the importance of the nature of the work *per se* in the development of neurosis.[44] Rather, they emphasised women's inexperience in the workplace, and women's supposed inability to adapt to the disciplines and rigours of factory life. Along with elderly, very young and sick workers, women workers were often viewed as part of the 'deterioration' of the workforce, incurred by the call-up of men into military service. That was the attitude expressed by one medical officer from a factory in the north of England, who, when describing the poor physiques and unsuitability for work of women transferred to his factory, remarked that 'It would frighten you to see the

[41] A. Massey and R. C. M. Pearson, 'Sick Absence Among Munition Workers', *British Medical Journal*, 2, (12 December, 1942), p. 694.
[42] Fraser, *The Incidence of Neurosis Among Factory Workers*, p.10.
[43] Elizabeth Bunbury, 'Psychiatric Advice in Industry: III', *British Journal of Industrial Medicine*, Volume 2, (January, 1945), p. 46.
[44] See E. R. A. Merewether, 'Industrial Health', in Anon, *Annual Report of the Chief Inspector of Factories for the Year 1942*, Cmd 6471, (London: HMSO, 1943), pp. 26-35, p. 27; Fraser, *The Incidence of Neurosis Among Factory Workers*, p. 5; Wyatt, *A Study of Women on War Work in Four Factories*, p. 41.

people who are now sent to this place.'[45] Factory women who developed neurosis, particularly those who had been compulsorily drafted into industrial work, were viewed in a very similar way to servicewomen whose neurotic disorders were judged to be confirmation that women were psychologically unsuited for a life of military discipline, duty and obedience.[46] As with women in the military, the focus of government and psychiatric attention was on the inability of women to adapt to the previously male dominated sites of industrial production.

Although psychiatric assessments of women's unsuitability for factory life were often permeated with gendered assumptions about women's inability to do the work, many writers also wished to help to improve women's working conditions. There was not a clear-cut division between psychiatrists and medical officers who blamed factory conditions for the development of neurotic states, and those who focused on the women's unsuitability for male-dominated factory work.[47] Indeed, many medics posited multiple factors for the propensity of women to develop neurosis, which included analysis of working conditions, home factors, gendered prejudices about women's ability to perform certain jobs, and

[45] Blacker, *Neurosis and the Mental Health Services*, p. 23.
[46] S.J. Ballard and H.G. Miller, 'Psychiatric Casualties in a Women's Service', *British Medical Journal,* 1, (3 March, 1945), pp. 293-295; Hazel Croft, 'Emotional Women and Frail Men: Gendered Diagnostics from Shellshock to PTSD, 1914-2010', in Ana Carden Coyne (ed.), *Gender and Conflict Since 1914: Historical and Interdisciplinary Perspectives*, (Basingstoke: Palgrave Macmillan, 2012), pp. 114-115. For a general account of women in the Auxiliary Territorial Service during the Second World War, see Lucy Noakes, *Women in the British Army: War and the Gentle Sex, 1907-1948*, (Abingdon: Routledge, 2006), Chapter 6, pp. 103-132.
[47] Mathew Thomson has commented that the reports of industrial psychologists in this period could be double-edged, sometimes helping to mask class or economic interests, but in other instances acting as a 'tool of critique' against exploitation in the factory. Thomson, *Psychological Subjects*, p. 141.

preconceptions about females' biological or psychological predisposition to developing nervous and emotional problems.

A report by industrial psychiatrist Thomas Ling, in which he examined 100 workers referred to the psychiatric outpatient clinic attached to Mill Hill Hospital in North London, provides an example of the multifaceted explanations offered for why women were particularly prone to developing nervous conditions. Ling was outspoken in his critique of poor factory conditions, arguing that no more than 'lip-service' had been paid to improving conditions for workers in the past, leaving the majority of factories in a 'mediocre' state, with a minority leaving 'much to be desired.'[48] He also emphasised, however, women's inexperience as workers, and their inability to adapt to the 'excessively noisy', 'badly organised' and 'blacked out' atmosphere of factory life.[49] Neurosis developed, he suggested, as the women unconsciously attempted to take flight from the realities of the factory life. As Ling put it, in rather gendered language, women were 'not hardened to the discomforts of loud-voiced foremen or unsatisfactory sanitary arrangements, and will not infrequently escape from them into neurotic illness.'[50]

As noted by historian Geoffrey Field, female recruits to the factory were overwhelmingly working class, despite 'contemporary publicity and later myths' about the mixing of classes.[51] Psychiatric judgements about the mental health of the new recruits were infused with both classed and gendered assumptions about the women's lives both inside and outside of the workplace. Young single women,

[48] T. M. Ling, 'Industrial Neurosis', *The Lancet*, 1, (24 June, 1944), p. 830.
[49] Ibid, p. 831.
[50] Ibid, p. 830.
[51] Field, *Blood, Sweat and Toil*, p. 130.

who were the first group of women to be called up for industrial and military service in 1941, were thought to be particularly vulnerable to developing neurosis, especially those drafted into factory work from domestic service or rural areas.[52] In the section on industrial neurosis in his report, Blacker describes how, 'some of the girls have never been away from home; some can't stand the noise; some develop phobias of machinery; many are lonely and unhappy in their billets.'[53] Yet psychiatrists rarely noted that domestic service, agricultural or other types of work previously carried out by some of the young women drafted into factories could have been equally physically tiring, lonely or alienating.

Similarly, Davidson was sympathetic about young female workers forced to lodge with strangers. 'Uprooted from the conditions of life to which she has become accustomed, and thrust into billets, her lot is often a hard one,' he wrote. Although Davidson was sympathetic to her plight, his analysis was imbued with gendered presumptions. 'Such a girl all too often is not a good mixer; she has little idea of true values, no experience of judicious budgeting and next to no knowledge of the principles of nutrition,' he opined. Moreover, if she was 'of the quiet introspective sort,' he considered, she would be 'rather bewildered by the bustle of the large, soulless factory, and suffers in consequence from acute homesickness.' In contrast to this image of a quiet, and presumably 'good' young woman, Davidson painted a picture of what he called 'the tougher type of young female', who tended to spend her wages on 'fripperies of all sorts', and to spend her leisure time 'in

[52] See Wyatt, *A Study of Women on War Work in Four Factories*, pp. 38-39; Ling, 'Industrial Neurosis', pp. 830-831; Howard E. Collier, 'Neurotic and Psychiatric State as Causes of Inability to Work in England, 1940-1', *British Medical Journal*, 2, (9 October, 1943), p. 461.
[53] Blacker, *Neurosis and the Mental Health Services*, p. 27.

taverns and picture palaces.'[54] Thus psychiatrists often both reflected and reinforced gendered views which categorised women in a binary opposition of timid 'good girls'/glamorous 'good-time girls'.

In her report of women working in engineering firms during the war, social observer and novelist Amabel Williams-Ellis described how the new recruits to one steel factory had 'seemed like savages' and compared the young women's behaviour to that of problematic evacuee children. She wrote of how the girls 'had given no end of trouble' because they found it difficult to adapt to the discipline of the factory. Girls who arrived from poverty-stricken areas were, according to Williams-Ellis 'dirty in person and habits', and because they were 'young and for far too long "under-privileged", she considered that they spent their first earnings unwisely and frivolously.'[55] Such descriptions of young women acting like 'savages' and comparisons to children were not only highly gendered, but were also ridden with assumptions about class attributes and behaviour, confirming prejudices about how working-class women were expected to act and to feel at work.

In most psychiatric reports of industrial neurosis during the war, the situation of married women was treated far more sympathetically, and less moralistically, than that of young, single women who were viewed as emotionally immature. Young married women were, however, identified in government and psychiatric reports as being more at risk of developing neurosis than both single

[54] J. M. Davidson cited in Anon, 'Discussion on the Effect of Wartime Conditions on the Health of the Factory Worker', p. 276.
[55] Williams-Ellis, *Women in War Factories*, p. 38.

women and older married women over age 35.[56] The predominant explanation proffered in psychiatric reports, as well as by numerous social observers, was that female neurosis was a result of the strains incurred by the 'double burden' of combining paid work, especially full time work, with responsibility for childcare, housework, shopping (an arduous task during the war), along with fire-watching and other civil defence duties.[57]

This was particularly the case with those medics who were concerned with trying to improve social and working conditions for working women. Horace Joules was the Medical Director of the Central Middlesex Hospital in North West London and was also one of the founders of the Socialist Medical Association. He worked with both inpatients and outpatients in an area surrounded by aircraft and light engineering factories. Noting that the number of workers visiting the outpatient clinic had increased in a 15-month period between 1941 and 1942, Joules argued that the 'nervous debility' these patients experienced would be 'more accurately described as either an anxiety state or exhaustion phenomenon.' In recounting a series of case studies to the Royal Society of Medicine, Joules identified six main factors causing neurotic conditions in the workers he treated: excessive hours of work over a too long period; inadequate holidays; inadequate meals, especially among married women with home duties; inadequate travelling facilities; inadequate lighting and ventilation; and civil and fire-watching duties

[56] S. Wyatt, *A Study of Certified Sickness Absence Among Women in Industry*, Industrial Health Research Board Report No. 86, (London: HMSO, 1945), p. 20.
[57] S. Wyatt, 'Study of Absence from Work among Women in a War Factory', *British Journal of Industrial Medicine*, Volume 2, (April, 1945), p. 88; Dr. Joan Harwood in Anon, 'Discussion on Effects of War-time Industrial Conditions on Mental Health', p. 696; Williams-Ellis, *Women in War Factories*, p. 79.
[57] Wyatt, *A Study of Women on War Work in Four Factories*, p. 36.

'superimposed' upon long working hours. In one case study, Joules detailed the gruelling schedule of a typical day in the life of one of his outpatients, a 37 year-old woman with three children who worked long shifts as an assembler in a light engineering factory. On working days, Joules reported

> She gets up at 5.30am, cooks a midday meal for her children and then gets their breakfast. She reaches work at 7.30am. She returns home at 7.30 p.m. when she gets her husband's meal, does the housework, and usually retires to bed at 12.30 a.m.... The patient complained of severe headaches, increasing depression, general lassitude and loss of weight... Six weeks at a convalescent home restored her to normality, but she does not feel able to resume factory work.[58]

Although some psychiatrists, such as Joules, emphasised working conditions as a factor in the development of nervous symptoms, the majority of government reports emphasised factors outside the factory, and largely outside the control of the employers, as being the main factor in precipitating neurosis. This was the case even when the patient herself believed her nervous state was due to hours of work and conditions in the factory. Factory health investigator Stanley Wyatt, for example, wrote that it 'seemed fairly certain that several of the women blamed factory conditions when the real cause lay elsewhere.' He cited the example of a woman who had taken 152 days off sick through the course of one year. 'I was quite healthy till I worked here,' she said in her interview. 'But when on the night shift I couldn't rest in the day time, because the baby needed attention, and I only got three to four hours sleep. I couldn't stick it, and it caused a breakdown.'[59]

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[58] Horace Joules, cited in Anon, 'Discussion of the Effect of Wartime Conditions on the Health of the Factory Worker', p. 278.
[59] Wyatt, *A Study of Women on War Work in Four Factories*, p. 36.

Wyatt, however, identified the home burdens of looking after her baby and worries about her husband serving abroad, rather than the night shifts at the factory, as the main causes of the woman's disturbed sleep patterns and consequent nervous breakdown. As Williams-Ellis put it, it was 'outside things that steal the strength that is so much needed inside the factory.'[60] The problem of the double burden could thereby be conceived as one where it was the woman's home burdens that stole the energy needed by the employers in order to maintain wartime productivity.

Many psychiatrists and medical officers encouraged and welcomed the government's limited provision of nurseries, canteens, factory shops and other facilities to ease the pressures of child care and housework on women workers. They rarely questioned, however, whether these domestic jobs should remain the primary responsibility of the woman. Factory work, particularly of the heavier industrial variety, was considered to be a temporary phenomenon that would last only for the duration of the war, especially in the case of married women. Moreover, despite expressions of concern with the social situation of women workers facing the strains of wartime living, psychiatrists rarely viewed social and environmental factors as being the primary cause of neurosis. In accord with the dominant psychiatric view in this period, factory conditions were considered to be a precipitating factor that brought to the surface more deep-seated and individualised psychic conflicts or underlying physical or psychological disorders. In discussions about the aetiology of industrial nervous disorders, psychiatrists and

[60] Williams-Ellis, *Women in War Factories*, p. 79.

medical officers emphasised pre-factory emotions and events, especially those of childhood, in stunting the development of the individual's personality, leaving them emotionally ill-equipped to deal with life. [61]

Emotional women and timid men[62]

So far in this chapter I have highlighted how many of the writers of reports on industrial neurosis used gendered language to describe how women workers were seen as being more prone to neurosis due to their 'unsuitability' for work in the wartime factory. Many of the reports undertaken during the war, however, also examined the neurosis experienced by male workers. In the case of men, however, gender-inflexed pronouncements were much less prominent. Masculinity, unlike femininity, was marked by its 'invisibility'.[63] Whereas neurotic women workers were considered to be 'out of place' in the factory, neurotic men were not marked out on the basis of their gender. This did not mean, however, that psychiatric attitudes to working-class men were any less shaped by gendered assumptions.

In the following analysis of the psychiatric judgement of male workers I have been influenced by Sonya Rose's notion of a 'temperate' masculinity, whereby the construction of an idealised civilian man during the Second World War incorporated both military ideals of strength and bravery, along with a more domesticated ideal

[61] See, for example, Ernest H. Capel, 'Neurosis in Industry', in Rolleston and Moncrieff (eds.), *Industrial Medicine*, p. 88.
[62] This sub-heading is an adaption of the title of Croft, 'Emotional Women and Frail Men'.
[63] I have taken this concept of the 'invisibility' of masculinity from John Tosh, 'What Should Historians do with Masculinity? Reflections on Nineteenth-Century Britain', *History Workshop Journal*, Volume 38, (1994), p. 180.

of the family man, who provided stability and security.[64] In 1944, the male workforce numbered 10.3 million, and this included men in reserved occupations as well as those too young, elderly or sick to fight. Idealised images of civilian masculinity tended to be polarised between men who were considered fit (for military service, heavy industrial labour or civil defence on the home front) and those considered unfit (rejected from military service, sick or elderly).[65] Men who experienced nervous problems during the war, even if they were in reserved occupations, were viewed as not matching up to the ideal of a fit and healthy citizen, who could provide protection for his family and the nation. Psychiatrists viewed the wartime male workforce as containing a greater proportion of civilian men who were psychologically vulnerable and, like the influx of women, contributing to the 'deterioration' of the workforce. Lewis, for example, wrote of how there had been a 'deterioration of the men employed, the healthiest having left to join the Forces,' in his letter that prompted the survey.[66] This 'weaker' section of the male workforce included men who had suffered war neurosis in the First World War, those disqualified from joining up or discharged on the grounds of neurosis in the later war, and men who had previously found it difficult to find any work, especially through the 1930s, but who were able to find jobs in the context of wartime labour shortages.[67]

Russell Fraser's study, introduced earlier in the chapter, provides a useful way of analysing some of the more subtle ways in which psychiatric assessments of

[64] Rose, *Which People's War*, p. 153, pp. 151-196.
[65] For this analysis, I have drawn on Summerfield, *Reconstructing Women's Wartime Lives*, p. 117.
[66] TNA MH 76/115, Letter from Aubrey Lewis, Mill Hill Emergency Hospital to Professor F. R. Fraser, Ministry of Health, 4 March, 1942, p. 6.
[67] See Lewis, *The Social Effects of Neurosis*, pp. 167-170.

the workers' stability and personality were inflexed with such gendered assumptions of both female and male workers. Fraser's study was based on 3,000 workers, 1,466 who were male and 1,448 female, in 13 light engineering firms in the Birmingham area, supplemented by some later investigations in London.[68] Rather than study sickness records, which were often poorly kept and inaccurate, Fraser's team conducted psychiatric interviews, noting down detailed personal histories, using a similar methodology to the neurosis survey Fraser had conducted in Hull.[69] The results of the factory study showed that in a given six-month period, nine per cent of men and 13 per cent of women would suffer from a 'disabling' form of neurosis, which would lead to time off work. In addition, some 19 per cent of male workers and 23 per cent of female workers were considered to be suffering from minor forms neurosis.[70] According to Fraser, the diagnosis of neurosis accounted for the equivalent of an annual absence of three working days for every male worker studied and of six working days for every female worker.[71]

Some of the interviews on which the findings were based offer an insight into the way that both psychiatrists and workers conceptualised nervous symptoms. Before analysing some of these interviews, it is worth pointing out that the methodology deployed by Fraser, as well as the wording of drafts of his report provoked controversy, which may have been one of the reasons why its publication

[68] Fraser, 'The Incidence of Neurosis among Factory Workers', p. 1, p. 4. The supplementary studies in London were conducted by industrial investigator Elizabeth Bunbury.
[69] Ibid, p. 4. Fraser, who in 1942 was working at the Mill Hill Emergency Hospital neurosis centre and had just finished conducting the Hull neurosis study, was suggested as the head of the investigation by Aubrey Lewis and the government's psychiatric advisor Bernard Hart for his ability 'to bring out the incidence of neurosis'. TNA 76/115, Memo by F.R. Fraser, Ministry of Health, 27 May, 1942. For details of the Hull study see Chapter Six of this thesis.
[70] Fraser, 'The Incidence of Neurosis among Factory Workers', p. 4.
[71] Ibid, p. 5.

was delayed until 1947. Fraser was criticised by several members of the Industrial Health Research Board for the report's 'subjective symptomology', which based its assessment of levels of neurosis on how the workers described and felt about their neurotic symptoms.[72] From a different angle, Elizabeth Bunbury, who conducted some of the London interviews, criticised drafts of Fraser's report because it dovetailed too closely with the government's obsession with maintaining high productivity. The report seemed to 'smack too strongly of Taylorism', she wrote in a letter to the board, and gave the impression that the interviewers had 'only been interested in health in so far as it affected production.'[73]

In the final report, Fraser argued that the main reason for the development of neurosis, in both male and female workers, was a 'decrease in social contacts'. 'Those whose leisure was usually spent alone, or only with their immediate family, suffered more than average neurosis, whether their contacts were reduced because of solitary interests, restrictions imposed by home duties, or other reasons,' Fraser concluded.'[74] The reasons for an individual's isolation could of course be conceived as resulting from social factors, connected with the worker's living and working situation, family life and the accessibility of leisure facilities. In the interviews, however, psychiatrists repeatedly highlighted that social isolation and solitariness were long-standing problems, which stretched back to the workers' pre-factory life and were often seen to have developed in their childhood.[75] One

[72] TNA FD 1/6924, Comments received by members of the Industrial Health Research Board, 1945.
[73] TNA FD 1/6924, Letter from Elizabeth Bunbury to the Industrial Health Research Board, 9 September, 1945.
[74] Fraser, 'The Incidence of Neurosis among Factory Workers', p. 9.
[75] The interviews were carried out by six industrial health investigators, with one psychiatrist present at each interview. Most of the workers were interviewed in two sessions, lasting one and a half hours in total. Physical investigations were also carried out, including blood tests and x-rays. Nine of

case study, for example, was of a 45 year-old single woman, who worked on a tapping machine in a light engineering factory and had complained of suffering from 'nerves'. 'She doesn't enjoy her present job, which she does inefficiently, as she feels rightly that the charge-hand is critical of her,' recorded the investigator. She had a difficult and long journey to work and had 'not been happy' since starting at the factory, suffering from bouts of depression. The investigator concluded the report, however, by emphasising that she had 'always been solitary, and sensitive, and easily upset, "though she tries to do her best": she has never been able to mix in company with any ease. She has been subject to moods and depression all of her life.'[76] The implicit suggestion was that her current problems in the factory were precipitated by feelings more deeply embedded in the woman's personality and psychic make-up.

Similarly, in another case study, a 23 year-old single woman started to suffer from her current depression when she moved from domestic service to work in a factory near London. At the factory 'she found the work burdensome, could not mix with the people, and she also found the bombing trying.' Her fiancé was about to be sent abroad with the RAF, and 'her distance from home and her mother's poor health, cause her some anxiety.' The interviewer emphasised the isolation of this young woman who 'by choice... has no friends' and 'few interests outside her work.' The interviewer also stressed that the worker had 'been all her life solitary and moody', 'never had much energy' and had 'always been nervous of the dark,

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the case studies were published in the 1947 edition of Fraser's study. An additional six case studies are included in TNA FD 1/6924.

[76] Ibid, Psychiatric Needs of the Civilian Population – Neurosis in Industry, Case 5183.

and of crowds.' By doing so, the interviewer conveyed the impression that this woman's depression was more profoundly connected with her pre-factory past life than with her troubles at work.[77] The interviewers thereby placed greater emphasis on factors, either inherent or acquired, which had formed the personality of the worker from a young age. The implicit assumption was that the worker's personality had played a greater part in the aetiology of the neurosis than the conditions and events they experienced in the factory or the stresses incurred through bombing-raids or the other events of war.

The case studies in Fraser's report are notable, however, for containing far less explicitly gendered language about either the female or male workers than in many of the published accounts of female neurosis by psychiatrists and social observers discussed earlier in the chapter. The interviews with the men, for example, were remarkably similar to those of the women, with both containing frequent references to solitariness and 'sensitive' personalities. In the case of the men, however, this language was in contrast to normative masculine attributes, such as strength and self-confidence. A 34 year-old setter in an engineering firm, for example, was described as having been a 'nervous child', who would 'faint at the sound of guns' during the First World War and who was 'much upset by sirens' in the later conflict.[78] Another case study highlighted the situation of a male sheet metal worker in charge of supervising 30 to 40 workers. The 38 year-old man was diagnosed as suffering from minor neurosis and fatigue syndrome. He was described as 'shy', with 'a paucity of contacts outside home limits'. The investigator

[77] Ibid, Case 5210.
[78] Fraser, 'The Incidence of Neurosis among Factory Workers', p. 59.

noted that the man 'found the war years strenuous and trying', but, in a similar vein to the female case studies, the interviewer wrote that 'he has always been rather solitary', 'has never had many friends' and that 'all his life he has been bothered with slight obsessional symptoms'.[79]

Civilian men, especially but not only those who had been refused entry or who had been discharged from military service for psychiatric reasons, were regarded as having weak and timid personalities, whose emotional inadequacies made them incapable of dealing with wartime working conditions.[80] As seen in Chapter Six, even those men working in the masculinised site of the Hull dockyards who suffered nervous reactions to the raids were judged to be more likely to have timid personalities.[81] When nervous women's personalities were noted as being inadequate, solitary and fearful, these words reinforced notions of women's physical and emotional fragility. The same attributes in men were rarely explicitly related to gender, but repetition of the words 'timid', 'weak' and 'inadequate' when applied to male workers implicitly controverted notions of rationality, confidence and strength associated with masculinity. The implication was that such neurotic men had failed to emulate and match up to wartime masculine ideals of strength and courage, and to fulfil their duty as protectors of the home front. What constituted a 'normal' or 'abnormal' psychological state amongst the workforce was thus judged in terms of gendered assumptions and expectations about masculine and feminine behaviour and emotional response. There was no

[79] TNA FD 1/6924, Psychiatric Needs of the Civilian Population – Neurosis in Industry, Case 6062.
[80] See the male case studies in Harry Stalker, 'Panic States in Civilians', *British Medical Journal*, 1, (1 June, 1940), pp. 887-889.
[81] See Chapter Six.

agreement amongst medics, however, about what types of behaviours and feelings could be viewed as evidence of a neurotic condition, or even how 'neurosis' should be defined.

'Normal' and 'abnormal' emotions in the workplace

One government review of sickness absence during the war period made a sharp distinction between rational and irrational fears among workers. 'Normal' anxieties, the authors stated, included those of women worrying about their loved ones serving abroad, or who had a husband wounded or taken prisoner. Such 'normal' anxieties were 'inevitably widespread in wartime', they argued.[82] Some of the nervous states caused by the turmoil of war could be cast as a 'normal' and temporary anxieties, much like the minor neurotic reactions to bombing discussed in the previous chapter. The authors of the report contrasted these 'normal' anxieties of wartime with what they judged to be 'irrational' anxieties prevalent in the workplace. Such 'irrational' fears included the fear of being in closed spaces or crowds, worrying about making decisions, as well as 'apparently groundless dread of persons in authority'.[83] The report categorised the worries about the relationships at work as located in the psyche of the individual worker, rather than based on a rational judgement of the workers' situation, making an implicit judgement on what anxieties and fears were legitimate or not. Which anxieties

[82] Anon, *Why is she Away? The Problems of Sickness among Women in Industry*, Industrial Health Research Board of the Medical Research Council, (London: HMSO, 1945), pp. 7-8. On the normality of women's feelings of fear about the safety of loved ones see Wyatt, *A Study of Certified Sickness Absence among Women in Industry*, p. 31.
[83] Anon, *Why is she Away?,* p. 7.

were judged as 'rational' or 'irrational' in the workplace were highly contestable, and depended on the politics, values and judgement of the psychiatrist or medical officer doing the assessing, and also on the ways the worker expressed and articulated her fears.

There was even less agreement among medics as to what emotions and symptoms in the workplace could be classified as a diagnosable 'neurosis'. Some industrial investigators believed that the official figures underestimated the real extent of nervous conditions experienced in the factory. Wyatt, in his study of the sickness absence of female workers in five munitions factories, believed that many cases of 'nervous debility' or 'fatigue' were simply not recorded in the sickness records or were classified as organic diseases. He noted that when patients had both a physical and a nervous complaint, industrial medics invariably recorded the organic disorder as the primary cause of the illness. 'Such cases were accordingly included in the diseases of the circulatory system and not in the group of functional nervous disorders,' he wrote.[84] Industrial investigators believed that many illnesses officially classified as organic illnesses had a psychological cause. One factory medical officer described workers experiencing stomach complaints due to stress and fatigue caused by frequent shift changes, long hours and excessive travelling time, as the 'unnecessary casualties of war.'[85] Another report by the Industrial Health Research Board claimed that up to 20 per cent of cases diagnosed as digestive disorders 'might better have been called "nervous", since much digestive

[84] Wyatt, *A Study of Certified Sickness Absence Among Women in Industry*, p. 16.
[85] G. P. B. Whitwell, 'Stress Dyspepsia in Industry', *The Lancet*, 2, (20 September, 1944), p. 450.

trouble is due to worry or emotional stress.'[86] The authors considered that 'disordered stomach and bowels' were often symptoms of fear, even though workers may not be aware of such a connection because 'fear is not always present to the conscious mind.'[87]

As well as the misdiagnosis of psychological disorders as physical illnesses, the Industrial Health Research Board contended that many nervous disorders were simply not diagnosed at all. Workers could take non-consecutive days of sick, without having either medical certification or a diagnosis. Such 'casual absenteeism', accounting for much unrecorded sickness, was viewed as being 'especially excessive among women.'[88] The Board also noted that many women carried on working whilst they were ill or overtired, relying on occasional days off or on tonics purchased from the chemist to get them through. 'Many busy women try to avoid visiting their doctors, as they feel they cannot afford the time involved, and therefore do not ask for the certificates to which they are entitled,' noted the report.[89] One woman described how she managed to 'keep going', but argued that workers needed 'all the willpower we've got and we shall have to pinch time off if we don't get it. Most of us are taking tonics, and in my own case it costs almost 10/- a week.'[90] The time that these women 'pinched' from the employers was usually not recorded, and could take the form not only of occasional days off sick, but also through workers slowing down the pace and intensity of their work.[91]

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[86] Anon, *Why is she Away?,* p. 5.
[87] Ibid, p. 8.
[88] Anon, *Hours of Work, Lost Time and Labour Wastage*, p. 8.
[89] Anon, *Why is she Away?*, p 3.
[90] Cited in Anon, *Hours of Work, Lost Time and Labour Wastage*, p. 5.
[91] TNA INF 1/292, Home Intelligence Weekly Reports, No. 33 May 14th - May 21st, 1941.

Some industrial medical officers doubted whether minor emotional conditions could be counted as neurosis at all. In Blacker's research, for example, industrial medical officers were asked what percentage nervous illness had played in their sickness absence figures. Their answers varied between two per cent and 75 per cent, depending on where the medical officer 'drew the line' in their definition of neurosis.[92] It is difficult to explain such a huge discrepancy in these results, except to note they indicate that factory medical officers found it impossible to define what neurosis actually was. Indeed, Blacker concluded from his investigations that accurate figures on rates of neurosis in factories were impossible to obtain.[93] In his report, Blacker distinguished between 'tangible' psychological illness and 'intangible' or 'borderline' nervous conditions. In the 'tangible' category he included what he called 'text book' neuroses, such as anxiety states where the patient suffered tremors and sweating, and 'definite' hysteria or obsessional symptoms. He defined the 'intangible' category, by contrast, as 'illnesses equivalent to a lack of well-being', which could be cured by a holiday by the sea and plenty of sleep.[94] The implication was that such 'intangible' nervous conditions were not only less serious, but did not constitute verifiable psychiatric illnesses. In a similar conceptualisation, psychiatrists Hugh Crichton-Miller and W. J. T. Kimber, writing to the *BMJ* on behalf of the National Council for Mental Hygiene, categorised workers with minor neurotic ailments as 'the employed subneurotic', a category they claimed was assuming greater prominence. This group were 'mainly women', who the writers considered 'immature in their emotional development owing to having

[92] Blacker, *Neurosis and the Mental Health Services*, p. 32.
[93] Ibid, p. 23, p. 32.
[94] Ibid, pp. 26-27

led a sheltered life with restricted opportunities for making social contacts.' It would be 'unjust to style them neurotics,' argued Crichton-Miller and Kimber, reconfirming that to be diagnosed with a nervous disorder retained a level of stigma in the workplace.[95] Moreover, the themes of gender, emotional immaturity, social isolation, all remarked upon in Fraser's factory interviews and in the psychiatric studies discussed earlier in the chapter, were reiterated, albeit using slightly differing terminology, as psychiatrists grappled with trying to conceptualise, diagnose and understand the range of minor neurotic symptoms they encountered in the context of the wartime workplace.

While some industrial medics believed that 'intangible' emotional conditions should not be classified as 'neurosis', others were concerned that fatigue or minor emotional problems could precipitate the onset of more serious mental disorders and thus needed to be taken more seriously. For Bunbury feelings of 'being browned off' could lead to the development of more serious psychological complaints.[96] Midlands-based industrial medic Ernest Capel contended that 'straightforward fatigue' could lead to 'special emotional strain' and was 'a potent factor in causing breakdown under otherwise normal stresses.' He argued that even 'simple likes and dislikes', such as being moved to work away from friends, 'could at times cause emotional stress leading to real illness.'[97] Although such feelings would

[95] H. Crichton-Miller and W. J. T. Kimber, 'Neuroses Among Civilians in War-Time', Letter, *British Medical Journal*, 1, (3 April, 1943), pp, 444-445, p. 445.
[96]Bunbury, 'Psychiatric Advice in Industry: III', p. 45.
[97] Capel, 'Psychiatric Advice in Industry II', p. 43.

not show up in official sickness records, many medics feared that they could develop into more serious mental disorders if not recognised and treated.[98]

'No time now to be ill!'

Minor nervous conditions and disturbed emotional states were seen as intimately connected to workers' subjective attitudes towards their jobs. As one Ministry of Labour investigation put it, in some cases 'absence is due primarily to "feelings" as distinct from "facts"', and provided as an example workers who complained of feeling depressed solely because their factory was permanently 'blacked-out'. Such 'intangible' psychological states thus could be ascribed to workers' lack of interest in their job or, as one report put it, 'a lack of conviction of its importance and urgency, due often to ignorance.'[99] The implication was that if workers changed their attitudes towards their job, they could prevent nervous illnesses from developing.

Individualised notion of workers' mental health, and the importance ascribed to subjective feelings were connected to a wider process, begun during the war, whereby employers and industrial medical officers sought to harness workers' emotions in a positive direction to boost productivity and the war effort. This increased emphasis on workers' subjectivity in the workplace has been described by Foucauldian scholar Nikolas Rose as an attempt to 'align the needs of industry with

[98] Anon, 'Discussion on Effects of War-Time Industrial Conditions on Mental Health', p.64; Merewether, 'Industrial Health', p.27.
[99] TNA LAB 26/132, Enquiry into absence from work: papers submitted to the Factory and Welfare Advisory Board. The Problem of Absenteeism, p. 2.

the satisfaction of the worker.'[100] Rose refers to the wartime increase in the use of psychology in industry, such as through selection tests and a focus on 'human relations', as 'the productive use of psychological intervention to increase national efficiency.' [101] On the one hand, there was growing recognition that new forms of capitalist production methods – such as the concentration of industry into ever bigger units, the introduction of assembly line methods, and the increasing specialisation and division of labour – were creating a range of major and minor physical and mental health problems.[102] On the other hand, employers increasingly believed that paying attention to their workers' emotional needs could be beneficial not only for the worker, but for productivity and profitability.

This process can be seen in wartime health reports that urged managers and supervisors to create a 'group atmosphere' and to encourage a positive working atmosphere.[103] The concentration of industry into ever larger units meant, according to an editorial in the *Lancet*, that it was 'important to assimilate the worker into the social life of the factory and into a social group to offset tedium.'[104] Williams-Ellis' pamphlet about women workers contained a chapter headed 'Factories as Personalities', in which she urged factory managers to create 'a happy ship'.[105] The government encouraged employers to set up initiatives such as 'music

[100] Nikolas Rose, *Inventing Our Selves: Psychology, Power and Personhood*, (Cambridge: Cambridge University Press, 1998), p. 137.
[101] Ibid, p. 136.
[102] Vicky Long, '"A Satisfactory Job is the Best Psychotherapist": Employment and Mental Health, 1939-1960', in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability Since 1850*, (Abingdon, Routledge, 2006), pp. 183-184.
[103] Russell Fraser, 'Psychiatric Advice in Industry: IV', *British Journal of Industrial Medicine*, Volume 2, (January, 1945), p. 47.
[104] Anon, 'The Happy Worker', p. 407.
[105] Williams-Ellis, *Women in War Factories*, pp. 29-41; p. 29.

while you work' and social clubs in order to develop a sense of communality in the workplace.[106] This was linked to government efforts to boost morale among the workforce.[107] Workers should be encouraged to develop a closer emotional attachment to their workplace and to feel they were 'members of family and not of a crowd', as the head of the Post Office's medical services put it.[108]

How much did these attempts to involve workers in the 'community' of the factory constitute the development of new relationships in the workplace during the war? Scholars Peter Miller and Nikolas Rose have argued that the cultivation of workers' subjectivity during the war 'forged links between the subjective capacities of the individual and the well-being of the nation.'[109] Miller and Rose contend that such measures were not merely a different means whereby employers sought to legitimatise existing power-relations, but were productive of new relations at work which would come to fruition in the post-war economy.[110] Although the wartime emphasis on workplace relationships foreshadowed the development of post-war 'human relations' in industry, in practice there is little evidence that workers' mental health improved as a result of these efforts.

The government may have urged employers to pay more attention to their workers' mental well-being, but the setting up of recreational facilities and social clubs was limited to initiatives in a few large factories. Towards the end of the war

[106] John C. Bridge, 'Health', in Anon, *Annual Report of the Chief Inspector of Factories for the Year 1941,* Cmd. 6397, (London: HMSO, 1942), pp. 19-21.
[107] Gertrude R. Schmeidler and Gordon W. Allport, 'Social Psychology and the Civilian War Effort: May 1943-May 1944', *Journal of Social Psychology*, Volume 20, (August, 1944), p. 165.
[108] Bashford, 'Some Aspects of Sick Absence in Industry', p. 10.
[109] Peter Miller and Nikolas Rose, 'The Tavistock Programme: the Government of Subjectivity and Social Life', *Sociology*, Volume 22, (1988), p. 175.
[110] Ibid, p. 174.

the government's chief medical inspector for factories admitted that the setting up of industrial medical services had been 'very partial', and was further curtailed by the wartime shortages of doctors and nurses. By the end of 1944 there were only 180 full time doctors employed to cover 275 factories, with 890 part-time doctors.[111] In Williams-Ellis' investigations of the lives of female factory workers she found great discrepancies in the psychological understandings of factory medical officers in the 30 plus factories she visited. 'No one in industry, as far as I have been able to discover, as yet uses trained people for dealing with the quite frequent emotional upsets, hurt feelings, depression and so on that crop up in factories,' she reported.[112]

Moreover, the health initiatives were at best only ameliorative, particularly in the context of a wartime factory system that depended on long working hours and the performance of repetitive and alienating tasks over which the worker had little control.[113] Employers aimed to get workers to adjust to existing conditions and the nature of work in the factory, rather than to adapt the factory to better suit the psychological needs of the individual worker.[114] As the reports examined in this chapter have illustrated, the 'happy ship' contained many fatigued, ill and disgruntled workers. There was often a gulf between management rhetoric and the reality of life on the factory floor as workers themselves perceived and experienced it. One welfare officer interviewed by Williams-Ellis, for example, had been given the nickname 'Illfare' by the workers due to his unfriendly attitude and his dismissal

[111] E. R. A Merewether, 'Industrial Health', in Anon, *Annual Report of the Chief Inspector of Factories for the Year 1944*, Cmd. 6698, (London: HMSO, 1945), pp. 45-75, p. 70.
[112] Williams-Ellis, *Women in War Factories*, p. 28.
[113] Long, *The Rise and Fall of the Healthy Factory*, pp. 153-154.
[114] Ibid, p. 153.

of women workers' health complaints as a 'darned nuisance'.[115] The problem of the relationship between workers and management was not only about the attitudes of individual managers towards workers, but also stemmed from the attitudes of those at the top of the factory hierarchy, according to the Chief Inspector of Factories, A. W. Garrett. Although managers and foremen may have resisted new systems of 'personnel management', he argued, 'the main trouble lies in the Board Room and until there is a right attitude of mind in that room, the system will not be a success in the individual works.'[116]

Attempts by the government and employers to encourage workers to take more care of their mental health were often double-edged. Wartime government reports, for example, contained repeated references to how workers themselves could influence whether or not they developed nervous conditions. As a government pamphlet on fatigue put it, 'it is not only bad conditions, but also the way people *think* and *feel* about those conditions that is important, since the way they think and feel influences the way they behave.'[117] The responsibility for the prevention of illness not only lay with the employer, to cut working hours, institute rest breaks, improve sanitation and provide facilities such as workplace canteens and nurseries. It equally rested with workers themselves, who were urged to take responsibility for their own emotions at work, to organise their lives better outside work and even to 'give up those pleasures which interfere with work'.[118] At a time

[115] Williams-Ellis, *Women in War Factories*, p. 34.
[116] Anon, *Annual Report of the Chief Inspector of Factories for the Year 1941*, p. 9.
[117] Anon, *Absence from Work: Prevention of Fatigue*, (London: HMSO, 1944), p. 6.
[118] Ibid, p. 9.

of war, personal anxieties were 'extravagant wasters of energy', and, in the words of the pamphlet, 'There is no time now to be ill!'[119]

These inculcations to workers to take responsibility for their own physical and psychological well-being also encouraged the view that it was workers themselves who were at fault if they developed an illness or experienced nervous problems. There could be a fine line between responsibility and blame, however. Blame was often attached to workers who took time off, as is implied in one government report which suggested that 'While domestic problems and minor illnesses account for the absence of so many women workers from their posts, there is still a substantial residue of absenteeism due to frivolous causes.'[120] There could also be confusion about what counted as a medical diagnosis, and whether it was induced, consciously or unconsciously, by the worker. 'Poor morale' was the diagnosis assigned to some 16 cases in Ling's analysis of 100 workers referred to his psychiatric clinic. Ling argued that the symptoms of 'poor morale' were often associated with 'psychopathic disorders', including anxiety and hysteria. Yet Ling suggests that these patients did not have genuine nervous disorders. He admitted that 'Poor morale is a social outlook rather than a clinical diagnosis,' and suggested it was applied to those workers who 'prefer their own interests' to those of the nation and the community. A patient could thus be diagnosed as 'ill' if their attitudes were judged to not fit those of the national interest, and then be blamed for causing their illness by their attitudes. In addition, Ling believed that many

[119] Ibid, p 16.
[120] Anon, *Third Report from the Select Committee on National Expenditure, Session 1942-1943. Health and Welfare of Women in War Factories*, (London: HMSO, 1942), p. 12.

industrial doctors inadvertently encouraged workers to be malingerers by misdiagnosing them with physical illnesses that were seen to be 'honourable' rather than with a psychological injury which was seen to be blameworthy.[121]

Reports of absenteeism were thus infused with moralistic judgements about whether the worker was really sick or not. Although many industrial medical officers contended that 'true' malingering was rare, many reports expressed scepticism that workers were suffering from a 'real' psychological condition.[122] Donald Norris, for example, warned that the doctor needed to be 'constantly on his guard against the possibility of deception', as the nervous system, 'is, perhaps, the favourite choice of most malingerers.'[123] There was 'every gradation of dishonesty,' he contended, including

> the hard-working woman who attempts to undertake a whole-time job in a factory and also continue with her domestic responsibilities, finds that she has insufficient time for both, and seeks a medical certificate to cover unpunctuality.[124]

Thereby even the woman juggling work and home responsibilities could be judged with suspicion if not outright malingering. In a review of reports on absenteeism collated by the Home Intelligence section of the Ministry of Information, the mental attitude of the worker was listed as one of the main factors leading to workers taking time off. The third most important cause for absenteeism among women, after domestic duties and illness, was what the report called in

[121] Ling, 'Industrial Neurosis', p. 831.
[122] See, for example, Henry Bashford, 'Supervision of Sick Absence in Industry', *The Lancet*, 2, (6 September, 1942), p. 289.
[123] Donald C. Norris, 'Malingering', in Rolleston and Moncrieff, *Industrial Medicine*, p.101, p.105.
[124] Ibid, pp. 103-104.

shorthand, '"The Sheep for a Lamb" situation', where a worker took the whole day off rather than be criticised for being late.[125] Other 'mental factors' causing absenteeism listed in the report included 'lack of incentive to work', 'lack of feeling of active participation in the war effort', 'lack of colour' in wartime life, workers' views that the 'bosses are incompetent', and 'lack of ambition, particularly among women and youths.'[126] Such was the 'contempt' for many nervous patients, argued industrial medic Capel, that many industrial medical officers implied that the worker 'is either a malingerer or is at least responsible himself for his state, and is given treatment consisting of bottles of the foulest possible "tonic"... and is told to "pull himself together".'[127]

This focus on individual responsibility was congruent with more established psychiatric theorisations which emphasised individual predisposition and defects in an individual's heredity, physiology or personality. This is not to understate the complex and multifaceted nature of psychiatric explanations for neurosis, or to deny the importance of different psychiatric theorisations as to aetiology, definitions and symptoms. It does suggest, however, that notions of individual predisposition – whether conceived as somatic, psychological, or a mixture of both – remained the primary way psychiatrists understood the emotional disorders of workers in wartime Britain.

[125] TNA INF 1/292, Home Intelligence Weekly Reports, No. 33, 14 May - 23 May, 1941, 'Absenteeism in Industry', p. 6.
[126] Ibid. The other factor listed was 'A belief that the "Lease and Lend bill will do it all for us"'.
[127] Capel, 'Neurosis in Industry', p. 86.

Conclusion

This chapter has focused on how the wartime factory became one of the main sites of government and psychiatric concern about civilian neurosis during the war. This concern centred not on the effects of bombing-raids on the mental health of workers, but rather on the lack of adaptability to factory life and discipline of an industrial workforce that was viewed as having been weakened by the military call-up of male workers. The majority of the psychiatric reports considered in this chapter used gendered language to try to explain why female workers seemed more prone to developing neurosis. Many psychiatrists and medical officers considered that a multiplicity of factors led to the development of neurosis in female factory workers, including monotonous work, long hours, women's double burden of work and home responsibilities, and wartime separation from loved ones. But as the reports and case studies have illustrated, these explanatory factors were framed and subsumed within a psychiatric discourse that viewed the inherent physiological and psychological make-up of the individual woman as the primary factor in the aetiology of neurosis. Although the psychiatric judgement of neurotic male workers was less explicitly gendered, neurotic men were also judged to be part of a section of the workforce that was inherently weak. Male workers suffering neurotic symptoms, as highlighted in the case studies from Russell Fraser's study, were seen to be those with timid and reserved personalities. Nervous illness was thus viewed as a confirmation of mental and emotional frailty in both male and female workers.

The studies of the mental states of factory workers included in this chapter have also brought to the fore a question that has dominated this thesis – how did psychiatrists and other medics define neurosis? This question became particularly acute in the non-medical arena of the factory, as psychiatrists and medical officers grappled with understanding how to diagnose and treat those symptoms that were seen as 'nearly normal'. These practitioners were dealing with similar issues to the ones faced by psychiatrists and social observers working with air-raid victims. Which nervous symptoms could be viewed as part of a 'normal' response to the abnormal situation of the war? Could seemingly minor emotional states, like the 'fed-upness' experienced in the factory, be a sign of the onset of a more serious mental illness? Should such minor symptoms be pathologised as a mental illness? These discussions about the definition of 'neurosis' and what were 'normal' and 'abnormal' psychological reactions illustrate themes that have been at the heart of this thesis. Firstly, this study has illustrated that wartime diagnostic categories were inherently unstable, and the meaning of 'neurosis' was constantly shifting and incorporating new elements. Secondly, the research has shown that the sorting of psychological reactions into 'normal' or 'abnormal' responses, whether to the war or to the factory, was never a neutral, scientific assessment but depended on the political stance and social power of the person making such a categorisation.

Lastly, psychiatric assessments of workers during the war were framed by the government's and employers' interests to maintain high productivity, industrial stability and high morale within the existing factory system. This ensured that, despite increased attention to human relations in the workplace, the psychiatric view of the worker remained individualised, and focused more on the adaption of

the worker to fit the needs of the employer than the adaption of working conditions to suit the psychological well-being of the worker. The ways in which workers' nervous disorders and symptoms were conceptualised during the war thus cohered with mainstream wartime theorisations, which downplayed external traumatic and social-environmental factors and prioritised factors inherent within the worker's physical and psychological make-up. Ultimately, it was the individual worker who was seen to be responsible for the development of his or her neurosis.

Chapter Eight: Conclusion

This thesis has explored civilian mental health in Britain during the Second World War period through examining medical discourse, government policy, and psychiatric practice at four major wartime sites. In doing so, this research has for the first time brought together previously disparate accounts of civilian psychiatric practice and experience. Examining government and psychiatric discourse in the context of where and how it was practiced has provided a new lens through which to view mental health during the war. The findings of the research indicate that there was a far more varied and complex picture of the psychiatric experience than has previously been acknowledged in the extant historiography.

More specifically, this research has contributed to the historiography of the Second World War in five areas: the ways in which civilian wartime diagnoses were constructed and articulated in psychiatric thought; the relationship between psychiatric discourse and government policy; how official discourse was applied in practice during the war; the ways in which dominant narratives about the psychological effects of the war were created and sustained; and the effects of the war in shaping post-war psychiatric ideas and services.

Firstly, this research has demonstrated how developments in psychiatric theorisations and diagnostic categorisations during the interwar period, which were developed throughout the war itself, shaped how the nervous disorders of civilians would be conceptualised and experienced. The view that mental illnesses would only develop in certain types of people and/or those with past traumas or illnesses was articulated by psychiatrists from across the theoretical spectrum, including

psychoanalysts as well as those who advocated a physical causation to mental disorders. The flexibility of the notion of predisposition meant that psychiatrists could explain how a wide range of pre-war factors, including mental illnesses, family histories and traumatic childhood events, were the primary cause of nervous disorders. In this way, psychiatrists viewed the war as merely a precipitating factor to more individualised and deeply-rooted factors in the patient's physical or psychical constitution or in their earlier, pre-war, life.

Although ideas of predisposition had been prevalent in explanations for shell-shock during and after the First World War, developments in psychiatric theorising and diagnostics in the interwar years, as detailed in Chapter Two, meant that psychiatric understandings of war neurosis among civilians were conceptualised differently from those of shell-shocked soldiers. In particular, increased attention to more minor neurotic disorders ensured that the nervous reactions of fear and anxiety could be viewed as temporary and 'normal' reactions to the experiences of the war, including its most violent and terrifying events.

These developments in psychiatric understandings of war neurosis in civilians did not take place in a vacuum, but were closely intertwined with political and economic factors. The second contribution this thesis makes to understanding civilian war neurosis is in its analysis of the relationship between psychiatric diagnostics and the policies and priorities of the wartime government. Psychiatrists helped to shape government policy, which, in turn, shaped psychiatric discourse and practice during the war. Anxious not to repeat the experience of shell-shock, government officials formulated policies that aimed to contain and manage

psychiatric casualties by strictly defining what mental disorders would be attributed to the war. In this way, the state sought to limit and control the social and the financial costs of the war. As shown in Chapter Three, government ministers and officials relied on the advice of selected psychiatric advisors, who emphasised theories of physical or psychical predisposition. They formulated strict definitions about which mental disorders would be counted as psychiatric casualties of war, and deserving of compensation and extensive treatment.

At the same time, developments in psychiatric understandings about the onset and manifestation of more minor neurotic conditions meant that 'emotional shock' experienced during air-raids could be viewed as a 'normal' reaction to the extraordinary events of the war. This division between long-term and temporary nervous reactions was cemented in the government's directives to medical practitioners on how to treat civilians' nervous disorders during the war. Only those who were judged to have intractable, long-term disorders were to be referred to mental hospitals or for further longer-term clinical treatment. Those who had experienced emotional disturbances following air-raids were to be sent home as quickly as possible to cope on their own or to rely on their families or GPs. This suited government interests to limit the numbers of psychiatric cases referred to the overcrowded and over-subscribed mental hospitals where, as was seen in Chapter Four, the numbers of beds and staff had been further depleted to meet the wartime needs of the EMS and the military authorities. There was a mutually reinforcing relationship between the views of leading psychiatric figures of the period and the formation and implementation of the government's wartime health policies.

The third contribution of this thesis has been its exploration of how this official discourse was realised in practice. In doing so, this research has shown tensions as well as synergies between official discourse and the experiences of psychiatrists and doctors in the conditions and exigencies demanded by the war. As noted in the introduction to the thesis, historians have tended to focus their attention on the numbers of psychiatric casualties or on considerations of morale and social order, often focusing on one particular aspect of psychiatry during the war, such as admissions to mental hospitals or clinics. These histories have often neglected the various disputes between medics, as well as the diversity of civilians' psychological responses to the war. In contrast, my focus on different sites of practice has highlighted the diversity of psychiatric practice and civilian experience.

Tensions between official discourse and wartime practice were particularly evident in sites of psychiatric intervention outside of institutions. At these sites, psychiatrists assessed and treated civilians who had experienced bombing-raids, as illustrated in some of the reports and case studies discussed in Chapter Six. This research has pointed to two ways in which medics questioned the official discourse about wartime psychiatric casualties. Firstly, the trauma of raids could produce neurotic symptoms in those who had never previously experienced mental illness or who had no 'predisposing' characteristics. Although, in line with the government's directives, these symptoms could be viewed as temporary and 'normal' emotional reactions to air-raids, some of the patients doctors observed experienced more severe nervous reactions to the bombing.

Secondly, some psychiatrists believed that such patients needed further treatment and longer-term care, which was rarely offered at the First Aid Posts and other 'front-line' sites. Many civilians were discharged back into the community without receiving such follow-up care, and yet continued to experience serious psychological and physical symptoms. Psychiatric studies of those who had experienced bombing-raids were often more circumspect and contingent in their analysis of the psychiatric effects of the war. Psychiatrists and other mental health workers worried that there might be delayed or longer-term effects from such traumatic experiences. The psychiatric interviewers of workers and their families in Hull, for example, categorised civilians involved in traumatic raid experiences as suffering from diagnosable neuroses. Yet the majority of these civilians had never received any medical attention and were never counted as psychiatric casualties.

Similar cases of undiagnosed neuroses caused medical and social observers to worry about psychological problems being unrecognised and undiagnosed during the war. They concluded that that there were greater levels of psychological suffering than was accounted for in official government communications and many psychiatric reports. The extent of such undiagnosed cases can only be speculated upon by historians, but the concerns expressed at the time draw a much more diverse picture of the psychological effects of the bombing than conveyed by the notion of collective civilian resilience.

Psychiatric practice at the institutional sites examined in this research was more in keeping with the mainstream view that mental disorders were deeply-rooted in the individual's body or psyche rather than in the traumatic events of the

war. This was the approach that dominated the discourse and practice of psychiatrists who continued to be based in the public mental hospitals during the war. As shown in Chapter Four, these hospitals continued to house and treat tens of thousands of certified patients in overcrowded premises, whose spaces had been further compromised by the government's instructions to clear one-quarter of the beds for use by the EMS or the military authorities. Far from providing a refuge, the war impinged of every area of patients' lives, including causing death and injury from bombing-raids and compromising space, privacy, and occupations and entertainments within the hospitals. Psychiatrists rarely wrote of the effects of the war on their patients, however, whose mental conditions were viewed as disconnected from the effects of bombing-raids and the hardships of the war. Hospital doctors did, however, continue to espouse and put into practice somatic ideas and treatments. Indeed, if anything the idea there was a physical cause of mental illness, based within the bodies of mental patients, became even more prevalent during the war. Some medical superintendents continued to pursue new physical treatments, while de-prioritising alternative methods, as was the case at Rubery Hill Hospital in Birmingham. Treatments such as psychotherapy and occupational therapy thereby became more marginalised in the context of shortages of space, facilities and staff.

The public psychiatric clinics examined in this research in many ways straddled the divide between mental hospitals and treatment at non-institutional sites. Although the clinics retained close connections with mental hospitals, psychiatrists mainly dealt with patients suffering more minor neurotic disorders. Like mental hospitals, the clinics suffered from severe shortages of staff, space and

resources, and could not keep up with the demand the numbers of patients placed upon them. Although historians have often cited the numbers attending the clinics as evidence that the war did not increase the numbers of psychiatric casualties, this research has found a hitherto unacknowledged demand for the psychiatric services offered by the clinics. By 1943, the clinics were overcrowded, with patients prepared to forego comfort and privacy in order to seek help for their nervous symptoms.

Whether patients' nervous complaints were connected to the events of the war or not remains a matter of dispute. Blacker's survey, examined in detail in Chapter Five, argued that there was no evidence that air-raids had caused an increase in neurotic disorders. My analysis of the way in which this conclusion was reached, however, has highlighted how the construction of the questions for the survey prejudged its outcome, by asking psychiatrists to only count patients who had verifiable proof that they had been directly involved in an air-raid. In this Blacker used the same assumptions contained within the government's pensions' policy in the first years of the war, whereby civilians had to have been physically injured to qualify for any compensation. Although few psychiatrists interviewed for Blacker's survey believed that air-raids were the sole cause of the neurotic conditions they encountered at the clinics, many feared that nervous problems might manifest when the war was over. Others highlighted the detrimental psychological effects of the 'abnormality' of life during wartime. Factors that were inextricably connected to war conditions, such as witnessing bombing raids, losing loved ones or neighbours, excessive working hours or the tedium of some periods of the war, were thereby not necessarily classified as *war* neuroses.

Practitioners at psychiatric clinics, rest centres and public shelters, often viewed the civilian population as containing a distinct section who were inherently mentally unstable. This idea was also prevalent in assessments of the industrial workforce, which were examined in Chapter Seven. Most of the studies of neurosis in factory workers were conducted after the bombing-raids of the Blitz, and air-raids were rarely considered to have played a part in the development of the workers' nervous ailments. The main finding about industrial neurosis from my research is that the focus of industrial doctors was not so much on whether air-raids, or wartime conditions in workplaces, damaged individual psychologies, but rather on whether an inherently psychologically unstable workforce was harming productivity and national efficiency. Although class and gender biases inflected all psychiatric judgements during the war, these became particularly prevalent in the context of the wartime factory. The influx of women workers and the higher proportion of male workers who were too elderly, ill or weak for national service, were viewed as part of the 'deterioration' of the workforce, and their mental travails threatened to act as a destabilising factor in the prosecution of the war effort. This research thus confirms Mathew Thomson's view that government and psychiatric concern shifted during the war from fears about national security to a focus on national efficiency and policing malingering.[1]

An analysis of these shifts in the narrative of the war provides the fourth original contribution of this research. Although historians have referred to Edward Glover's characterisation of a pre-war mass neurosis myth transforming into a no

[1] Thomson, *Psychological Subjects*, p. 228.

neurosis myth, introduced at the beginning of this thesis, little attention has been paid to how this dominant narrative of the war was constructed and sustained. By examining the relationship between government and psychiatric discourses, the thesis has shown that the development of this narrative involved a complex overlapping of government and medical interests and assumptions about the nature and extent of mental disorders.

In part, the notion of civilian resilience was also sustained because the pre-war predictions of three to four million psychiatric casualties, which Glover described as 'merely figments of the psychopathologists' own imagination', became the benchmark by which government officials and psychiatrists judged the extent and type of psychological reactions to the war.[2] This was illustrated in an article by Felix Brown, referred to in Chapter Three, where he highlighted a number of cases of extreme emotional shock and other forms of neurosis. Brown began the article by noting that the 'swarms of hysterics which were by some expected to follow bombing have not appeared,' almost as if he had to justify his examination of wartime psychiatric cases.[3] Despite this caveat, Brown considered that the experience of being bombed could 'release underlying conflicts' which would *not* have resulted in the development of the mental disorder if there had been no bombing.[4]

The narrative of civilian resilience thus developed its own momentum during the war. The way that psychiatrists wrote about the civilian cases they

[2] Glover, 'Notes on the Psychological Effects of War Conditions on the Civilian Population, (III)', p. 17.
[3] Brown, 'Civilian Psychiatric Air-Raid Casualties', p. 686.
[4] Ibid, p 690.

encountered, often using platitudes about high morale and emphasising the paucity of cases, reinforced the message that the war had created few civilian psychiatric casualties. Indeed, by the later stages of the war there were very few psychiatric reports about the psychological effects of air-raids in the medical and psychiatric press.[5] Of course, the dominant psychiatric narrative of the war was also sustained by a range of other social and cultural factors, including government propaganda, articles in the press and wartime films, which have not been the focus of this thesis. Sociologist Jeffrey Alexander has argued that the transformation of individual traumas into a collective trauma entails 'cultural work', such as the cultivation of 'speeches, rituals, marches, meetings, plays, movies and storytelling of all kinds', which reconstruct and re-imagine traumatic events rather than provide a reflection of the actual suffering of individuals.[6] In this thesis I have suggested that government and psychiatric discourse involved a similar process whereby civilians' individual experiences were transformed into a narrative of collective resilience, which did not simply reflect the psychological states of the individual civilians who made up the wartime civilian population. This narrative was not settled at the start of the war, but was often questioned in psychiatrists' encounters with civilian patients in psychiatric clinics, and in front-line sites where civilians were suffering considerable nervous symptoms after raids. Drawing on Raymond Williams' concept of 'structures of feeling', this research has underlined how the notion of a

[5] In my reading of the medical and psychiatric journals of the period, I found no references during 1944 and 1945 to the psychological effects of the V1 and V2 bombing campaigns.
[6] Jeffrey C. Alexander, *Trauma: A Social Theory*, (Cambridge: Polity Press, 2012), pp. 3-4.

collective psychological response to the war has in some ways helped to conceal the multiplicity of feelings and emotions that were experienced during the war.[7]

The fifth major contribution of this thesis has been to show how psychiatric policy and practice during the 1939-45 period would shape future mental health services. In this account, the war has been viewed not merely as providing an interlude in the progression from asylum to community care, but was itself constitutive of post-war developments.[8] As noted in Chapter Six, in the later years of the war, especially when an Allied victory seemed inevitable, psychiatric attention became focused on the organisation of mental health services in the peace that was to follow. In June 1945, the British Medical Association, along with the Royal College of Physicians and the Royal Medic-Psychological Association, published a joint memorandum on the future of organisation of psychiatric services, in the light of the imminent establishment of the NHS. Its recommendations centred on creating greater links between psychiatry and general medicine, the reorganisation of mental hospitals to provide facilities for 'all degrees of mental ill-health, including neuroses,' and an expansion of all types of outpatient facilities.[9] These recommendations echoed the views of some of the psychiatrists cited in Chapters Four and Five, who wanted mental hospitals to provide inpatients beds for those with minor neurotic disorders and to be viewed as places of high-quality medical treatment.

[7] See Williams, *Marxism and Literature*, pp. 128-135.
[8] This view of the war as providing a temporary halt to the progressive development of services is encapsulated in Jones, *A History of the Mental Health Services*.
[9] Anon, 'Memorandum on the Future Organization of the Psychiatric Services', *Supplement to the British Medical Journal*, 1, (16 June 1945), pp.111-116.

It is beyond the scope of this thesis to examine whether and how these suggestions were implemented in the post-war years. It is worth noting, however, that the overcrowded conditions, shortages of staff and the worsening state of dilapidated buildings and facilities of the war years did not suddenly disappear when the war was over but marked mental hospitals and clinics in the post-1945 era.[10] Moreover, as this study has shown, government policy and wartime exigencies helped to entrench rather than overcome the dichotomy between how psychotic and neurotic patients and disorders were judged and treated. Overcrowding in public mental hospitals during the war meant that mental hospitals increasingly became seen as institutions mainly for those who were considered to have intractable, usually psychotic, mental illnesses. At the same time, the desire not to allow those with more minor nervous disorders to be sent to mental hospitals became further established, as the government urged practitioners to consider minor nervous reactions to the war as part of the 'normal' psychological spectrum. In this way, wartime developments in psychiatric treatment intensified the abnormalisation of the psychotic and the normalisation of the neurotic.[11]

In providing a new approach to these aspects of civilian mental health, this thesis has attempted to address a lacuna in the historical understandings of the Second World War. I do not claim here to have comprehensively covered every facet of psychiatric practice or every manifestation of civilians' psychological responses to the war. Rather, it is hoped that the findings of this research provoke

[10] Anon, *The Thirty-Third Annual Report of the Board of Control for the Year 1946*, pp. 1-2.
[11] See Ramon, *Psychiatry in Britain,* p. 152.

new questions about the mental health of civilians during wartime and stimulate new avenues of research that historians can fruitfully pursue in the future.

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