For Soldier and State. Rehabilitation and World War One.

Leo van Bergen
Medical historian
VU-University Medical Centre, dep. of Medical Humanities

Introduction

The relationship between war and medicine can be looked at in several ways. One could talk about the nature of the wounds or illnesses, about the way the sick and wounded are aided, or about the way the wounded soldier is rehabilitated, the way he is supported to get back his place in society. In this lecture I will try to say something about the medical reasons behind rehabilitation, and Wold War One will serve as the example. The title I choose, *For Soldier and State*, refers to what in human rights circles is called 'dual loyalty'. This dual loyalty, for instance also influencing the work of company and insurance physicians, in theory has typified since war and medicine have come into being, but in harsh practice it has true meaning nor before the midst of the nineteenth century. For instance, in spite of some fierce differences in opinion, most physicians during World War One agreed that, at least in theory, war circumstances had severely altered doctor-patient relationships and, completely justified, not in favour of the patient. Refusing according to the doctors necessary treatment was compared with refusing a military order; life threatening treatments not included. This theory was hardly touched by the difficulty to act accordingly in practice. For instance: as far as known only seldom real harsh measures were taken to enforce obedience. Most doctors tried to get their way by pointing at a presumed higher morality and at the sense of guilt many sick and wounded felt towards their colleagues who had remained in the trenches.[1] But whatever the practical translation was: most physicians during the 1914-1918 war were convinced that he had not only to keep the patients' interests in mind, but also those of his nation in arms.

That the dual loyalty to as well Mars as Hippocrates has been and is characteristic for healthcare in wartime is of course not to say that it has been so always and everywhere and with each individual doctor in the same manner and to the same degree. Depending on personal character and/or ideological or religious beliefs on the one side and war circumstances on the other - what kind of war, how many sick and wounded, how many doctors and nurses, amount and quality of available medication - there is a certain range varying between how to take care best for the patient without forgetting the interests of state and army, and how to take care best for the interests of state and army without completely forgetting those of the patient. Naturally in practice the boundaries of this range have often been trespassed. If this happened in favour of the soldier-patient it could lead to a fallout by the military superior.[2] If it happened in favour of state or army it led to a medical care often described as excellent and justified at that particular time and place, but in hindsight often called highly unethical. This immediately means that it is a kind of healthcare not confined to Germany or Japan during World War II, as is often thought.

In this lecture I hope to demonstrate that besides the mentioned criteria, also the nature of the wound or disease itself partially determined which place the doctors took within the dual loyalty range.

The importance of medicine for warfare

Why now is this theoretically everlasting dilemma not of any practical importance before the midst of the nineteenth century? Simply put because it was from that moment on that medical care began to have a really life saving effect. Because of the rise of knowledge about at first hygiene and later on bacteria, the art of healing became indeed an art of *healing*, instead of an art of which the practitioners indeed often with best intentions and with all the energy and knowledge they had, did their utmost best, bit with often little or no result; and certainly not within the war's time span. Return to the battlefield of a saved wounded soldier, and saved without removing of one or more of his limbs, before the war had ended, was seldom. It was a

kind of medical care cynics often described by saying that the sick and wounded were not healed because, but in spite of the physician. However, because of this grown life saving power of medicine for the first time in history she became of military importance. It therefore is no wonder that precisely in those days the Red Cross movement came into being. Hence, the success of this organisation - which was not the first of its kind, but it was the first surviving time and place of erection - is better explained by looking at military instead of humanitarian reasons.[3, 4]

Before 1850, before the time of the Crimean War, the American Civil War or the Prussian-Franco war, chances of soldiers surviving an illness or wound during times of war were negligible, and therefore money spend on medical care from a military point of view at best good for morale, but from as well a medical point of view as for the strength of army or navy, in fact wasted. Of course previous to those days of medical revolution there had been what we now call eminent doctors, such as the famous Dominique Jean Larrey or Pierre-François Percy during the Napoleonic wars, but chances of being treated found by them, let alone saved, were about as slim as nowadays chances of falling victim to a terrorist attack. The hope on the first is perhaps as great as the fear of the second, but statistically spoken they both are next to nothing. As said, from the midst of the nineteenth century chances of surviving war related diseases gradually began to rise and the First Wold War was the first war in ages in which more soldiers died of battle wounds resulting from enemy or friendly fire instead of disease.

Of course the military usefulness of healthcare for military operations had not gone unnoticed. And so soon after war's beginning the medical services began to explode. For instance: the British Royal Army Medical Service counted 20.000 doctors and nurses in 1914. The American army had 500 doctors when the United States declared war upon Germany in 1917. In 1918 the number had risen to 31.000.[5-7]

The character of the First World War

The First World war was a war in which more soldiers fought than ever before; in which those soldiers had to fight for a longer stretch of time than ever before; in which those soldiers fought on battlefields vaster than ever before; in which those soldiers had to move further away from the battlefield than ever before, before being really safe for the millions of grenades that have flown through the air almost constantly and of which shrapnel or content after explosion kept on flying across the so called 'field of honour', mutilating everybody that got in the way. Because of this it was a war in which the death percentage amongst soldiers was twice as high as it would be in that next great war, the one of 1939-1945, although that one too is known to have been bloody. [7, 8] On top it was a war showing new kinds of weaponry or in which already known weaponry came into its own, discovering its effectiveness when used in a militarily correct, or humanitarianly disastrous way. The machinegun is the perhaps best example of this. When in August 1914 the armies went to war, they only carried a handful of Maxim and Lewis-guns, and they were in the hands of the cavalry. Not completely coincidental as the amount of doctors, their number began to rise soon and fast and they became the hallmark of the infantry, the *Frontschweine* as the Germans called them. Together with the war defining artillery, the machine gun, as his twin brother, barbed wire, made that the defence was at the advantage in a time that attacking to the utmost, the *attaque á l'outrance*, defined military theory. A second conundrum, was that although defence was best, the war could only be won and ended by offence. [9]

Death and injury in 1914-1918

This fatal combination of aggressive theory and necessity, millions of soldiers and, after a while, a vast healthcare on one side, and an enormous amount of effective defensive weaponry on the other, not only resulted for four years and three months in about 5000 deaths per day, but also for around and about 20.000 wounded, not counting the sick. O(f these wounded of course within a narrow stretch of time a severe part died as well, which makes the death percentage of World War I about 10 percent. By the way,

only a small percentage of these deaths was caused by poison gas, nowadays known as one of the three weapons of mass destruction, but because of this small percentage after the war by many war theorists pictured as a humane weapon. [10]

Naturally, this almost uninterrupted flood of wounded was hardly controllable, in spite of the enormous amount of doctors and nurses, but in times of heavy battles, such as Verdun, Somme or Ypres III, chaos ruled. For instance, the complete, meticulously planned medical path, from stretcher bearer to base hospital, set up by the British before the Somme battle, had already become obsolete. No planning could lift the problems raised by 20.000 dead and, especially, 40.000 wounded on one day. [11, 12 (33), 13]

All these wounded needed care. On one side because else even more of them would die, against which the Hippocrates in the heart of the medical men came into resistance, on the other side because if possible these wounded had to be made fit for battle again, a demand of Mars living inside the military medics chest.

What now was the result on the therapy these doctors had set upon their sleeve for the wounded? This of course differed from doctor to doctor and from wound to wound, and so it differed with every individual patient. But nevertheless it is possible to draw some general Lines. I will limit myself to three categories of wounded: the facially disfigured, the invalidated and the neurotics.

The facially disfigured

The facially disfigured often had fallen victim to the flamethrower, shrapnel or splinters of exploded shell. Therapy first of all was pointed at making the face as whole as possible, at making it as good as it gets. It is important to note that these soldiers were of no importance for battle anymore, nor would they ever be again, if only because they would leave the hospital specialized in facial reconstruction not before the war would long be over. Twenty different operations on one single patient was anything but an exception. Pointing at important historical figures such as Dutchmen Johannes Esser, working in Berlin, Vienna and Budapest, or Harold Gillies, in his famous Sidcup-

hospital, it has often been said that because of the First World War facial surgery has made a giant step forward. A lot can and has been said about this, but what is important is to know that even if this step actually was made, at the end of the facial surgery war still was in its infancies. The moment the surgeons were at the end of their possibilities was inevitable, and although most patients at that moment certainly looked far better than they had when entering hospital, still their faces often were hideous. Probably more than ever in history, 'better' showed itself to be a relative term. Having been almost or completely faceless, they now looked like Monsters of Frankenstein or, as one of the nurses said, gargoyles.[12 (169), 14] So the question was: how do these people in spite of their gruesome fate ever again get their places back in society? This was considered of utmost importance, on the one side for the patients themselves who would have a better self-image and more self-confidence if they had a job or even could start a family, but on the other side also for the state. For if it was not possible to give the facially disfigured a full-fledged place in society, they could turn out to be extremely costly. One of the solutions to this problem was the manufacturing of masks to be put on when stepping outside the save boundaries of the hospital walls.[15] The monsters of Frankenstein turned into phantoms of the Opera.

These masks have certainly been successful, but it is evident that they only kept the gruesome truth out of sight. They did not take it away. So they only postponed showing the truth to the outside world, a truth that, certainly when engaging into a relationship, one day or another had to come out in the open. As a result, in spite of the masks, a considerable part of the disfigured never set foot outside hospital doors, al least not for a considerable stretch of time. Only inside hospital walls they could be themselves; were the inhabitants - doctors, nurses and other disfigured - used to watching them without blinking or looking away out of fear or disgust. This by the way certainly the nurses has cost some time. They were the ones most directly involved with the patients and fear of them was not uncommon at first; fear not because of the patients' character, not because of some gross misbehaviour, but solely because of the way they looked. One of them wrote that he never had imagined what moist, empty

eye sockets, smashed or missing jaws, and noses partly or entirely blown away could do to a person's appearance, but now he knew and it often turned his stomach.[16, 17]

Intra mural the disfigured made themselves useful as housekeepers, gardeners, cooks or even nurses. In this way at least one of the objectives was reached. Although one could hardly say that they had become party of society - that society even often had no knowledge of their existence - because of their activities they were not a burden to society either.

The invalidated

Invalids were partly comparable to disfigured. They too would no longer have a contribution to the war effort, at least not as soldiers. Thousands lost one or more limbs on the field of battle and the sight of men on crutches, in wheelchairs or with bound-up sleeves became a normal one in warring countries. Even so normal that British historian Joanna Bourke thinks that the Great War completely changed the way we look upon the male body or manliness altogether.[18] And if conceptions of manliness change, those on femininity change as well. And this was not only the result of the physical consequences of invalidation. Up until then emotions and feelings were feminine. Men were beings of reason and emotional restraint. But the loss of hands meant also the loss of touch, the loss of actual feeling, which brought a deep sense of the value of emotional feeling, which was perhaps wakened the most by touch, and therefore missed the most when loosing the ability. French author Gabriel Chevallier wrote that the ability to feel was perhaps our most valuable sense,[18a] and in his poem 'Disabled' Wilfred Owen wrote 'Now he will never feel again how slim; Girls' waists are, or how warm their subtle hands.' And his next line he showed that being touched also never would be the same again. 'All of them touch him like some queer disease.' Later in his poem he added: 'Tonight he noticed how the women's eyes; Passed from him to the strong men that were whole.'[18b]

This having been said the impossibility of serving in the forces, was the only communality between the disabled and the disfigured. If a nice prosthesis was

delivered these wounded could make a firm contribution to the war effort, and after the war to society in general. There were crudely spoken three options: the orthopaedic expedients, who by the way were free for officers, were tuned to functions by the state considered to be of great importance to that same state; to the function the soldier had fulfilled before the war, or to the function the soldier is longing to fulfil. Of course except discrepancies there are also similarities between these options. The function the state wants the ex-serviceman to fulfil can be the same as he had and still wants to have.

Nevertheless it lead to remarkable national differences. For instance in Germany normally the prosthesis was adjusted to the former, often industrial, functions the invalid had fulfilled. This means a state servant who lost his legs was entitled to wooden replacements leg, but in case of having lost an arm, he could receive highly technical prostheses making him able to type again. In America however the interest of the state was kept in close view. As a result after the war many war invalided found themselves having a job in the agricultural sector. This means that the vast amount of invalids gave the opportunity to restore the human being, restoring humanity, as well as creating a new human being, innovating humanity. The similarity is that restoration and innovation both kept an eye on state interest; as well directly financial by giving the opportunity to get an income, but also by keeping an eye on the future economic power of it.[15, 19-22]

The war neurotics

How different the fate of the war neurotics would be. Difference between neurasthenics and hysterics on the one side and facially disfigured and invalids on the other was that in the case of these last ones one could actually séé 'that they had done their bit for the Fatherland', as the British said. In those days certainly many non-medical military men, but a lot of physicians as well, were convinced that an invisible ailment was not an ailment at all. A second difference were chances on self mutilation or aggravation, who were considerably greater at the group of psychologically

damaged. Naturally there have been lots of soldiers wounding themselves or trying to fake a mental or physical illness,[18, 20, 23] but the amount of soldiers deliberately removing an arm or leg, or cutting up the own face, will have been relatively small. This also means in the case of disfigurement and invalidation fear of an epidemic effect was absent, contrary to the psychologically sick or wounded. Fear of an epidemic of war neurotics was all to real.[2, 7, 18, 24-27] These differences are crucial if the nature of revalidation and the arguments behind it have to be explained. And within the category of mental problems one also had to consider if the diagnosis - which by the way easily could be false - was hysteria or neurasthenia or shellshock-sick or shellshock-wounded. The difference between the first two was that neurasthenia also could have external causes (such as the strains of war), whereas hysteria was completely explained out of the man himself (character weakness, strange family members). Neurasthenia therefore was less stigmatizing. It explains why, even when symptoms were equal, hysteria was more often a soldiers diagnosis whereas an officer, coming from the same social classes as the physicians, more often was declared neurasthenic.[24, 28-33]

The difference between 'sick' en 'wounded' was of importance for other reasons. The war changed definitions. Sick meant that one was either sick or wounded not as a result of the fighting, and wounded meant that one was either sick or wounded as a result of the fighting. One could get 'sick' always and everywhere and so there was no direct relationship with the war. Therefore the diagnosis 'sick' gave no right to a war pension, contrary to the diagnosis 'wounded'. It was expected from doctors to declare as mucgh soldiers sick as possible. Of course this was especially the fate of the psychologically damaged because of the mentioned unfamiliarity, as a result of the invisibility even denial of the phenomenon and because of the suspicion and possibility of simulation. After severe but fruitless attempts to get rid of the term 'shellshock' and replace it with the much more neutral, and not to the war itself referring terminology 'Not Yet Diagnosed (Nervous)', in September 1918 it was forbidden for British doctors to declare patients shellshock-wounded. Every shell-

shocked soldier was shellshock-sick, although, as with hysteria, the cause of this mental illness was supposed to be inside the patient himself and was therefore was more stigmatizing as the term shellshock-wounded. It must however be said that this measure was partly the result of a habit of some doctors, knowing that they had far too little knowledge of psychological problems to make a trustworthy diagnosis, always declared their patients wounded.[2, 24, 34]

In Germany in 1916 the theory of traumatic neurosis, nowadays at the heart of PTSD, was declared completely wrong and out of date. The few that kept clinging on to it marginalised themselves within the occupational group. The shared assumption became that war in itself could not be a reason for psychological suffering. So in fact every neurotic was sick instead of wounded. And if nevertheless there was a connection between war and madness, it at best was that the war had functioned as the spark setting the already present *Nervenschwache* in motion.[30, 35-38]

As a consequence in general the shellshock-cases and the *Kriegszitter* were not to be envied, and this goes for the ones suffering from *trouble nerveux* as well. Psychiatric hospital should, at least for the soldiers amongst the patients, not be a safe haven, not a place of rest from front or hierarchy, but a place resembling as much as possible military barracks. Therapy for heavy cases was derived from this, again: if they were common soldiers. Officers were all but spared these harsh treatments. There were many different treatments, but they all came down to a very forceful, authoritarian, swift sort of therapy - by the British called 'quick cure' by the Germans *Überrumpelungsmethode* - that guaranteed success. The patient was not allowed to leave the room - by some referred to as the torture chamber - before the symptoms had disappeared. This already shows that the cause of the symptoms - for instance limbs refusing work without a detectable, physical cause - was of no importance. Sessions were as short as possible, involving fierce intimidation often accompanied by hypnosis or the administration of electricity, followed by the command: 'Thou shall heal'.[8, 25-28, 30, 32, 35-46]

Be this as it may, one has to mention one great difference in looking at the mentally disturbed between the British and the French on one side and the Germans on the other. In general the Germans spoke of neurasthenic in economical terms. These soldiers were comparable to workers on strike, which for many, including the often politically conservative physicians, was about the same as lazy workers. As the striking worker in the interest of the state had to get as soon as possible back into the factory, so the striking soldier had to get back to delivering his part to the war effort as soon as possible. However, partly because of this comparison, German psychiatrists and neurologist often were satisfied if the patient could be transferred to a war factory, which immediately kept him from returning to hospital within days. In this factory the soldier declared healed could heal further and proof he had shaken of his void.

On the contrary the British and French spoke of the neurasthenics and hysterics in terms of masculinity and femininity. If they were unable to handle the stress of war the soldier had proved to have lost his masculinity and that he had feminised. Which test was more suitable to prove that his masculinity was restored, that he had regained his masculinity, than renewed service at the frontline.[35-38, 41, 45]

The resemblance between the two was that, as the weapons factory in Germany, frontline service for the British and French madmen was as well goal as part of the treatment. How longer one was able to stay in the trenches, how stronger the regained masculinity proved itself and was further restored. And the second resemblance was that much more as was the case with the facially disfigured, with whom war effort and state finance were secondary; more as was the case with the invalidated with whom renewed fighting was out of the question, as well with the Central Powers as with the powers of the Entente therapy for neurotics was pointed at trying to keep state costs as low as possible and war effort on track.

Dual loyalty and the role of illness

All this means that the mentioned range between looking after the interests of the patient and those of state and army the therapy for the facially disfigured must be placed at the side of the patient, the therapy for the invalidated somewhere in the middle, and the one the physicians had in store for the lunatics, at the side of state of army. And according to many the last therapy not seldom broke through these boundaries. Not for nothing already during the war, but mainly after 11 November 1918, some doctors were charged, not missing its influence on the history of patient autonomy.[8, 27, 30, 41-42, 47] But before this autonomy was completely recognised another war had to be fought, including even harsher violations of medical ethics.

As the command to declare nobody shellshock-wounded anymore, medical policy was strengthened by political measures. France, for instance, in principal never gave pensions to war neurotics. Nevertheless, it has to be said that these measures were not only the result of misplaced frugality or an aversion of exaggerators. It also could be the simple result of bitter financial necessity, certainly in the Weimar Republic, that besides fighting economic despair had to fulfil its financial obligations agreed on in Versailles. As a result Weimar had a very restricted pension policy of which the neurotics were the main victims. As of 1926 it was even impossible for them to receive a pension, which by the way according to some doctors had a distinct healing effect. It prevented them from getting a pension neurosis as well. On top many of them turned them from victims into perpetrators by mentioning them together with Jews, communists and anarchists as the ones guilty of the German defeat, by stabbing the army in the back. Nevertheless the costs of pensions in the Weimar Republic were immense. Almost ten percent of society depended upon them. At least one third of the finances at the governments disposal were tied up in pension funds. The enormous pension problem is certainly one of the factors behind the tragic history of the republic, a problem of which one party in particular profited and not the most sane one in the political spectrum. Many war invalids backed up the Nazi-party and cheered the *Führer* in 1933, although the one leading their protest and taking care of their interests in the Inter War Years had been a social-democrat, Erich Kuttner, executed in 1942 in

Mauthausen by the ones ‘his’ invalids had helped gain power.[21] Paradoxically this was in part the result of the fact that the German state had as much as possible taken to heart the fate of its physically and mental invalids. The politicians of the Weimar republic had decided that taking care of the veterans was a state task. Because of that these veterans became mad at seemingly uninterested fellow-citizens and on the other side these fellow-citizens became mad at the state for subsidizing according to them favoured war invalids, adding again one stone of resent to the already strongly split Weimar-society. In Great-Britain the government took the in fact harsh stand that taking care of the war invalids was in fact an act of charity. But because of that the bitter contrasts defining Weimar stayed out.[21, 27, 41, 48-50]

1: Susanne Michl, *Im Dienste des 'Volkskörpers'. Deutsche und französische Ärzte im Ersten Weltkrieg*, Göttingen 2007, pp. 79-82
2: Anthony Babington, *Shell-Shock. A history of the changing attitudes to war neurosis*, London 1997, pp. 87-88, 96-97, 104-105, 120
3: Leo van Bergen, *De Zwaargewonden Eerst. Het Nederlandsche Roode Kruis en het vraagstuk van oorlog en vrede 1867-1945*, Rotterdam 1994, pp. 37-91
4: John F. Hutchinson, *Champions of Charity. War and the rise of the Red Cross*, Oxford/Boulder 1996, pp. 57-104
5: Fielding H. Garrison, *Notes on the History of Military Medicine*, New York 1970 (2), pp. 196-197
6: J.A. Verdoorn, *Arts en Oorlog. Medische en sociale zorg voor militaire oorlogsslachtoffers in de geschiedenis van Europa*, Rotterdam 1995 (2), p. 338
7: Denis Winter, *Death's Men. Soldiers of the Great War*, London 1979 (2), pp. 136, 197, 204
8: Hans Binneveld, *Om de geest van Jan Soldaat. Beknopte geschiedenis van de militaire psychiatrie*, Rotterdam 1995, pp. 47, 52, 100, 139-140, 142-143, 145-148
9: John Ellis, *The Social History of the Machine Gun*, London 1976, pp. 113-116, 128-129, 135, 142
10: Leo van Bergen, 'The poison gas debate in the inter-war years', in: *Medicine Conflict and Survival*, jrg. 24, nr. 3 (July-Sept. 2008), pp. 174-187
11: Martin Middlebrook, *The First Day of the Somme*, London 2001, p. 84, 153, 228, 266
12: Paul Fussell (ed.), *The Bloody Game. An anthology of modern war*, London 1992
13: Martin Gilbert, *First World War*, London 1994, pp. 261-262
14: Andrew Bamji, *The Queen's Hospital, Sidcup. Physical and psychological rehabilitation after facial injury 1917-1925*, Sidcup 1998 (ongep. man.), pp. 4-6
15: Lyn Macdonald, *The Roses of No Man's Land*, London 1984, pp. 147, 149, 151, 154

16: Andrew Bamji, ‘Facial surgery: the patient’s experience’, in: Hugh Cecil, Peter H. Liddle, *Facing Armageddon. The First World War Experience*, London 1996, pp. 490-501, pp. 496, 499
17: Richard Heijster, *Ieper 14/18*, Tielt 1998, p. 158
18: Joanna Bourke, *Dismembering the Male. Men’s bodies, Britain and the Great War*, London 1996, passim, m.n. pp. 86, 109-110, 112, 116
18a: Gabriel Chevallier, *Heldenangst* (orig.: La Peur), Amsterdam [Cossee] 2009, p. 85
18b : Wilfred Owen, ‘Disabled’, in: Geoff Barton (ed.), *The Voices of the Great War*, w.p. [Longman] w.y., pp. 45-46
19: Heather Perry, ‘Re-Arming the Disabled Veteran’, in: Katherine Ott, David Serlin, Stephen Mihm (eds.), *Artificial Parts, Practical Lives. Modern histories of prosthetics*, New York/London 2003, pp. 75-101, pp. 76, 81-4, 87-93, 97
20: Siegfried Sassoon, *The Complete Memoirs of George Sherston*, London 1972, pp. 379, 421
21: Robert Weldon Whalen, *Bitter Wounds. German victims of the Great War, 1914-1939*, London 1984, pp. 16-17, 61, 104-105, 121-124, 132, 141, 143, 148-9, 156, 168, 178-179, 191
22: Helen Valier**,** *Disabled WWI Veterans in the American New South*. Lezing op de Society for the Social History of Medicine-conference, Durham 09-07-2010
23: Bruno Schrep, ‘Gebrochen an Leib und Seele’, in: *Spiegel Special 1. Über den 1. Weltkrieg und die Folgen*, 2004, pp. 58-60
24: Charles M. Myers, *Shell Shock in France 1914-1918. Based on a war diary*, Cambridge 1940, pp. 51-52, 59, 90-91, 95-99, 101, 112, 120-121, 124
25: Hans Binneveld, ‘Herstel op bevel. Beknopte geschiedenis van de militaire psychiatrie’, in: H.M. van der Ploeg, J.M.P. Weerts (red.) *Veteranen in Neder*land, Lisse 1995, pp. 63-76, m.n. pp. 66-67, 74
26: Joanna Bourke, *An Intimate History of Killing. Face-to-face killing in twentieth-century warfare*, London 1999, pp. 252-253

27: Ben Shepard, *A War of Nerves. Soldiers and psychiatrists 1914-1994*, London 2000, pp. 12, 71, 76-78, 98, 104, 135-136, 152

28: Allan Young, *The Harmony of Illusions. Inventing post-traumatic stress disorder*, Princeton 1995, pp. 61-63, 69-70, 72

29: George Mosse, *Shell Shock as a social disease.* Lezing Peronne 3-7-1998 (ongep. man.), p. 4

30: Doris Kaufmann, 'Science as a cultural practice: psychiatry in the First World War and Weimar Germany', in: *Journal of Contemporary History*, 34, (jan. 1999), pp. 125-144, pp. 133-134, 137, 141

31: Joanna Bourke, 'Effeminacy, ethnicity and the end of trauma. The sufferings of "shell-shocked" men in Great Britain and Ireland 1914-39', in: *Journal of Contemporary History*, 35, 1 (jan. 2000), pp. 57-69, p. 60

32: Marijke Gijswijt-Hofstra, Roy Porter, *Cultures of Neurasthenia. From Beard to the First World War*, Amsterdam/New York 2001, pp. 10, 16, 377

33: Joan Busfield, 'Class and Gender in Twentieth-Century British psychiatry: shell-shock and psychopathic disorder', in: Jonathan Andrews & Ann Digby (eds.), *Sex and Seclusion, Class and Custody*, Amsterdam/New York 2003, pp. 295-322, p. 307

34: Ian Whitehead, 'Third Ypres. Casualties and British Medical Services: an evaluation', in: Peter H. Liddle (ed.), *Passchendaele in Perspective. The Third Battle of Ypres*, London 1997, pp. 175-200, p. 192

35: Mark Micale, Paul Lerner (eds.), *Traumatic Pasts. History, psychiatry and trauma in the modern age, 1870-1930*, Cambridge 2001, pp. 142, 157, 160, 162-163, 170-171, 270

36: Paul Lerner, *Hysterical Men. War, psychiatry, and the politics of trauma in Germany, 1890-1930*, London 2003, pp. 1, 63-64, 67-71, 74-85, 102, 126, 138, 219-220

37: Wolfgang U. Eckart, Christoph Gradmann (Hrsg.), *Die Medizin und der Erste Weltkrieg*, Pfaffenweiler 1996, pp. 93-96

38: Edgar Jones, Simon Wessely, *From Shell Shock to PTSD. Military psychiatry from 1900 to the War*, New York 2005, pp. 14-15, 38-39

39: Hans Binneveld, ‘Shell Shock Versus Trouble Nerveux’, in: Hans Andriessen et al. (eds.) *De Grote Oorlog. Kroniek 1914-1918*, deel 3, Soesterberg 2003, pp. 54-71, pp. 57, 66, 69
40: Hans Binneveld, ‘Beter worden op bevel. De psychisch gewonde soldaat en het ontstaan van de militaire psychiatrie’, in: *Kleio*, dec. 2007, pp. 30-33
41: Paul Lerner, ‘Psychiatry and Casualties of War in Germany, 1914-1918’, in: *Journal of Contemporary History*, 34, (Jan. 1999) 22, pp. 13-28, p. 13, 16-17, 22, 27-28
42: Marc Roudebush, ‘A Patient Fights Back. Neurology in the court of public opinion’, in: *Journal of Contemporary History*, 35, 1 (jan. 2009), pp. 29-38
43: Eric Leed, *No Man’s Land. Combat & identity in World War I*, Cambridge 1979, pp. 174-175
44: Hans Magnus Hirschfeld, *Sittengeschichte des 1. Weltkrieges*, Hanau z.j. (1978), pp. 359-360
45: Ben Shepard, ‘Shell-Shock’, in: H. Freeman (ed.), *A Century of Psychiatry*, London 1999, pp. 33-40, p. 34
46: Interview with Pat Barker, *NOVA*, 28-3-1996
47: Klee, Ernst, *Auschwitz, die NS-Medizin und ihre Opfer*, Frankfurt a/M. 1997, p. 116
48: Deborah Cohen, ‘Will to Work: Disabled Veterans in Britain and Germany after the First World War’, in: David A. Gerber (ed.), *Disabled Veterans in History*, Michigan 2000, pp. 295-321
49: Cohen, *The War Come Home. Disabled veterans in Britain and Germany, 1914-1939*, Los Angeles/London 2001, pp. 3, 7-9, 12
50: Stephanie Neuner, *State Insurance and Welfare Policy for “War Neurotics” of WWI. Politics and psychiatry in Germany, c. 1920-1939*, z.p. 2006 (ongep. man.), pp. 12-13