“THE TOUCHSTONE OF INSANITY:” PERCEPTIONS OF THE PSYCHOLOGICAL TRAUMA OF WAR WITHIN THE UNITED STATES FROM 1861 TO 1918.

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A dissertation submitted to the faculty at the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of History.

Chapel Hill
2018

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ABSTRACT

Rachel J. Levandoski: "The Touchstone of Insanity:" Perceptions of the Psychological Trauma of War within the United States from 1861 TO 1918.
(Under the Direction of Wayne Lee)

This dissertation examines how American medical professionals and the lay public constructed parallel discourses on the psychological effects of war from the Civil War through World War I. I analyze the development of these concurrent debates within the pages of medical journals and wartime coverage in national news media in order to uncover whether Americans were able to construct a shared understanding of the role of war in the psychological breakdown of soldiers.

Medical interest in combat-related psychological trauma expanded from tentative recognition during the Civil War to the full-scale mobilization of military psychiatry in response to WWI. This growth was due to evolving medical paradigms about the nature of mental illness and the role of trauma in the development of psychiatric disorders. Equally important was the emergence of a professional, unified mental health field. These changes between 1861 and 1918 created an environment on the eve of WWI where mental health experts were prepared to investigate the legitimacy of war-related mental breakdown.

I conclude that the medical discourse which developed among American mental health practitioners during the Civil War, the Spanish-American War, and WWI influenced popular perceptions of the suffering of soldiers, but it did so without a cohesive effort by the psychiatric profession to educate the public. Absent the guidance of experts, the populace relied on the

sensationalist reporting of journalists. This led the public to construct an image of war-related mental illness that was more severe than that current understanding within the medical community. Thus, while both professionals and non-professionals at the end of WWI accepted the broad premise that warfare could have a deleterious effect on the mind, there was no national consensus on the cause or characteristics of psychological breakdown in war. This inability to reach a shared understanding prevented the construction of an enduring disease identity derived from combat-related psychological trauma before, during, and after World War I. As a result, mental health professionals and the public had to constantly relearn about the psychological effects of war on the mind, limiting the ability of either to respond to the needs of soldiers and veterans.

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INTRODUCTION

By April 1918, Dr. Thomas Salmon had been at war for six months. Though stationed in France as the chief consultant in neuropsychiatry for the American Expeditionary Force, Salmon was not among the hundreds of thousands of young men who spent their days in muddy trenches either preparing for – or awaiting – the next attack across No Man's Land. Instead, Salmon's time was devoted to questions of administration, organization, and the numbing bureaucracy so essential to a military's successful prosecution of a war. This did not mean, however, that he was ignorant of the visceral horrors occurring just beyond his doorstep. His duties often took him to the front where he saw first-hand the true nature of the fighting. As a medical professional interested in the processes of the mind, Salmon tried to reconcile these divergent experiences of war, but despite his efforts, he found the duality difficult to comprehend. Once, he tried to describe this conflict in a personal letter to a colleague back home. "War, from behind the lines," he wrote, "is a dizzying jumble."

> Revolving chairs, stuffy offices, dry-as-dust reports, blue prints one day and the next – with the help of [a] broken-down Ford and a few gallons of gasoline – marching men with grimy faces and shining eyes, horses plunging and straining at guns, little white clouds drifting under the big ones and piles of bloody clothes and leggings lying outside the door of a Field Hospital. Everything which is dull and stupid and everything which yanks at your heart-strings, all mixed up together so that at the end of the week you can't quite remember whether you spent Tuesday going over the specifications of a portable laundry or skirting the edges of Hell in an automobile.[1]

[1] Letter to K.B. from Thomas Salmon, April 12, 1918, Thomas Salmon Papers, Box 2, Folder 4, Courtesy of the Oskar Diethelm Library, DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell Medical College. Hereafter ODL.

For Thomas Salmon, this unsettling mental dissonance was compounded by his daily work, which served as a reminder that his role in the war was to help others make sense of the very violence he struggled to understand. "It is given to us grand Directors to see a lot of [the war] and a lot of different sides of it, for which I am profoundly grateful," he told his friend. But, Salmon lamented, "it is also given to us to help a little – far less, I imagine, than we think."[2] Just like the soldiers he worked with, Salmon was tasked with confronting a difficult enemy. He and his neuropsychiatric colleagues represented the first organized effort by the American military to address psychiatric trauma in war.

Mental breakdown in wartime is an old problem, even if the tenets of military psychiatry as practiced by Salmon in 1918 were new. In this dissertation, I examine how Americans discussed – or did not discuss – mental illness during wartime from approximately 1850 until 1919. In particular, I describe how these conversations expanded from a vague interest in psychological symptoms that seemed unique to soldiers during the Civil War to a tentative acceptance among psychiatrists by the end of WWI that the trauma inherent to the horrors of war could contribute to the breakdown of men during battle.

Though this dissertation demonstrates that medical practitioners had a more sophisticated understanding of the psychological trauma of war at the start of the twentieth century than during the nineteenth, it also shows a continual process of relearning on the part of mental health specialists when confronted by mental breakdown in combat. What appears, on the surface, to be an apparent progression in knowledge was not, in fact, a smooth process by which old ideas served as the stepping-stones for new discoveries. Medical professionals did not build on their tentative observations of psychiatric casualties during the Civil War to better understand their

[2] Letter to K.B. from Thomas Salmon, April 12, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

military patients during the Spanish American War. Similarly, the new military psychiatrists of WWI did not draw upon the wartime observations of their predecessors a generation earlier. Instead, professional understanding of combat-related psychological trauma was predicated on the broader contemporary paradigms of mental illness, many of which underwent considerable changes at the turn of the century. Equally important was the status of the field of psychiatry and whether these ideas had a professional environment conducive to the development of an ongoing discourse in which they could be shaped and refined.

American doctors first began to discuss the psychiatric complaints of soldiers during the Civil War, though some European doctors had made similar observations even earlier. Battlefield surgeons in the Civil War reported encountering men with symptoms ranging from tremors, gastrointestinal distress, and a general lack of appetite, to psychological difficulties including depression and anxiety. They labeled this illness "nostalgia." However, without the benefit of a concerted military psychiatry effort, few of these men received treatment for their condition. Those with the severest symptoms were sent to general hospitals behind the line or, if they were particularly bad off, doctors ordered them to the Government Hospital for the Insane in Washington, D.C.. Sadly, arrival at a hospital did not always ensure that a soldier received effective treatment. Mental health care was in its infancy in the United States in the mid-nineteenth century and the medical understanding of diseases of the mind was only just beginning to expand beyond the broad designation of "insane." This lack of expert knowledge during the Civil War was compounded by the absence of an organized psychiatric profession. Mental health experts in this era were limited to general physicians with an interest in mental disease. Even then, they were solitary figures who focused on running their asylums, not on undertaking a shared exploration for new ideas about the etiology and treatment of mental

illness. Thus, even if psychiatrists at this time accepted that war could cause mental breakdown, they did not have the organizational structure in place to coordinate a unified response.[3]

A lack of consensus around a diagnostic identity for the combat-related mental suffering of soldiers meant that same problems hampered the national response to psychiatric casualties when the United States deployed its military to Cuba and the Philippines in the closing years of the nineteenth century. As during the Civil War, battlefield doctors diagnosed soldiers with nostalgia and, just as before, psychiatrists remained cloistered in their asylums instead of attempting to uncover more about the affliction affecting so many American troops. There was, however, change underway within the field of psychiatry.

The end of the nineteenth century saw a gradual shift towards the professionalization of psychiatry as well as the development of new theories about mental illness. The mental health community began to examine the effects of environment on psychological well-being. They worried that the fast pace of industrialization was depleting "nervous energy," so they encouraged patients to seek treatment for neurasthenia in the growing number of private neuropsychiatric practices. Most significantly for the evolution of professional understanding of war-related psychological disorders, psychiatrists and neurologists at this time began to theorize about the role of trauma – both physical and psychological – in the development of psychiatric symptoms. They were not led to this research by reports of the suffering of American soldiers in Santiago or Manila, however. Instead, their interest was piqued by the mysterious symptoms exhibited by survivors of railway accidents, leading them to name the condition "railway spine."

[3] George Rosen, "Nostalgia: A 'Forgotten' Psychological Disorder," *Clio Medica* 10 (1975): 28-51.; Albert Deutsch, "Military Psychiatry: The Civil War, 1861-1865," in *One Hundred Years of American Psychiatry*, ed. J. K. Hall et al. (New York: Columbia University Press, 1944).

Noted European physicians such Jean-Martin Charcot and Hermann Oppenheim, as well as lesser-known neurologists like Eric Erichsen and Herbert Page, studied how traumatic events led to nervous reactions in their patients. Their early research produced divergent conclusions about the effects of trauma on the mind and body, but set in motion new avenues of research that informed generations of mental health practitioners to come. Similarly, while their findings did nothing for the American soldiers fighting in the Spanish and the Philippine wars, these studies laid the groundwork for a connection between trauma and mental illness that proved fruitful for psychiatrists during WWI.[4]

When Salmon and his colleagues deployed to Europe in 1917, they possessed a very different idea of mental illness than their predecessors fifty years earlier. This included an expanded notion of the nature of psychiatric disorders, as well as early theories about the way in which a traumatic event could shape an individual's mental health. These new paradigms made it possible for psychiatrists during WWI to view the effects of war differently than they had during the Civil War and the Spanish-American War. If a railway accident could cause a breakdown, they asked, what could an artillery shell do?

To be sure, some of the older views of the etiology of mental illness remained prominent. In the age of eugenics, mental health experts still clung to the notion that something in a man's character or in his background made him more likely to develop a mental illness. This notion of predisposition heavily influenced the approach of American psychiatrists during WWI. The

[4] George Frederick Drinka, *The Birth of Neurosis: Myth, Malady, and the Victorians* (New York: Simon and Schuster, 1984), 184-209.; Mark S. Micale, "Jean-Martin Carcot and *les névroses traumatiques:* From Medicine to Culture in French Trauma Theory of the Late Nineteenth Century," in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, ed. Mark S. Micale and Paul Lerner (New York: Cambridge University Press, 2001).; Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 46-72.

impact of this belief was most obvious in the mental health community's strong support for the rigorous screening of potential military recruits. They argued that a careful examination could identify the men who would become psychiatric casualties and allow for their dismissal from the service before, as one psychiatrist put it, such individuals "interfered with the training of their brighter or better-adjusted comrades." Psychiatry need not only be reactive, experts claimed, it could be prophylactic as well.[5]

American psychiatrists on the eve of WWI were vocal in their advocacy for screening because they understood the scope of the mental health crisis the U.S. military could face in Europe. As early as December 1914, the British military was already requesting assistance from psychiatrists to help mitigate the problem of psychiatric breakdown effecting thousands of their soldiers. An alarmingly high number of men had to be evacuated from the lines due to symptoms seemingly caused by invisible wounds. Protected by President Wilson's decree of neutrality, American psychiatrists could only watch as their European colleagues struggled to confront what British doctors had labeled "shell shock" and what Salmon called a "striking" medico-military problem.[6]

The mental health community in the United States did not remain passive spectators for long. Discussions of shell shock began to appear in medical journals in the U.S. in 1915 and American psychiatrists who found themselves in Europe when the war broke out, began to send back reports of the psychological symptoms they observed in French and British military

[5] Pearce Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 57.

[6] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2000), 21.; Thomas Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army", in "Appendix," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 497.

hospitals. These informal observations would eventually transition into official visits by leading American psychiatrists such as Thomas Salmon and Pearce Bailey. Motivated only in small part by professional curiosity, Bailey and Salmon were particularly concerned that America would eventually be called upon to enter the war. As a result, they wanted to learn as much as they could from their colleagues overseas in order to prepare both the mental health community and the U.S. military for the psychiatric casualties they were certain would result.[7]

This transatlantic learning significantly shaped the views of American psychiatrists on the nature of shell shock and informed their methods of treatment. However, they did not simply adopt the processes established by the Europeans. Instead, mental health practitioners in the U.S. crafted a system of military psychiatry that built upon what they viewed as the mistakes of the French and British. This method of treatment – called forward psychiatry – also reflected American psychiatrists' own understanding of shell shock; particularly, their belief that the condition had to be treated as close to the frontline as possible.[8]

The eventual deployment of American military psychiatry in response to World War I reflected more, however, than just the mobilization of the mental health profession for war. It also represented a reinvigoration of professional interest in the psychological suffering of soldiers that had begun – albeit tentatively – fifty years early during the Civil War. While the mental health community of the previous conflicts had only observed from afar, American psychiatrists in WWI were prepared to operationalize their understanding of trauma and mental illness in an effort to aid the war effort.

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[7] For an example of this trans-Atlantic learning see Henry Viets, "Shell-Shock: A Digest of the English Literature," *Journal of the American Medical Association* 69 (1917): 1779-1786. A more thorough discussion can be found in Chapter Four.

[8] Shephard, *A War of Nerves*, 128-132.

American psychiatrists had a deeper knowledge of combat trauma at the start of twentieth century than at any time before. This awareness, however, was not the result of a steady progression of ideas gained from wartime experiences, but instead, the consequence of professionalization and shifting ideas about mental illness. By failing to integrate their understanding of psychological trauma with what they had observed during war, mental health practitioners at the turn of the century doomed themselves to rediscovering the deleterious effect of combat on the mind. Unfortunately, this presaged the debates of mental health professionals around psychological trauma throughout the twentieth century.

Reports of psychological "wounds" also aroused the interest of the American public. While psychiatrists spoke little of nostalgia during and after the Civil War, soldiers and other participants in the conflict recorded their thoughts on the condition in memoirs, helping to solidify the illness in popular memory. Public interest in nostalgia drastically increased during the Spanish-American War. While medical experts downplayed the seriousness of nostalgia in Cuba and the Philippines, newspapers across the country featured sensational headlines about soldiers being driven insane overseas. Unsurprisingly, public concern for the psychiatric suffering of soldiers occurred again during WWI, with the first newspaper articles about psychiatric casualties in Europe appearing in the United States within the first weeks of the war.

To understand the changing American attitudes toward the psychological trauma of war in the early part of the twentieth-century we must also examine how non-professionals discussed war-related mental illness. Often, the popular debates about psychological trauma that developed in newspapers and magazines across the country were more rigorous than those in the professional sphere. This leads me to conclude that lay interest in combat-related psychiatric trauma was just as important as professional concern in shaping an understanding of war's effect

on the mind at the turn of the century. Indeed, it is likely that this vigorous public discourse on psychological trauma continues to influence our historical understanding of early discussions of these conditions. There is no clearer example of this than the refusal of the public to abandon diagnostic labels such as "nostalgia" and "shell shock," even when faced with disinterest and outright opposition to the nomenclature by psychiatrists. This public persistence solidified these terms in popular memory despite a lack of support or legitimacy from the professionals of the day.[9]

Scholars of the history of psychological trauma must, however, examine the role of the American public during this period beyond its ability to perpetuate terminology. Popular understanding of psychological trauma from 1861 to 1919 and the interaction – or failed interaction – between the public discourse and the medical discourse on combat trauma also influenced the legitimacy of any diagnosis surrounding such suffering. Historians of medicine have long studied how the medical profession has discovered, treated, and sought to prevent various diseases that afflict society. In doing so, these historians have also traced the ways doctors as well as non-professionals have constructed and reconstructed the identities of these many diseases. In these circumstances the notion of identity was not only thought of as the biological factors that comprised a particular illness, but also as the meanings ascribed to a disease based upon its causes, symptoms, its treatments, and the people it affected -- whether these people were physicians, drug companies, patients, or those not even afflicted.[10]

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[9] One need only do a brief perusal of the historical literature – popular and academic – to see how ingrained these names have become despite. While "nostalgia" as a name for psychiatric trauma remains fairly obscure outside of studies of the Civil War, "shell shock" has gained wide notoriety that persists to this day.

[10] The historiography of disease identity is voluminous. Good examples include Charles E. Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1987).; R. A. Aronowitz, "Lyme Disease: The Emergence and Social Construction of a New Disease," *The Milbank Quarterly* 69 (1991): 79-112.; Steven J. Peitzman, "From Bright's Disease to End-Stage Renal Disease," in *Framing Disease: Studies in Cultural History,* Charles Rosenberg and Janet Golden, eds. (New Brunswick, NJ: Rutgers University Press, 1992),

Today a disease's identity is perpetuated through an understanding, or even a misunderstanding, of both its cause and its symptoms. This form of identity creation becomes complicated, however, when professionals and society attempt to categorize mental illnesses. The natures of such conditions do not allow for clear testing or easy diagnosis, and symptoms often differ between patients. Perhaps most challenging to researchers into mental illness is the lack of a universal necessary cause for psychological disorders. In other words, there is no circumstance under which a person is guaranteed to develop a mental illness. This is especially the case when it comes to understanding the effects of psychological trauma on the mind and body, since an event that triggers a chronic mental disorder in one individual can leave another unaffected. For example, during WWI, this phenomenon baffled military psychiatrists who sought to understand why a shell explosion could cause the mental breakdown of one soldier while the man next to him remained unfazed. Ultimately, this reality led mental health professionals in 1915 and 1916 to give greater weight to the potential for psychological causes of shell shock rather than physical ones.[11]

Absent easily observable symptoms, mental health practitioners and their patients must create a shared understanding of psychiatric illness. This is why an historical study of early perceptions of psychological trauma in war must include the perspectives of the public as well as the medical professionals. Only then can scholars construct a more complete picture of how different groups, including not just mental health experts, but also non-professionals such as the

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3-19. For two competing perspectives on the role of social construction in the historiography of medicine see Charles Rosenberg, "Framing Disease: Illness, Society, and History," in *Framing Disease: Studies in Cultural History,* xiii-xxvi and Roger Cooter, "'Framing' the End of the Social History of Medicine," in *Locating Medical History: The Stories and Their Meanings*, Frank Huisman and John Harley Warner, eds. (Baltimore: John Hopkins University Press, 2004), 309-338.

[11] For further discussion on the role of universal necessary causes in the formation of disease identity see K. Codell Carter, *The Rise of Causal Concepts of Disease: Case Histories* (Burlington, VT: Ashgate Publishing Company, 2003). I go into greater detail on the shifting perceptions of shell shock in Chapters Four, Six, and Seven.

general public, military leaders, and even the soldiers themselves, understood the effects of war on the mind.

In the case of the American experience from 1861 to 1919, while the medical community refined its understanding and response to the psychological trauma of war, its failure to successfully construct a shared understanding with the lay public meant that a legitimate and durable diagnostic label failed to develop in the postwar periods of the Civil War, the Spanish American War and World War I. As a result, this dissertation argues that mental health practitioners, as well as military leaders, government officials, and soldiers themselves, had to continually rediscover ways to mitigate the devastating effects of war on the mind. During WWI, professionalization and new ideas about the role of trauma in mental illness meant that American psychiatrists put forth their most sophisticated response to combat-related psychiatric casualties to date. Yet even then, the ineffective collaboration between the public and the mental health community meant that a shared understanding about psychological trauma never coalesced. Absent such agreement, the American people, including many psychiatrists, came to question the legitimacy of the condition in the period following WWI. Ultimately, the lessons of the First World War were forgotten and left to be relearned by soldiers and psychiatrists in WWII.

In order to trace the construction and interaction of the public and the professional discourses, I rely primarily on two types of documents: medical journal articles and popular pieces published in the news media. Undoubtedly, public and professional debates developed across other avenues as well. Psychiatrists would have exchanged their thoughts on new theories during medical conferences or in personal correspondence. Regular Americans likely encountered subtle and overt discussions of the mental suffering of soldiers within literature,

plays, or even around their dinner tables. Faced with this potentially overwhelming body of sources, I decided to limit my analysis to medical journals and newspapers partly to keep the project at a manageable size. However, my selection of this body of documents is also purposeful because of the scope of audience they each offer. Medical journals and newspapers were both published with the purpose of reaching many readers, providing a rich source for analysis of the spread of ideas across a wide part of the nation.

The one notable exception where I deviate from published materials is in my use of the private papers of Thomas Salmon. His letters and reports to military officials provide a valuable look into how American psychiatrists constructed and adapted the practice of military psychiatry during WWI. Additionally, Salmon was a leading voice in the professional discourse on combat-related psychological trauma. His most significant contributions to these debates, however, came in the form of widely circulated articles, which allows me to continue to emphasize published material available to a wide body of medical practitioners.

By analyzing journals from a wide swath of the medical profession, as well as exploring dozens of newspapers and magazines that appeared across the country between 1860 and 1919, I demonstrate that ideas about psychiatric trauma would have been readily available, if not widely consumed by a large portion of the country. In the case of journals distributed by medical organizations, that audience was certainly narrowed by the constraints of professional affiliation. However, the official organs of these associations served as a ready medium through which their members could communicate with each other about broad concerns related to their field. Whereas the reach of personal correspondence or a conference paper would have been limited to a handful of individuals, the content of a medical journal had the potential to a reach a wider audience. In some instances, the journals served as a platform upon which medical

professionals carried out discussions on issues related to mental health, either in competing articles or in letters responding to each other's research. Such exchanges allowed me to see how ideas about psychological trauma were debated with in the mental health community. Newspapers and magazines filled a similar function for the general public, particularly as the reach of print journalism increased at the start of the twentieth century. Popular media served as a space through which members of the public could learn about and discuss the issues of the day.

The news media provided an important point of intersection between the public and professional discourses on war-related psychological trauma. Descriptions of both nostalgia and shell shock appeared in the popular press, with nostalgia featuring prominently in the coverage of the Spanish-American War and newsmen offering up frequent articles on shell shock before the first U.S. soldier even set foot in Europe during WWI. The amount of coverage varied from newspaper to newspaper, but the themes were often the same, regardless of the article's provenance and the war under discussion. Journalists presented war-related mental illness to the American people in stark, and often sensational, terms. "Troops Crazed by Nostalgia," announced one Georgia newspaper in 1902. A *Los Angeles Times* article described "trench insanity" in February 1915.[12]

In order to craft these articles, journalists utilized testimony from soldiers and, when possible, individuals with medical expertise. Rarely, however, did newspapers present their readers with insights or quotations from psychiatrists themselves. Mental health experts did not engage the public in an organized way during the Civil War, the Spanish-American War, nor even in the midst of WWI, despite the profession having mobilized around the cause of military

[12] "Troops Crazed by Nostalgia," *The Atlanta Constitution*, November 16, 1902.; "Troops have Wild Dreams," *Los Angeles Times*, February 28, 1915.;

psychiatry. Lacking insights from the psychiatrists themselves, journalists often reprinted medical articles verbatim or relied on observations they gleaned from medical conferences in an effort to educate their readers. Therefore, although the medical discourse did shape the popular debates on war-related mental illness, it did so in a passive way. Ultimately, the public was left to craft its own understanding of the psychological trauma of war, which did by appropriating the language of the mental health community without the mediation of psychiatrists. In the case of WWI, psychiatrists complained that this understanding proved to be misguided. Yet, the mental health community did little to correct the public misunderstanding.

This work spans across a number of different historiographies. The primary focus on the development of intersecting public and medical discourses on mental illness during war, however, speaks to two main bodies of scholarship: the construction of historical understandings of disease identity described earlier, and the history of psychological trauma in war. Just as public and professional discussions of combat-related mental illness shaped one another, this project demonstrates how these historiographies can speak to each other to create a fuller picture of how Americans at the start of the twentieth century constructed ideas about the effects of war on the mind.[13]

[13]The broader study of psychological trauma has developed along many different paths and often in fields outside of history. The largest body of research, of course, is generated by medical professionals themselves. These are the men and women who today are continuing the work of the medical professionals described in this dissertation by studying the symptoms of trauma-related mental illness in an effort to find effective ways to treat and even prevent patient suffering. A great resource for current research on war-related psychological trauma packaged for public consumption is the website administered by the Defense Centers of Excellence for Psychological Health and Brain Injury. Its mix of medical articles and practical advice demonstrates a modern take on the interaction between mental health professionals and a popular audience. See https://health.mil/News/Authors/Defense-Centers-of-Excellence-for-Psychological-Health-and-Traumatic-Brain-Injury. From a historiographical perspective, scholarly research into psychological trauma appears in multiple disciplines, including trauma theory in literary criticism, social histories of violence and genocide, studies of survivors of abuse, and even sociological and ethnographic studies on the social construction of PTSD. Noteworthy titles include Cathy Caruth, *Unclaimed Experience: Trauma, Narrative, and History* (Baltimore: John Hopkins University Press, 1996).; Kalí Tal, *Worlds of Hurt: Reading the Literatures of Trauma* (New York: Cambridge University Press, 1996).; Judith Herman, *Trauma and*

A significant portion of the scholarly discussion on the trauma of war can be found in works that trace the historical development of the field of combat psychiatry. Unfortunately these studies are apt to describe changes in practice and definition over time rather than attempt to address the potential causes for those changes and their consequences for military and medical history. One such example is *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry* (1997), a summary by Dutch historian Hans Binneveld of military psychiatry from the Thirty Years War of the seventeenth century through American involvement in Vietnam. Also notable are the works of social scientist and military historian Richard A. Gabriel: *No More Heroes: Madness & Psychiatry in War* (1988) and *The Painful Field: The Psychiatric Dimension of Modern War* (1988). While these texts offer an important narrative history of how scientists and members of the military have tried to address psychological trauma, they do little to place military psychiatry in a larger social or historical context. This limits their ability to comment on what influenced the construction of professional notions of war-related mental illness. More significantly, it prevents them from conveying a fuller of picture of how psychiatrists used these ideas to shape a response to psychological trauma in war.[14]

My research seeks to historicize the study of combat psychiatry beyond simply a discussion of change over time. We cannot understand how medical professionals conceptualized the trauma of war without positioning them within their broader contemporary understanding of the nosology of mental illness. By exploring the broader changes occurring

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Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror (New York: Basic Books, 1992).; Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995).

[14] Hans Binneveld, *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry* (Amsterdam University Press, 1998).; Richard A. Gabriel, *No More Heroes: Madness & Psychiatry in War* (New York: MacMillan, 1988).; Richard A. Gabriel, *The Painful Field: The Psychiatric Dimension of Modern War* (Santa Barbara: Praeger, 1988).

within the mental health profession from the mid-nineteenth century through the end of WWI, and putting them next to parallel developments in American society, I demonstrate how these new theories influenced professional perceptions of psychiatric trauma and ultimately influenced the theories underlying the construction of military psychiatry during WWI.

This approach somewhat mirrors that of Ben Shephard in his important text, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (2000) while also building on his existing work. Shephard traces the evolution of military psychiatry from World War I through the official recognition of post-traumatic stress disorder by the American Psychiatric Association after the Vietnam War in 1980. He describes his work as an effort to correct a lopsided history that, prior to the late twentieth-century, relied too much on the writings of medical professionals and less on careful reflection by historians. Despite this noble goal, *A War of Nerves* remains very much an operational history of combat psychiatry between WWI and the start of the Gulf War. It directs much of its attention to the two world wars and, in the case of WWI, relies heavily on the British perspective. Shephard attempts to draw connections between larger theories of mental illness and the actions of military psychiatrists on the frontline, but ultimately he is most interested in, as he describes it, "the psychological problems soldiers developed in the World Wars and during and after Vietnam and… the steps doctors took to counter them. [15]

[15] Shephard, *A War of Nerves,* xix. Another good example of this approach is David H. Marlowe's monograph entitled *Psychological and Psychosocial Consequences of Combat and Deployment: With Special Emphasis on the Gulf War* (2001). He argues that the trauma created by the high-stress environment of combat or simply by being in a theater of war could lead to both immediate and long-term physiological and psychological consequences, a theory he correctly identifies as an outgrowth of previous conclusions drawn from the Vietnam War. Marlowe complicates this premise by further hypothesizing that it is too simple to consider stress the sole catalyst for the undiagnosed illnesses of Gulf War veterans. In particular, he stresses that medical professionals, scholars, and military officials must also take into account social and cultural inducements such as the media, the Internet, support groups, and people in positions of authority because all of these factors influence a veteran's perception of his or her illness. Marlowe argues that only a better understanding of how the symptoms of combat stress have presented themselves in past wars could enable clinicians and academics to determine what might be a common psychological reaction to combat and what is unique to Gulf War veterans. David H. Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment: With Special Emphasis on the Gulf War* (Washington: RAND Publishing, 2001).

My research supplements Shephard's by expanding the temporal scope back to the mid-1800s and shifting focus from the British perspective to that of the Americans. By doing this, I present a more thorough examination of how a pre-professional mental health field dealt with early examples of psychological breakdown in war. This deeper analysis illuminates how professionalization and the influence of science at the start of the twentieth century played a key role in shifting how psychiatrists characterized the nature of mental illness. Additionally, by directing my attention away from Britain and across the Atlantic to the United States, I am able to demonstrate how the close interchange of ideas about shell shock between British, French, and American psychiatrists significantly influenced the way the mental health profession within the U.S. constructed their response to WWI.[16] The American understanding of shell shock and its construction of military psychiatry was truly a transnational phenomenon.

Finally, through its discussions of the parallel discourses developed by medical professionals and the public, this dissertation adds further support to the historiographical argument that any understanding of psychological trauma must be carefully contextualized within the contemporary historical moment. Chronic suffering from psychological trauma remains a persistent problem that affects an untold number of people around the world. In the twenty-first century, as in the last decades of the twentieth, medical professionals and lay persons refer to this particular kind of illness as Post-Traumatic Stress Disorder (PTSD), a diagnostic label codified in 1980 in the wake of the Vietnam War. Scholars of trauma, including literary theorists, social scientists, and historians, debate the extent to which the present understanding of PSTD can be applied to earlier discussions of psychological trauma.

[16] See Chapters Four, Five, and Six.

An example of this discussion can be seen in historiographical debates surrounding nostalgia during the Civil War. Perhaps the most well-known historical analysis of psychiatric casualties during the American Civil War is Eric Dean's *Shook Over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* (1997). In this work, Dean sought to uncover whether psychiatric trauma – particularly Post-Traumatic Stress Disorder – was unique to veterans of the Vietnam War. To answer this question he examined the Civil War through the lens of late-twentieth century understandings of PTSD and the trauma of war. By applying this framework, Dean concluded that Vietnam veterans were not unique and soldiers in the Civil War also confronted psychological trauma in great numbers.

While Dean is undoubtedly correct that Union and Confederate soldiers did suffer from war-related mental illness, his decision to view the suffering of these men strictly through a post-Vietnam understanding of trauma neglects the necessary periodization of medical and non-medical perceptions of disordered behavior which are crucial for understanding the contemporary beliefs about mental illness. For example, Dean – who is not a mental health professional – analyzed the medical records, journals, and letters of Civil War soldiers and their families for examples of symptoms delineated by psychiatrists in the 1980s as applicable to PTSD.[17] In one instance, Dean described a soldier whose thoughts turned to his dead friends, which led Dean to conclude "Psychologists in the post-Vietnam era would characterize what was happening to [the soldier] as the experience of 'intrusive recollections' and 'survivor's guilt.'" Additionally, in numerous places Dean used the modern term "flashback" to characterize events

[17] See Eric Dean, *Shook Over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* (Cambridge: Harvard University Press, 1997), 91-114. Eric Dean was not the only historian to apply modern understandings of mental illness to the Civil War. See also Bryan Stinson, "Battle Fatigue and How it was Treated in the Civil War," *Civil War Times Illustrated* 4 (1965): 40-44. and John E. Talbot, "Combat Trauma in the American Civil War," *History Today* 46 (1996): 41-47.

described by soldiers and civilians who would have had no concept of that term. He used this, and other evidence, to draw a line connecting the symptoms of Civil War soldiers to modern PTSD. He admitted that "retrospective clinical analysis of men long dead is not possible and … engagement in the nineteenth century of different terms and concepts to describe psychopathology make[s] retrospective diagnoses difficult." This did not prevent him, however, from concluding that "records reveal a range of behaviors and symptoms typical of the twentieth-century victim of PTSD."[18]

Recently, historians such as Francis Clarke have challenged the work of Dean and others on the basis that applying modern standards of psychiatric thought to the Civil War can cause scholars to neglect "the shifting categories through which people interpreted and ordered their experiences." Clarke states that a modern understanding of war trauma assumes that the trauma was the result of witnessing or participating in disturbing or horrifying events. The nineteenth century definition of nostalgia defined the traumatic event as the separation from home and the "loss of family connections." She contends that historians who try to situate nostalgia within the modern understanding of PTSD ignore "an historically specific understanding and experience of war's emotional toll."[19]

Critiques like Clarke's of the "timeless" nature of psychological trauma, and PTSD specifically, existed even before Dean published *Shook Over Hell*. In 1995, ethnographer Allan Young argued that the understanding of trauma – what he called "traumatic memory" – did not

[18] Dean, *Shook Over Hell*, 100.

[19] Frances Clarke, "So Lonesome I Could Die: Nostalgia and Debates over Emotional Control in the Civil War North," *Journal of Social History* 41 (2007): 254. For a broader discussion about the historiographical trend of situating discussions of psychological trauma within their historical contexts see Paul Lerner and Mark S. Micale, "Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction" in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, ed. Mark S. Micale and Paul Lerner (New York: Cambridge University Press, 2001), 1-27

"possess an intrinsic unity" across time. Rather, he claimed that the way the medical profession perceived the disorder at any given moment was "glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented . . . by the various interests, institutions, and moral arguments that mobilized these efforts and resources." As such, he concluded, professional conceptions of psychological trauma must be viewed within their specific historical moment in order to be fully understood.[20]

This dissertation does not question the veracity of PTSD and the very real suffering experienced by those afflicted with the condition. By supporting the argument that any understanding of psychological trauma must be done by examining it within a specific historical context, I do not mean to suggest that "nostalgia," "shell shock," or "PTSD" were in some way invalid or the patients and doctors incorrect in their beliefs. As historian Tracey Loughran so aptly described her own approach to studying shell shock, "I am not writing about a type of suffering which exists in nature independently of being named… I am writing about a collection of ideas about illness rather than about an illness."[21]

In the case of this dissertation, I examine the ideas surrounding multiple illnesses, including nostalgia, traumatic neurosis, and shell shock, in order to understand how medical professionals and the public understood the effect of war on the mind. The contextualization of each condition within is specific historical moment shows the way outside influences such a technological advances, scientific trends, and social movements influenced the way psychiatrists and lay persons thought about psychological trauma. Through this approach I demonstrate how

[20] Young, *The Harmony of Illusions*, 5.

[21] Tracey Loughran, "Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories," *Journal of the History of Medicine and Allied Sciences* 67 (2012): 99-100.

such factors helped or hindered the intersection of the public and professional discourses, preventing the development of lasting disease identity surrounding combat-related mental illness.

Finally, the themes described in this dissertation broader implications beyond the historiographical. Thomas Salmon once referred to military service as "the touchstone of insanity" because he believed it had such a negative effect on the mind. The current mental health crisis among American veterans proves that his observation remains correct a century later. Public and professional interest in war-related mental illness is ongoing, and yet, we still have an imperfect understanding of psychological trauma. The answers to this complex medical question undoubtedly lie in the future. However, scholars can gain valuable insights by looking to the past as well. By examining how psychiatrists and the general public worked – or failed to work – together to craft a shared understanding of mental trauma at the turn of the century, we can better understand how disease identities are constructed. Perhaps in doing so, we can move towards creating a lasting knowledge of psychological trauma and its treatment.[22]

[22] Thomas W. Salmon, "War Neurosis ('Shell Shock'), *The Military Surgeon* 41 (December 1917): 674.

CHAPTER ONE: THE AMERICAN CIVIL WAR AND EARLY INTEREST IN NOSTALGIA

When the men of the North and the South took up arms against one another in 1861, they did so at a fortuitous moment in the history of medicine. In recent decades, American doctors had begun to turn towards scientific exploration to remedy the ailments of the body. For Civil War soldiers, this meant a focus on sanitation practices, newly constructed hospitals, and improvements in the effective treatment of war wounds. These advances in medicine, however, were not mirrored in the field of psychiatry. Medical professionals in the mid-nineteenth century were only just starting to explore mental illness with greater depth. While this did lead to some new forms of treatment in asylums, the United States on the eve of the Civil War lacked a unified psychiatric profession capable of offering a cohesive approach to dealing with diseases of the mind. As a result, when the war began, neither side deployed an organized military psychiatry apparatus to deal with psychiatric casualties.

The lack of a systematic response from mental health practitioners during the Civil War does not mean there was an absence of psychiatric illness among the soldiers of the Union and the Confederacy. As the war progressed, general medical officers, as well as soldiers, began to discuss a strange set of symptoms that appeared to affect a man's mind as well as his body. Military surgeons described soldiers showing signs of nervousness, anxiety, and depression that, in some cases, became so severe that they had to order the soldier's removal from the fighting. They referred to this condition as "nostalgia" because of their belief that the symptoms were a manifestation of the sufferer's desire to return home.

Battlefield observations of psychiatric disorder among frontline soldiers generated only a limited medical discourse on nostalgia, although that term remained popular in the lay literature and among soldiers. Mental health practitioners who encountered soldiers with psychiatric complaints rarely applied the label of nostalgia. Instead, psychiatrists opted for diagnoses that reflected the limited nosology of mental illness in the mid-nineteenth century. In doing so, they limited early professional discussions into the effects of war on the psyche. As a result, some of the most rigorous discussions of mental illness related to war occurred outside of the sphere of mental health expertise.

The State of Psychiatry before the Civil War

In the United States, as in the rest of the Western world, the professional understanding of mental illness during the nineteenth century reflected developments within the broader field of medicine. The physicians of the seventeenth and eighteenth centuries had successfully moved the practice of medicine from the realms of religion and the supernatural into more secular domains inspired by Enlightenment thought including philosophy, rationalism, and most importantly, science.[1]

Medicine's growing acceptance of the importance of science accelerated at the start of

[1] There is an extensive historiography on the history of medicine during the Enlightenment Period. Useful survey texts include: Roy Porter, ed. *Medicine in the Enlightenment* (Amsterdam – Atlanta, GA: Rodopi, 1995) and Andrew Cunningham and Roger French, eds., *The Medical Enlightenment of the Eighteenth Century* (Cambridge: Cambridge University Press, 1990); For a contextualization of Enlightenment medicine see Ray Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: W.W. Norton & Company, 1999), 226-303. For a discussion of pre-nineteenth century medicine in America with a particular attention to the development of a unique, professional medical class within the United States see Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 30-59. See also Richard Harrison Shyrock, *Medicine and Society in America: 1660-1860* (New York: New York University Press, 1960).

the nineteenth century. The industrialization of Europe, and later the United States, made the 1800s a period of population growth, technological innovation, and unprecedented wealth. Some of this wealth made its way to physicians in the form of new hospitals and better training, and the burgeoning medical community responded with new inventions and discoveries that transformed key aspects of the practice of medicine. Examples included the stethoscope – invented by French physician René Théophile Hyacinthe Laennec in 1816 – the growth of laboratory investigation aided by the microscope, and the recognition of early pharmacological drugs which, by the end of the century included such important medicines as morphine, quinine, ephedrine, and digitoxin. These medical advances created new treatment options for patients and even more importantly, allowed for greater physiological examinations by doctors. No longer limited to the cadaver, physicians could use the living body as a tool for observation and as a means of developing medical knowledge.[2]

Prior to the late nineteenth century, the treatment of mental illness fell under the purview of the general physician. Thus, any ideas about diseases of the mind that existed prior to the Civil War often reflected the wider professional consensus about illness and the body. The increased focus of post-Enlightenment doctors on science and reason helped to alter public perceptions of mental illness just as it helped cultivate public knowledge about other diseases. Perhaps more so than with physical maladies, the pre-Enlightenment public was quick to associate symptoms of mental illness with the supernatural. Most often they drew connections between mental disorders and the wrath of God. When the families of the insane were unable to derive a clear, physical cause for the dissociative or abnormal behavior of their loved one they assumed the individual had committed a sin worthy of divine punishment, perhaps an immoral

[2] Porter, *The Greatest Benefit to Mankind,* 305-335.

act or even congress with the devil. Such beliefs by laymen were substantiated by the authority of the Church which encouraged exorcisms as cures for the insane.[3]

Enlightenment physicians argued that, like a physical disease, a mental disorder was a natural illness found within the body and not the result of supernatural influences. They believed that mental illness could be treated with science in the same way as other illnesses. However, their ideas about what constituted mental illness limited the treatment options available to physicians who worked with the insane. Regardless of the symptoms or the severity of the condition, professionals in the nineteenth century as well as the public, grouped all mental illnesses under the label of insanity. Doctors made little or no distinction between individuals whose insanity was chronic or acute, the possible symptom of a neurological condition or other illness, the product of low intelligence, or the manifestation of a hereditary condition.

Over time the medical community began to outline categories of insanity: mania, melancholia, dementia, psychosis, and idiocy. These categories reflected observations of symptoms and not the development of a professional nosology of mental illness.[4] In reality, the categorization of an insane patient meant little to the treating physician. A lack of distinctive categories or gradations of mental illness meant medical professionals and the public viewed all mental patients as essentially the same with the exception of a few symptoms. As a result, when an individual was hospitalized he or she received a non-specific form of treatment which varied from hospital to hospital.[5]

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[3] Norman Dain, *Concepts of Insanity in the United States, 1789-1865* (New Brunswick: Rutgers University Press, 1964), 4.

[4] Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 35.

[5] Albert Deutsch, *The Mentally Ill in America: A History of Their Care and Treatment From Colonial Times* (Garden City, New York: Doubleday, Doran & Company, Inc., 1937), 208. and Richard H. Shyrock, "The

At the start of the Civil War the majority of the medical profession in the United States was in agreement that insanity was a physical malady situated in the brain; however, the etiology of the disordered brain was a source of somewhat greater contention. Some located the source of insanity in somatic causes such as an irritation of the nervous system or in the shape of the skull made popular by the study of phrenology. Other explanations evoked the social fears of the day. For example, some doctors viewed the forward progress of civilization with its attendant physical and emotional stresses as injurious to the brain. In the rapidly changing nineteenth-century, over-stimulation of the brain brought on by leisure and the cultivation of the arts was considered as likely a cause for insanity as poverty, vice, or an individual's ethnicity. Finally, there were those in the medical community interested in applying philosophical ideas of the mind popularized by Europeans like John Locke and David Hume to understand how the mind functioned and ultimately failed. These early attempts remained unsystematic and the majority of doctors were uninterested in developing a non-somatic view of mental illness. Ultimately, most psychiatrists in the nineteenth century believed insanity was caused by a combination of somatic, environmental, and psychological triggers and for many this understanding remained the extent of their professional interest in the science of mental illness.[6]

An excellent example of the extensive scope of causes for mental illnesses embraced by nineteenth-century physicians can be found in the doctoral essay submitted by a medical student in 1811. His list of potential causes of insanity included "Repeated intoxication; blows, and other injuries on the head; fever, particularly when attended with delirium… suppression of periodical or occasional discharges and secretions;… great heat of climate…changes of the

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Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association," in *One Hundred Years of American Psychiatry,* ed. J. K. Hall et al. (New York: Columbia University Press, 1944), 22-23.

[6] Dain, *Concepts of Insanity in the United States, 1789-1865,* 57-64, 84-113.

moon; influence of the seasons, particularly summer; in England, the *month of November* [italics in original]…" Equally important, he argued, was the country of origin due to the effect of national character on the mind as "England, Switzerland, and Spain, have the greatest number of lunatics."[7]

In large part this professional disinterest in mental illness was perpetuated by a lack of knowledge and training in mental disorders and compounded by a lack of interest on the part of medical schools to provide specialized education in psychiatry. Furthermore, the majority of doctors who demonstrated an interest in the care and treatment of the mentally ill in the 1800s served as the superintendents of asylums or state-funded hospitals. Despite his medical training, the superintendent's duties were largely those of an administrator and not a clinician. The many guises of the asylum – hospital, domestic sanctuary, and often farm or small business – meant the roles of the presiding superintendent were diverse and time consuming. The superintendent of one large asylum lamented his situation to a relative, writing,

> The principal objection I have to this place is that I have to work too hard; in fact, I work almost all the time beyond my strength, and I do not think it pays to keep that up. I have, therefore, kept my eye out for other openings, and I think if I cannot see my way clear to change things here as I want them that I will have no trouble in making satisfactory arrangements elsewhere.[8]

The need to focus on the day-to-day care and maintenance of their patients and staff superseded any scientific interest in the characteristics of mental illness or its potential causes.[9]

Compounding the matter, the very nature of the asylum served to isolate mental patients

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[7] Theodore Romeyn Beck, "An Inaugural Dissertation on Insanity," in *The Beginnings of American Psychiatric Thought and Practice: Five Accounts, 1811-1830*, eds. Gerald Grob, et al., (New York: Arno Press, 1973), 22-23.

[8] William White to Edwin Evans, State Hospital Binghamton, N.Y. June 27, 1904, Letters Sent, Superintendent, July 18, 1903-Jan 2, 1905, Records of the Superintendent; Records of Saint Elizabeths Hospital, Record Group 418, National Archives Building, Washington, DC.

[9] Shyrock, "The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association," 1-28.; Deutsch, *The Mentally Ill in America*, 186-271. See also: Gerald N. Grob, *Mental Illness and American Society, 1875-1940*, 42.

but also the treating physician. Few doctors saw cause to leave their institution or learn new methods of care, further retarding individual professional growth as well as stunting the evolution of the field of psychiatry.[10]

This is not to say that asylum psychiatrists did not try to aid the individuals under their care. In 1843 the United States possessed only twenty-four hospitals – either publicly or privately funded – devoted to the care of mental health patients. For a nation which now boasted a population of over seventeen million, there were only 2,561 hospital beds designated for the care of the mentally ill. Not surprisingly, the number of Americans identified as needing medical help for mental illness well exceeded the number of beds available. An 1833 study completed by the Prison Discipline Society of Massachusetts estimated that there were approximately twelve thousand "lunatics" in the United States, only one-fifth of whom were likely institutionalized. The criterion by which the Society identified and labeled a "lunatic" is unclear, but the Society members remained confident that approximately one in one thousand Americans was suffering from a serious mental illness.[11]

For those few who made it into an asylum, the main purpose of the institutions was for psychiatrists to render cures to the mentally ill, often through treatments of rest, strict routine, and work. Some superintendents claimed incredible success at curing mental illness. For

[10] Shyrock, "The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association," 22-23.

[11] Shyrock, "The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association," 20. The data collected by the Prison Discipline Society was soon supported by the National Census conducted in 1840 which, for the first time, included statistics on mental disease. The Census claimed that there were 17,457 "insane and idiotic" persons living in the United States in 1840 or approximately one in every 977 Americans. Again, the criterion by which a citizen was judged to be mentally ill – and who exactly made these judgments – is unclear. Even in the twenty-first century medical professionals struggle to quantify and label mental illness despite the extensive diagnostic literature churned out by the mental health community. No matter the criteria used it is likely that the numbers would in fact have been much higher, with many individuals certainly having gone unreported or unaccounted for in the Census all together. Shyrock, "The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association," 20.

example, in 1828 the privately funded Hartford Retreat reported that after only four years in operation it had successfully cured ninety-percent of its patients admitted for treatment.[12] As one historian wrote of this era, "the asylum or hospital had become a fetish, as it were, with near magic powers unconsciously attributed it" and hopeful families hastened to relinquish their loved ones to the curatives methods of the superintendent.[13] The extent to which asylum superintendents were actually able to cure their patients of mental illness remains unclear. Historians are rightly skeptical of these claims in large part because no clear understanding of mental illness existed in the nineteenth century. Though many asylum superintendents were interested in curing their patients, there was little by way of scientific investigation into the origin, identification, or treatment of mental illness to support their methods.

This professional context of the understanding and treatment of mental illness informed those military doctors at work during the Civil War. The average battlefield surgeon would have had little knowledge about the latest theories regarding the diagnosis of psychiatric distress, and given that such theories were vague even to those physicians who specialized in mental illness, it is doubtful that such knowledge would have been immediately beneficial anyway. There was certainly no expectation among these military doctors that the war itself could bring about large-scale mental breakdown in otherwise healthy men, and there was no preparation for the care and treatment of such casualties if and when they entered the hospital tents. But just as they faced the other challenges of battlefield medicine during the Civil War, the physicians addressed this

[12] Shyrock, "The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association," 16-17. The Hartford numbers were high even by the standards of the time. Most hospitals marked their success rate at under thirty-percent though rivalries between doctors often drove these numbers higher. Deutsch, *Mentally Ill in America*, 135-136. For a discussion of how these doctors came by their often dubious statistics see Deutsch's discussion on "The Cult of Curability" in Deutsch, *Mentally Ill in America*, 132-157.

[13] Deutsch, *The Mentally Ill in America*, 187. For a more detailed look at the commitment process in the nineteenth-century and the reasons families committed sick relatives to the care of asylums, see Grob, *Mental Illness and American Society, 1875-1940*, 8-12.

particular patient population with professional curiosity and the duty to both heal the man and preserve the fighting strength of their military forces.

Mental Illness and the Civil War

The Civil War that began in 1861 between the Union Army of the northern United States and the Confederate Army of the South ultimately claimed approximately 620,00 American casualties before reaching its conclusion in 1865.[14] The nature and number of the casualties that characterized this war challenged practitioners of medicine on both sides. Military medicine was still in its infancy in the mid-nineteenth century and the science of medicine more generally was still making discoveries that would come to define its most basic ideas about germs, disease, sanitation, and best practices regarding patient care.[15]

In addition to dealing with the many physical wounds caused by the fighting, military surgeons also confronted a number of otherwise healthy soldiers suddenly unable to function within their regiments. Many of these soldiers displayed symptoms of fever, shortness of breath, headache, chest pain, and gastrointestinal distress. These afflictions in and of themselves were not uncommon and were often indicators of camp diseases such as diarrhea, dysentery, typhoid,

[14] James McPherson, *Battle Cry of Freedom: The Civil War Era* (New York: Oxford University Press, 1988), 854.

[15] The historiography of military medicine during the Civil War is large. Good general surveys include: George Worthington Adams, *Doctors in Blue: The Medical History of the Union Army in the Civil War* (Baton Rouge: Louisiana State University Press, 1952). and H.H. Cunningham, *Doctors in Gray: The Confederate Medical Service* (Baton Rouge: Louisiana State University Press, 1958). See also Louis c. Duncan, *The Medical Department of the United States Army in the Civil War* (Washington, D.C.: n.d.).; Paul Steiner, *Diseases in the Civil War: Natural Biological Warfare in 1861-1865* (Springfield: Charles C. Thomas, 1968).**;** Margaret Humphreys, *Marrow of Tragedy: The Health Crisis of the American Civil War* (Baltimore: Johns Hopkins University Press, 2013). Bobby A. Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917* (New York: Routledge, 2011), 14-74.; Mary C. Gillet, *The Army Medical Department: 1818-1865* (Washington, D.C.: Government Printing Office, 1987).

or malaria. Coupled with these easily recognizable symptoms, however, were complaints which could not be so neatly classified, including the inability to sleep, severe depression or melancholy, hyper-alertness, or an overwhelming sense of hopelessness. No organized military psychiatry apparatus existed to treat these men. However, even if the military had such a group of specialists at their disposal, the professional understanding of mental illness in the mid-nineteenth century was still so limited and the field of psychiatry so underdeveloped that it is unlikely such men could have provided much assistance. Given these conditions, it is not surprising that Civil War surgeons sought their own explanations for these symptoms.

Unsure about the root mental illness and with no help from psychiatrists on the front lines, battlefield doctors devised their own diagnoses and treatments for soldiers who presented with symptoms that seemed to suggest a mental health component. One of the most common and noteworthy labels the military doctors applied to these patients was nostalgia. The condition had long been a source of interest for European physicians, but as historian Susan Matt argues, it was only during the Civil War that the illness –and its particular danger to soldiers – received greater attention and ultimately, legitimacy in the United States.[16]

The discussions of nostalgia during the Civil War are important for understanding the development of a professional discourse on war-related mental illness for two reasons. First, nineteenth-century doctors recognized the condition as particularly dangerous to individual soldiers in the field as well as to the fighting strength of the army. Though this recognition was ultimately imperfect, it did pave the way for future doctors to consider the effects of war on an individual as opposed to other explanations such as the person's character, background, or physical prowess. Second, the early discussions on nostalgia informed a limited professional

[16] Susan J. Matt, "You Can't Go Home Again: Homesickness and Nostalgia in U.S. History," *The Journal of American History* 94 (Sept 2007): 482-484.

understanding of mental illness during war that would have a bearing on their approach to war-related mental breakdown in the future, particularly in the Spanish-American War.[17]

The condition of nostalgia was not unique to the Civil War and, indeed, was likely an illness that some doctors -- and even some laymen -- had some prior knowledge of even if they had never encountered it within their own practices. References to nostalgia can be found in literature and medical writing as far back as the seventeenth century, often under a variety of different names but almost always describing the desire of a soldier to return home.[18] The first important work on the subject, including a discussion of the symptoms -- both psychological and physiological -- of nostalgia and its possible causes, was a dissertation written by German medical student Johannes Hofer in 1678. Hofer concluded that "This ailment is curable if the yearning (*Sehnsucht*) can be satisfied; incurable, mortal, or at least very grave when

[17] See Chapter Two for discussions on nostalgia during the Spanish American war. Some Civil War doctors also demonstrated interest in a collection of symptoms that seemed to affect the heart, even in the absence of an apparent physical injury. One of the chief investigators of this condition was Jacob M. Da Costa. He labeled the disorder "irritable heart" to reflect its effects on the cardiac system. In 1871, Da Costa published "On Irritable Heart: A Clinical Study of a Form of Functional Cardiac Disorder and Its Consequences," which laid out his observations condition based on his study of over two hundred Union soldiers. In particular, Da Costa pointed to symptoms such as heart palpitations, increased pulse rate, chest pain, digestive issues, increased perspiration, and for some, difficulty sleeping. He argued that something unique to soldiering had brought about this malady, though he did not draw a connection between irritable heart and mental illness. Professional interest in irritable heart – or "soldier's heart" as it is sometimes referred to in the historical literature – continued through World War I and even into World War II. Medical professionals expanded on Da Costa's earlier research and by World War I, were starting to consider whether or not there was a psychological component to the symptoms he had identified decades earlier. See Jacob M. Da Costa, "On Irritable Heart: A Clinical Study of a Form of Functional Cardiac Disorder and Its Consequences," *The American Journal of Medical Sciences* 61 (1871): 17-52.; Thomas Lewis, *The Soldiers Heart and the Effort Syndrome*, 2nd ed. (Chicago: Chicago Medical Book Company, 1940).; Joel D. Howell, "'Soldier's Heart:' The Redefinition of Heart Disease and Specialty Formation in Early Twentieth-Century Great Britain," in *War, Medicine, and Modernity*, ed. Roger Cooter, Mark Harrison and Steve Sturdy (Gloucestershire, Great Britain: Sutton Publishing, 1998), 85-105.; Charles F. Wooley, *The Irritable Heart of Soldiers and the Origins of Anglo-American Cardiology: The U.S. Civil War (1861) to World War I (1918)* (Cornwall: Ashgate, 2002). I have decided not to integrate a discussion of soldier's heart and effort syndrome into this dissertation so as not to stray too far from discussions of psychological trauma into the realm of the somatic.

[18] Soldiers of the Spanish Army during the Thirty Year's War were thought to suffer from *el mal de corazon.* The same condition was also referred to some as simply *estar roto* meaning "to be broken." For a detailed look at the history of nostalgia pre-19th century see George Rosen, "Nostalgia: A 'Forgotten' Psychological Disorder," *Clio Medica* 10 (1975): 28-51.

circumstances prevent its satisfaction."[19] Further experience with the condition over the course of subsequent wars led medical writers and interested physicians in Europe and later the United States to draw numerous conclusions about the nature of nostalgia. Though opinions varied, the consensus was that individuals from rural or mountainous regions serving as soldiers far from home, particularly the Swiss and the Scottish, were most susceptible to severe bouts of nostalgia. In 1840 *The Penny Magazine,* an inexpensive periodical marketed towards England's working-classes, ran an extended article on the condition of nostalgia. In addition to a lengthy list of the debilitating symptoms verging on the hyperbolic – "the whole nervous system becomes shattered and open to every morbid impression" -- the article extended the list of potential victims of nostalgia to include not only the Swiss and Scottish soldiers, but also sailors, African slaves, and soldiers of the French Revolution.[20]

Nostalgia also found its way into the American press and medical journals in the decades before the Civil War, either in reiterations of European anecdotes or in relation to the Mexican-American War.[21] As early in the Civil War as 1861 the *Daily Courier* of Louisville, Kentucky ran an article about Union prisoners at nearby Camp Nevin suffering from nostalgia at a high rate. The piece concluded with the rather hopeful sentiment that "Before the Yankees succeed in

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[19] J. Hofer, *Diss. de nostalgia* (Basel: 1678), quoted in Rosen, "Nostalgia: A 'Forgotten' Psychological Disorder," 32.

[20] "Home-Sickness or Mal-Du-Pays," *Penny Magazine of the Society for the Diffusion of Useful Knowledge,* November 14, 1840. For more thorough discussions about early interest in nostalgia – particularly in Europe but also the United States – see Matt, 469-497.; Anderson, "Dying of Nostalgia: Homesickness in the Union Army during the Civil War," 247-282.; Clarke, "So Lonesome I Could Die," 253-282.; Lisa O'Sullivan, "The Time and Place of Nostalgia: Re-Situating a French Disease," *Journal of the History of Medicine and Allied Sciences* 67 (2012):626-649.; Jean Starobinski and William S. Kemp, "The Idea of Nostalgia," *Diogenes* 14 (1966): 81-103.; Stuart Tannock, "Nostalgia Critique," *Cultural Studies* 9:3 (Aug 2006): 453-464.

[21] "Case of Nostalgia or Pining for Home," *Philadelphia Recorder,* July 31, 1824.; "Homesickness Insanity," *The Sun*, Baltimore, Maryland, July 21, 1862.; George Johnson, "The Medical Topography of Texas and the Diseases of the Army of Invasion," *The Boston Medical and Surgical Journal* 36 (May 19, 1847).; William G. Proctor, "On the Diseases of the United States' Army on the Rio Grande," *The Western Journal of Medicine and Surgery* 6 (Jun 1848): 461.

subjugating Kentucky we rather think a good many more of them will be afflicted by nostalgia in its most aggravated form -- especially those who will be taken prisoner and sent further South."[22]

Many nineteenth-century medical professionals were familiar with nostalgia as a mental illness characterized by an intense and even debilitating longing for home. "This peculiar state of mind," wrote one doctor, "is a species of melancholy, or a mild type of insanity." A soldier with the early symptoms of nostalgia often presented with a loss of appetite, gastrointestinal distress, a slight "hectic" fever, "great mental dejection," and "indifference to external influences." More serious cases included symptoms such as headache, increased "hectic" fever, incontinence, anxiety in the form of "watchfulness," "hysterical weeping," and "a general wasting of all the vital powers." The prognosis for nostalgia varied from patient to patient; some men recovered while others succumbed to "cerebral derangement, typhoid fever, or any epidemic prevailing in the immediate vicinity."[23] When these secondary conditions took hold in the nostalgic patient, another doctor warned, "be extremely guarded in your prognosis. The patient will very probably die."[24]

During the American Civil War, military doctors were most interested in understanding nostalgia as it related to the effectiveness of the fighting forces. The official medical history of the Union Army recorded a total of 5,213 cases of nostalgia among white troops in the first year of the war, or 2.34 cases per every thousand soldiers. This increased to 3.3 in the second year of

[22] "Sickness Among the Yankees," *Daily Courier*, December 3, 1861.

[23] DeWitt C. Peters, "Remarks on The Evils of Youthful Enlistments and Nostalgia," *American Medical Times* 5 (February 14, 1863): 75. See also: William Alexander Hammond, *A Treatise on Insanity in its Medical Relations* (New York: D. Appleton, 1883), 411-412.

[24] J. Theodore Calhoun, "Nostalgia as a Disease of Field Service," *Medical and Surgical Reporter* 11 (February 27, 1864), 132.

the war before dipping to less than two cases per thousand for the remainder of the war.[25] Doctors theorized about the potential causes of nostalgia as well as possible cures for the condition. The two most important articles to appear on the subject of nostalgia took competing views on the precipitating factors of condition as well as the most effective treatments.

In February 1863, the *American Medical Times*, a supplement of the *New York Journal of Medicine,* published an article written by Assistant Surgeon General DeWitt C. Peters entitled "Remarks on The Evils of Youthful Enlistments and Nostalgia." In this article Peters sought to contribute to the national debate surrounding the decision to lower the enlistment age of young men from twenty years old to eighteen years of age in order to increase the manpower of the Union Army. Months earlier Peters's superior, Surgeon General Hammond, had condemned the decision in his annual report for the fiscal year ending in June 1862, stating that "youths of this age are not developed, and are not fit to endure the fatigues and deprivations of the military life. They soon break down, become sick, and are thrown upon the hospitals."[26]

Writing in 1863, Peters supported this sentiment and expanded on Hammond's concern for the physical well-being – and particularly the mental stability – of young recruits. "The statistics and experiences of the U.S Army conclusively demonstrate that persons received at the minimum standard of eighteen years are, in a majority of cases in this country, not sufficiently matured in mind and body to undertake successfully the arduous duties of a soldier."[27] A

[25] Statistics taken from the *Medical and Surgical History of the War of the Rebellion* and quoted in Albert Deutsch, "Military Psychiatry: The Civil War, 1861-1865," in *One Hundred Years of American Psychiatry,* ed. J. K. Hall et al. (New York: Columbia University Press, 1944), 376-377. See also Dean, *Shook Over Hell,* 130-131.

[26] Hammond report quoted in Deutsch, "Military Psychiatry: The Civil War, 1861-1865," 373.

[27] Peters did not include statistical data within the article nor did he cite studies to support this claim. It is likely that this opinion comes largely from personal experience and statistic Peters gathered himself. He discusses these statistics as well as some early thoughts on nostalgia in a letter to a colleague reprinted by the *Medical and Surgical Reporter* in February 1862. See DeWitt C. Peters, "Untitled Letter," *Medical and Surgical Reporter* 7 (February 16, 1862): 497-499.

continuation of the policy he argued, would not only decrease military effectiveness – he argued that those under twenty years old were "often extremely liable to prove a burden to the service" because of the many risks to their health – but could potentially be injurious to the lasting health of the young men called upon to serve. "Prematurely their health is undermined," he cautioned, "if not ruined for ever."[28]

In Peters's experience perhaps the greatest difference between the younger and older soldiers was evident in how their minds tolerated the rigors of war, not simply combat but also the day to day activities of marching and camp life. He argued that older soldiers possessed "the balanced mind" necessary to endure the physical and mental strains of soldiering whereas the mind of a young man on the verge of adulthood "begins to despond" after exposure to long marches, guard duty, and the other more violent aspects of war. Peters warned that such despondency left the young recruit at greater risk for fevers and other physical maladies, supporting his earlier claim that young men exposed to war could only be a burden on the military system they sought to bolster.[29]

In the opinion of the Assistant Surgeon General, one of the greatest risks to the young soldier was the condition of nostalgia. Peters had witnessed a particularly high number of cases among young men held as prisoners and among new recruits serving at frontlines deep in the South. The latter were especially vulnerable, he argued, because of the irregularity of the mail and the "debilitating" Southern climate that differed so much from the temperate climes of the North. He recounted a visit to a military hospital in New Orleans in which a significant number

[28] Peters, "Remarks on The Evils of Youthful Enlistments and Nostalgia,"75.

[29] Peters, "Remarks on The Evils of Youthful Enlistments and Nostalgia,"75. Peters did admit that there was an exception to the general mental and physical weakness of younger soldiers and that was in the case of young recruits in the cavalry. He theorized that the young cavalryman was "strength[end] against contagion in its worst forms" due to the recruit's constant exposure to excitement, competition with the others in his unit, and the close relationship he developed with his horse.

of the nostalgia cases were soldiers from the eastern region of the United States. Peters's reasoning that this higher incidence of nostalgia was due to the "love of home and kindred" that was a "characteristic trait" of young men from the East coast reflected the contemporary medical belief that geography and regional ties were strong predictors of who would fall victim to the illness. But his pointed argument for the underdeveloped nature of the young psyche and its greater susceptibility to the difficulties of war complicated the professional understanding of nostalgia while at the same time situated the condition within the heated debate about the age of enlistment.

A second important article about nostalgia amongst Civil War soldiers appeared a year later in the form of a paper presented by J. Theodore Calhoun, the Chief Surgeon of the 2nd Division, 3rd Corps of the Union Army, to the Medical Society of the 2nd Division and later published in the *Medical and Surgical Reporter*. Like Peters, Calhoun stressed the seriousness of nostalgia and its negative impact on the fighting capability of the Union Army. In this regard, he also placed the condition within the context of two national debates regarding military effectiveness: the issue of furloughs for wounded and non-wounded soldiers and the supposed lack of morale and patriotism endemic among the men this late in the war.

Whereas DeWitt Peters saw nostalgia as a disease most likely to strike the young and undeveloped mind, Calhoun identified it as a mental condition wrought out of dissatisfaction, low-morale, and perhaps even an overall lack of "manliness." The first soldiers of the war, he argued, were "impelled by the noblest of motives" to join the ranks of the Union Army. But as the war ground on year after year "our armies are recruited with unwilling men, either conscripted or bought up by enormous bounties." Calhoun observed that none of these most recent recruits were "animated by the patriotism or manliness of our early volunteers" which,

combined with a longing from home, was "every cause necessary to the production of nostalgia."[30]

Calhoun went on to suggest other causes of nostalgia more in line with the dominant contemporary medical beliefs about the condition. He cited, for example, severe homesickness as a result of the frequent letters exchanged between a soldier and his family. "Ours is emphatically a letter-writing army," he wrote, which served "to keep vividly before the imagination the home scenes and home ties." In this respect Peters and Calhoun were diametrically opposed: for Peters, a lack of letters spurred the homesickness that triggered a fatal nostalgia; for Calhoun, too much access to mail could have the same dire result.

In referencing the belief that Europeans from mountainous or rural regions were particularly vulnerable to nostalgia, Calhoun posited that military surgeons could use such knowledge to explain the "common remark in this army that troops from the country, have a much larger percentage of deaths, than those recruited in the city." The simple explanation for this phenomenon was the susceptibility of the rural American soldier to nostalgia. In his observations of soldiers from the state of New York, Calhoun found that all other things being equal -- military duties, lodging, food, hygiene, access to medical care -- the men from rural New York were more likely to become fatally ill than those soldiers from the more urban sections of the state. "Home sickness, as I think, was the complication that turned the scale against life," he concluded. In other words, nostalgia had a decidedly geographic component to its etiology.[31]

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[30] Calhoun, "Nostalgia as a Disease of Field Service," 130.

[31] Calhoun, "Nostalgia as a Disease of Field Service," 131. Statistical data compiled after the war bears out this observation by Calhoun and other military surgeons. Using regimental data published in 1889 historian James McPherson found that the death rate from disease of Union soldiers in the Army of the Potomac from the rural areas west of the Appalachian Mountains was forty-three percent higher than the number of deaths from disease amongst soldiers from the more urban Northeast. James McPherson, *Battle Cry of Freedom*, 471-472. The susceptibility of soldiers from rural areas to higher rates of illness was a very real phenomenon that was not unique to the Civil War. It would once again wreak havoc on the United States military during its mobilization for the First and Second

Perhaps the most interesting aspects of Calhoun's article on nostalgia were his suggested treatments for soldiers diagnosed with the condition. Here it is possible to see early versions of steps that later military doctors and psychiatrists would undertake when confronted with soldiers suffering from mental illness during war. For example, Calhoun recommended that the nostalgic soldier be kept as busy as possible since "idleness is a provocative of home sickness." In later decades military psychiatrists would also extol the merits of this simple treatment, though they often coupled it with distance from the fighting, something Calhoun would have disagreed with strongly. In fact, his strongest recommendation to medical colleagues faced with a regiment beleaguered by nostalgia was to find those men a battle as quickly as possible. He observed that a regiment of men from New York so afflicted by homesickness that "the regiment was but a regiment in name" only, but was "cured" after fighting the battle of Chancellorsville. Because the combat allowed the men to fight nobly "they felt they were men and soldiers" again and the regiment "has since enjoyed as good health as any in the division."[32]

Paradoxically, Calhoun also strongly favored removing men from war in order to prevent nostalgia from taking hold. He was a staunch advocate of military furloughs for non-wounded

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World Wars. However, once the medical sciences developed a better understanding of germ theory physicians would come to understand that this was the result of urban youth's frequent exposure to illness as a result of the crowded conditions common in city-living. Exposure to and survival of these diseases led to subsequent immunity. Young men from rural areas who lacked this extended contact to disease-causing germs were at a greater risk once they were herded into military camps at great numbers. Calhoun and some of his colleagues actually acknowledged something akin to this theory in the discussion of Calhoun's article published by the *Medical and Surgical Reporter* a week later. In it they mention the negative effects of what they refer to as "crowd-poisoning," a term making its way through medical circles at the time. As one physician described it, "The men from the country being habituated to a purer atmosphere, plenty of fresh air and sunlight, are much more readily affected by the poisonous effluvia generated in crowded vessels, than those who in cities have habitually breathed an impure atmosphere, whose system has become less susceptible to these effluvia." Calhoun conceded that rural soldiers were more apt to suffer the negative effects of "crowd-poisoning," but while he did not want to be misunderstood as saying nostalgia was the only cause of vulnerability in rural soldiers he argued that "nostalgia could not be overlooked" when physicians analyzed the phenomenon. "Medical Society of the Second Division, Third Corps, Army of the Potomac: Discussion on Nostalgia," *Medical and Surgical Reporter* 11 (March 5, 1864), 150-152.

[32] Calhoun, "Nostalgia as a Disease of Field Service," 131-132.

soldiers. Calhoun believed that soldiers who were able to anticipate a visit home would have higher morale, better incentive for good behavior, and best of all, little or no reason to develop the debilitating home-sickness that could become a fatal nostalgia. Furloughs, he expounded, were "a grand hygienic measure."[33] One hundred years later military psychiatrists in Vietnam would also turn to military furloughs or mid-tour R&R for similar reasons. Similarly, when psychiatric casualties at the start of the Vietnam War remained surprisingly low, medical professionals were quick to attribute the welcome turn of events to the positive psychological benefits associated with the definitive year-long deployment. Just as Calhoun believed furloughs raised morale and provided the soldier with a positive goal to anticipate, thereby limiting mental illness, military doctors in Vietnam considered R&R and short-deployments to have similar ameliorative effects.[34]

Military policy regarding furloughs and the availability of battles were two issues beyond

[33] Calhoun, "Nostalgia as a Disease of Field Service," 132.

[34] Peter Bourne, one of the leading military psychiatrists in Vietnam, described this theory in the influential edited volume *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War* (1969). He wrote, "Of all the administrative decisions that have been made concerning conduct of the Viet Nam war, the one with the most far-reaching implications for combat psychiatry is the 1 year tour. The GI in Viet Nam knows that if he can merely survive for 12 months his removal from combat is assured… A related factor is the rest and recuperation program which provides the soldier with 1 week of vacation during his tour in of the surrounding countries in Southeast Asia. These policies clearly exert a profound although measured effect in reducing the incidence of psychiatric casualties." Peter Bourne, "Military Psychiatry in Perspective," in *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War* ed. Peter Bourne (New York: Academic Press, 1969), 227-228. After the war, American psychiatrists would come to see the low incidences of psychiatric casualties touted by Bourne and others less as the result of good mental health practices than the misidentification of psychiatric suffering in soldiers. While there were fewer cases of the "traditional" psychiatric disorders that usually plagued soldiers – namely combat fatigue or combat reaction – there were higher numbers of men with what psychiatrists at the time labeled "behavioral disorders." Symptoms of such disorders manifested in disciplinary infractions, drug abuse, aggression, depression, and alienation. Ironically, psychiatrists attributed the increase in these conditions to the twelve month deployment schedule and individual R&R. They argued that the same policies which Bourne claimed helped the soldier in fact made him more motivated to protect his own survival, leading to individual isolation and preventing the formation of unit cohesion that could assist the soldier in maintaining a psychiatric equilibrium in combat. See Franklin D. Jones, "Military Psychiatry Since World War II," in *American Psychiatry After World War II (1944-1994)* eds. Roy Menninger and John Nemiah (Washington, D.C.: American Psychiatric Press, 2000), 17-18.; Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2001), 349-350.

the control of the military surgeon. Calhoun did have one more suggestion for the treatment of nostalgia, however, that could be administered at the unit level. Calhoun's claim that a lack of manliness could be a precipitating cause of nostalgia led him to recommend as a form of effective treatment "any influence that will tend to render the patient more manly."[35] In particular, he suggested ridicule and humiliation from the patient's fellow soldiers as the quickest way to relieve any lingering symptoms of mental illness, believing that "the patient can often be laughed out of [nostalgia] by his comrades, or reasoned out of it by appeals to his manhood." Calhoun's stigmatization of nostalgia as a form of weakness of the individual's character, general cowardice, or the result of some action or inaction of the sufferer would be repeated by soldiers, civilians, and medical professionals for the next one hundred years. The idea that combat-related mental illness was unique to men who were already flawed in some way – either physically or mentally -- would be a key component of professional discussion surrounding psychological trauma during WWI. The same sentiments would also lead to the extensive psychiatric testing of recruits before the Second World War under the misguided belief that a war-induced breakdown could be reduced if only the "right" kind of men were inducted into the military.[36]

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[35] Calhoun, "Nostalgia as a Disease of Field Service," 132. Calhoun's views about the "unmanly nature" of nostalgia were not universal. In his book *History of the First Kentucky Brigade* (1868) Confederate Army officer Edwin Porter Thompson described the near ubiquitous nature of the soldier's preoccupation with thoughts of home. "There are quiet hours, even to the soldier on duty," he wrote, when nostalgic thoughts "crowd upon the mind, and the yearnings of his heart, and the earnest sadness that gathers about it in those hours, can not be described." Thompson admonished the reader, however, to refrain from casting judgment upon such individuals, particularly with regards to their masculinity. "To say that such feelings are unmanly is simply to declare him that utters it a fool." Indeed, he argued, the very opposite was true. "The deeper, the more earnest and passionate, the more of true manhood there is in one's nature, the more apt he is to be affected by these feelings." Even Thompson had to admit, however, "the manly nature is also displayed in resisting it, so as not to be wholly overcome. The stern purpose must control the inordinate longings of the soul, and give the reins to reason and to duty." Edwin Porter Thompson, *History of the First Kentucky Brigade* (Cincinnati: Caxton Publishing House, 1868), 62.

[36] See Chapter Four for a discussion about military psychiatrists during WWI and their thoughts on predisposition in relation to shell shock. For a description of how the professional paradigm of predisposition informed medical screening in WWII see Ellen Herman, *The Romance of American Psychology: Political Culture in the Age of*

The two articles published by Calhoun and Peters were the only extended discussions of nostalgia to appear in the medical literature during the Civil War. Following the end of the war the medical discourse on nostalgia dropped off, reflecting the start of an unfortunate trend in which professional attention to the connection between war and psychological distress terminated almost immediately after the war ended.[37] From 1866 to 1899 the word nostalgia appeared only twelve times in the *American Journal of Insanity* and in the majority of instances the diagnosis was found in a table or graph describing the patient population of a specific asylum. There were, however, a few examples of doctors using nostalgia to explain the symptoms of particular patients, usually immigrants. Overall, the connection between nostalgia and soldiers remained tenuous and no serious studies during the Civil War existed beyond the research conducted by Peters and Calhoun. [38]

Experts (Berkeley: University of California Press, 1995), 82-95. Calhoun was not the first military physician to suggest harsh treatment or fear as a curative for soldiers presenting with symptoms of nostalgia. In his final book, *Medical Inquiries and Observations of Diseases of the Mind* (1812), Dr. Benjamin Rush recounted the story of a Russian general named Praxin and his novel treatment for the condition. In 1733 the general and his soldiers found themselves far from home on the bank of the Rhine River. Homesickness began to spread through the ranks and soldiers began to declare they were unfit for duty. Fearing for the fitness of his army General Praxin ordered that all soldiers afflicted with nostalgia would be buried alive. Rush reports, "This punishment was inflicted in two or three instances, in consequence of which the disease instantly disappeared from the army." Dr. Rush, who served as Surgeon General of the Middle Department of the Continental Army and is considered by many historians to be the father of American psychiatric thought, found the actions of Praxin to be too extreme. However, he conceded, "fear, excited by a far less cruel remedy, I have no doubt would have had the same effect." Benjamin Rush, *Medical Inquires and Observations Upon Diseases of the Mind* (1812; reprint, New York: Hafner Publishing, Inc., 1962), 113.

[37] There were scattered references to nostalgia within the popular media between the end of the Civil War and the start of the war against Spain. These few instances did not reference Civil War casualties but instead mentioned nostalgia as it appeared amongst European soldiers. See "Nostalgia," *The New York Times*, May 12, 1874, 4; "Nostalgia, or Homesickness," *Appleton's Journal of Literature, Science, and Art*, October 9, 1869, 238.; "Nostalgia, or Homesickness," *Appleton's Journal of Literature, Science, and Art*, May 23, 1874. Despite having the same title, the 1874 article published in *Appleton's* was a different piece than its predecessor of the same name.

[38] I derive my data from a keyword search for the word "nostalgia" in the digital database of historic issues of the *American Journal of Insanity*.

Diagnosing Civil War Soldiers

With no organized military psychiatry during the Civil War, Union and Confederate soldiers suffering from psychiatric distress relied on immediate treatment from general surgeons. Sometimes the soldier's suffering was so severe that it warranted evacuation from the frontlines and admittance into an asylum. Evidence suggests that civilian medical professionals who specialized in mental health in the mid-nineteenth century and undertook the care of these men rarely diagnosed Civil War soldiers or veterans with nostalgia. Instead, the majority of psychiatric casualties that required treatment beyond the initial echelons of care at the battalion or regimental level during the Civil War received one of the three standard headings used to describe all mental illnesses during the 19th century: mania, dementia, or melancholia.

Patient admission records of Union soldiers treated at the Government Hospital for the Insane in Washington, D.C. demonstrate the frequency with which mental health practitioners applied these labels in lieu of the diagnosis of nostalgia more commonly used by soldiers and military physicians. The Government Hospital for the Insane was created by Congress in 1855 in order to serve the indigent population of the nation's capital as well as mentally ill members of the United States Army and Navy. Though still relatively new at the start of the Civil War, the Government Hospital became a well-respected fixture of the mental health profession over the coming decades and it serves as an excellent historical example of psychiatric care in the mid-nineteenth century. Its joint funding by the local government of Washington, D.C. and the federal government reflected the growing national belief that state and local governments had a responsibility for the mentally ill in their communities. Indeed, leaders in Washington expanded on this public mandate by designating the Government Hospital as not only the refuge for the

impoverished mentally ill in Washington, D.C. — easing the burden on local jails and alms houses — but also as a site where the nation would see to the medical care of members of its armed forces. Additionally, this care would reflect the most modern medical ideas regarding the treatment of mental illness: the moral therapy made popular in Europe. At the Government Hospital patients worked outdoors on the asylum's farms, walked in the gardens, or visited the hospital's zoo. They had clean, comfortable living quarters and access to good food. Doctors and orderlies avoided restraints, and a greater focus on retaining the patient's dignity replaced the harsh treatment characteristic of previous decades. Medical professionals embraced moral treatment as not only more likely to be curative, but also more appealing to family and community members frightened and disgusted by rumors of dangerous and squalid conditions in asylums.[39]

Five years after creation of the Government Hospital, the start of the Civil War brought in a steadily increasing stream of military patients. Its location at the seat of the Union, not to mention its funding from the federal government, meant that only Union soldiers and sailors received treatment for mental illness at the Government Hospital.[40] The asylum opened its doors to soldiers and sailors, black or white, from across the Union. Between 1862 and 1878 the Government Hospital received 2,422 psychiatric admissions. The highest number of admissions occurred during 1864 at the height of some of the worst fighting. That year 478 Union

[39] Frances M. McMillen and James S. Kane, "Institutional Memory: The Records of St. Elizabeths Hospital at the National Archives," *Prologue* 42 (Summer 2010): 46-53.

[40] Like many of the few existing hospitals, as well as churches, schools, and other large buildings near the front lines, the Government Hospital for the Insane was called into service as a traditional military hospital once casualties mounted and the military became desperate to find beds. This military hospital, including its physicians and patients, was administered by the United States Army. Housed in separate buildings well apart from one another, the two patient populations and the medical staffs did not interact. Additionally, Government Hospital administrators did not include these more "traditional patients" in any of their book-keeping or medical records. For the sake of clarity, all references to military patients at the Government Hospital in this chapter should be considered psychiatric patients.

psychiatric casualties entered the Government Hospital for the Insane as opposed to the 342 admitted the year before. [41]

The psychiatric diagnoses given to these soldiers reflected the dominant diagnostic trends of mental health professionals during the nineteenth century. In March of 1865, for example, the Government Hospital admitted forty-three patients. The hospital recorded the "disease upon admission" for forty-two of these men. Of these forty-two patients, twenty-eight were given a diagnosis that reflected some sort of mania, often noted as either chronic or acute. Sometimes the admitting doctor noted an even more specific diagnosis of mania such as that of Pvt. William Long of the New York Volunteers who was designated as suffering from chronic epileptic mania or Pvt. John Bechtel of the 4th U.S. Artillery whose condition was listed as chronic paralytic mania. Other diagnoses included ten patients suffering from some form of dementia — including fifteen year-old S.H. Gump of the 2nd Ohio Cavalry who died after three months at the Government Hospital — and four patients admitted for melancholia. The diagnosis of one of these four melancholic patients, Nicholas Amos, a private in the Pennsylvania Cavalry, included a mention of nostalgia.[42]

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[41] I derived the number 2,422 by counting the individual recommendations for admission to the Government Hospital for the Insane from 1862 until 1878. These recommendations can be found within six bound volumes of records produced by the Office of the Adjutant General from January 1862 until December 1878. Records of Admissions, Insane Asylum January 1862-1917, Records Relating to the Government Hospital for the Insane, 1862-1919, Records of the Adjutant General's Office, 1780s-1919, Record Group 94, National Archives Building, Washington, DC. It is important to note that this number is not as exact as it might appear. The Office of the Adjutant General of the United States, acting on behalf of the Secretary of War, approved the institutionalization of each Union soldier at the Government Hospital. Given the sometimes chaotic nature of wartime bureaucracy it could be that a soldier who was admitted on more than one occasion, was counted more than once. Thus, it is possible that while the number of admissions to the Government Hospital stands at 2,422 the actual number of unique patients may have been slightly smaller.

[42] Asylum Register January 15, 1855-December 21, 1876, Registers of Cases, 1855-1941, Medical Records Branch, 1855-1955, Records of St. Elizabeths Hospital, Record Group 418, National Archives Building, Washington, DC. The Government Hospital for the Insane was renamed St. Elizabeths Hospital after the Civil War. Soldiers receiving treatment at the hospital – particularly those housed in the makeshift "traditional" army hospital – often referred to the Government Hospital as "St. Elizabeth's Hospital" in their letters to loved ones because the association with insanity carried too much of a social stigma. In was in deference to this patient discomfort that the

Admissions records for the Government Hospital indicate that an initial diagnosis connected to nostalgia was incredibly rare. Pvt. Amos was one of only three men in 1865 whose "form of disease on admission" reflected a designation of nostalgia. Between February 1865 and January 1868, 417 soldiers arrived at the Government Hospital, only four of whom did doctors link to nostalgia. In fact, of the over 2,000 Union soldiers and sailors received by the Government Hospital for the Insane between 1862 and 1876, hospital records identify only twenty-two men as having a mental illness which admitting physicians associated with nostalgia.[43]

In every one of these twenty-two cases doctors used the designation of nostalgia to add specificity to a broader diagnosis of melancholia. Men such as Pvt. Amos, for example, were admitted to the asylum with "Acute Nostalgic Melancholia." Another soldier, known simply as "John," was admitted with "Acute Suicidal Melancholia caused by nostalgia." For the mental health professionals at the Government Hospital, nostalgia itself was not a diagnosis but either a precipitating factor of a larger diagnosis such as melancholia — like in the case of "John" — or a characteristic or symptom of a mental illness brought on by some other factor. The latter can be seen in the admission record of Pvt. Patrick Connor. Pvt. Connor is the only recorded admission for a form of nostalgia at the Government Hospital between the conclusion of the war and 1876. Admitted to the hospital from the 15th Infantry Regiment in August 1866, doctors list his condition as Acute Nostalgic Melancholia. Fortunately for historians, the admission of Pvt. Connor was one of the few instances in which the reporting physician noted a potential cause for the mental illness that brought the soldier to the care of the Government Hospital. In the case of

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name was officially changed in 1916. McMillen and Kane, "Institutional Memory: The Records of St. Elizabeths Hospital at the National Archives,"49-50. It is unclear when or why the possessive apostrophe was dropped.

[43] Asylum Register January 15, 1855-December 21, 1876, Registers of Cases, 1855-1941, Medical Records Branch, 1855-1955, Records of St. Elizabeths Hospital, Record Group 418, National Archives Building, Washington, DC.

Pvt. Connor, the doctor listed sun stroke combined with intemperance. Thus, drink and hot weather, according to this medical professional, were the cause of the soldier's mental anguish, not necessarily his military service.[44]

These findings from the Government Hospital for the Insane mirror historian Jeffrey McClurken's findings in his study of the effects of the Civil War on individuals from Pittsylvania County and Danville, Virginia. In his efforts to understand the myriad consequences of the war — social, economic, and psychological — on the soldiers and civilians of this small region in the South, he turns his attention to the community members admitted to the nearby Western State Lunatic Asylum for possible war-related mental illness. McClurken identifies a sample of 455 patients admitted to the hospital between 1861 and 1868 and of these patients, "fifty-seven of them entered because of psychological problems attributed to 'The War.'" It is important to note that unlike the data gathered from the Government Hospital for the Insane, McClurken's data includes civilian admissions. His analysis also takes into account an additional nineteen patients "shown to be part of a veteran family" who were admitted from 1861 to 1900.[45]

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[44] Asylum Register January 15, 1855-December 21, 1876, Registers of Cases, 1855-1941, Medical Records Branch, 1855-1955, Records of St. Elizabeths Hospital, Record Group 418, National Archives Building, Washington, DC.

[45] Jeffrey W. McClurken, *Take Care of the Living: Reconstructing Conferedate Veteran Families in Virginia* (Charlottesville: University of Virginia Press, 2009), 119-120. McClurken is fortunate in that the historical record of the Western State Lunatic Asylum includes patient medical records with detailed patient histories collected by asylum doctors or, more likely, provided by concerned family members. Informed by these patient histories McClurken is often able to infer a connection between war service and institutionalization. He is careful to note, however, that while medical records "directly link" patients' mental problems to "some kind of involvement in the Civil War" the reader should not assume that "the conflict necessarily 'caused' all these mental illnesses." McClurken, *Take Care of the Living*, 120. Such thorough medical records were not available for the patients housed at the Government Hospital for the Insane. The National Archives maintains the individual records of only a few hundred of the thousands of patients treated at the Government Hospital during its decades of service to the D.C. area. However, even if all records were present there is no guarantee that they would provide much insight into the condition or treatment of the patient, particularly in the case of patients admitted during the Civil War. Of the twenty-two nostalgia patients recorded in the admittance ledger of the Government Hospital, only one patient file was available -- that of R.G. Thomspon of the 32nd Ohio Volunteers. The file contained a single letter from Thomspon asking for an official note from the hospital to support his pension application. A general perusal of other patient files turned up little more information about the post-Civil War period at the Government Hospital.

McClurken's observations from this dataset are in line with the information available from the Government Hospital for the Insane during roughly the same time period. He concludes that of the approximately seventy-six patients whose admission can be linked to the Civil War, mania was the most common diagnosis amongst soldiers or civilians. Seventy-two percent of those patients admitted during and immediately following the Civil War received this designation. Another nine-percent were labeled as delusional and a further nine-percent with dementia. Eleven-percent were diagnosed with a form of melancholia. Nostalgia makes no appearance in list of causes delineated by doctors, at least as mentioned by McClurken. It is, of course, possible that nostalgia appeared as an addendum to diagnoses of melancholia, such as in the records of the Government Hospital. However, McClurken does not indicate that nostalgia was itself a discrete diagnosis for any of the veterans at the Western State Lunatic Asylum.[46]

Both McClurken's data and the admissions data for the Government Hospital identify mania as the most common for which soldiers found themselves admitted to an insane asylum. In some ways this should not be a surprise. Manic behavior often included violent and uncontrollable outbursts, making the patient a danger to himself or others. McClurken argues that Western State housed so many manic patients because in an age where the majority of medical care happened at home, the residents of Pittsylvania and Danville, Virginia could not

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Many physicians reviewing a patient's file upon his or her death or discharge after 1900 lamented that good record-keeping on the part of the hospital staff did not start to appear until around 1906 or later. Sometimes the doctors noted that they tried to collect a patient history in 1900 but few patients provided useful information. The usual source of early information is the Asylum Register. Often the only contemporary data were letters written by interested or concerned relatives asking after the patient's current health and treatment. Consistent and detailed record-keeping was simply not a concern of the medical staff at most nineteenth century asylums, though this began to change at the turn of the century. See the impassioned plea and numerous recommendations made by St. Lawrence State Hospital Superintendent William Mabon in an attempt to address this very issue. William Mabon, "Value of Hospital Records," *The American Journal of Insanity* 55 (1898): 253-262.

[46] McClurken, *Take Care of the Living,* 129-131.

offer adequate home care to men and women with such severe symptoms.[47] Such an assertion can be extended to military units as well. Soldiers displaying manic symptoms posed a threat not only to the physical safety of comrades in camp but also unit morale. Perhaps most importantly, however, a soldier prone to sudden, loud outbursts or uncontrollable acts of aggression would have been a danger to the fighting effectiveness of a military system that relied so heavily on individual and collective discipline. It is likely then that these men were quickly removed to the rear and in some cases, sent to an asylum such as the Government Hospital or Western State.

The same reasoning which explains the frequency with which mania cases were treated away from the front lines and in hospitals could also explain why military surgeons and not civilian doctors at asylums seemed more concerned with nostalgia. Whereas the extreme symptoms of mania almost always went beyond the expertise or limited time of a regimental or battalion surgeon, the more docile symptoms of melancholia could be more easily treated "in house" or simply ignored by the treating physician. A depressed soldier who withdrew into self-isolation did not pose a threat to the safety of the unit, and military doctors bound by the mandate to preserve the fighting strength of the army – Union or Confederate – were not eager to remove physically healthy men from battle, at least until the soldier refused to pick up his rifle and fight. It was then that the surgeon would be forced to confront the severity of the soldier's melancholy and determine if he should be removed for more intensive care. But as Calhoun's study of nostalgia suggested, contemporary attitudes toward mental health meant that the military surgeon

[47] McClurken, *Take Care of the Living*, 131. Doctors who worked with the mentally ill also argued that such individuals would be better served in institutions or hospitals, but not so much for the safety of family members as for the well-being of the patient. As one doctor argued, insane men and women often held strong beliefs that the sane person would not understand. Family members who attempted to challenge those beliefs in an effort to help the patient would no longer be a support to the patient but a hindrance to his or her recovery. "They become his tormentors, his defamers, his enemies," wrote the doctor, and as a result these well-meaning loved ones, "are not only powerless for any good under such circumstances, but increase and aggravate the evil which they are striving to overcome." Quoted in the 1864 report of the McLean Asylum, Reviewed by P.E. in "Review of Reports for American Hospitals for the Insane," *The American Journal of the Medical Sciences* 100 (October 1865): 468-469.

had a variety of methods at his disposal to "cure" the afflicted soldier, from threat to ridicule. It is likely that only the most severe cases of melancholia or nostalgia would have induced the doctor to recommend the soldier's hospitalization or even institutionalization away from the frontlines. Therefore, unit-level military doctors were more likely to encounter and treat what they considered nostalgia than civilian mental health professionals at the highest echelon of mental health care available. This would also explain the dearth of professional attention to nostalgia in the medical lecture – during and after the war – and why, instead, the two major articles on the subject came from two frontline military physicians.

Discussions of nostalgia outside of the medical community also popularized the term and perpetuated its associations with Civil War soldiers. One medium through which this occurred were the numerous memoirs and books published by veterans and military physicians after the war. Geared towards a civilian audience and designed to portray the often difficult totality of an individual's war experience, these forms of textual memory frequently discussed nostalgia as one of the myriad challenges the soldier encountered.

In this way we can already see the intersection between the popular understanding of mental trauma associated with wartime service and the professional medical viewpoint. The public and the professionals would continue to contribute to this dialectic over the next century, each influencing the other's interaction with the condition and its sufferers. Given psychiatry's general disinterest in war-related nostalgia during the post-Civil War period, memoirists had, perhaps, more influence on the shaping of popular understanding nostalgia than did medical men.

After the War

While discussions of nostalgia connected to military service remained rare within the professional literature following the Civil War, the term appeared with greater frequency in texts designed for public consumption. Evidence of this can be found in some of the regimental histories published by civilian researchers, veterans, or veterans' groups in the decades following the war. These often informal works chronicled the exploits of a particular regiment, usually from the muster and initial training of the men in their home state to the first harrowing encounters with the enemy, extended marches in unfamiliar territory, the dangers of battle punctuated by acts of heroism by men in the regiment, and the eventual conclusion of the war. Authors also devoted significant attention to the tedium of day-to-day camp life and it is here that the mentions of nostalgia most often appear. The various discussions of nostalgia are all brief but taken together they offer a variety of different opinions on the validity and severity of the affliction from those outside of the mental health profession.

In some cases the author or compiler of the history was a medical officer in the regiment, allowing him to offer a more professional perspective on the condition. Charles M. Clark, a surgeon in the 39th Illinois Infantry Regiment, dismissed nostalgia as both inconsequential — associating it with the "general discomfort" experienced by the men during a week-long rain storm — and a justification for malingering. He recalled that "aside from the large amount of actual sickness in McClellan's army" he encountered many soldiers claiming nostalgia as a justification for discharge. "As a rule," he wrote, "they were disapproved."[48] James A. Mowris was more sympathetic in his recollection of nostalgia. He described how, in his experience as a

[48] Charles M. Clark, *The History of the Thirty-Ninth Regiment Illinois Volunteer Veteran Infantry (Yates Phalanx) in the War of the Rebellion: 1861-1865* (Chicago: 1889), 56, 92.

regimental surgeon for New York's 177th Regiment, nostalgia often compounded the other illnesses of the regiment's soldiers. As a result of the "unpromising complication" of nostalgia, he concluded, "the younger soldiers and such elder ones as were constitutionally more prone to this home yearning, were least likely to recover from serious illness."[49]

The disparate opinions of Clark and Mowris reflected the larger uncertainty within the medical community on the definition of nostalgia and its effects on Civil War soldiers. Both doctors recognized the potential danger of nostalgia to the effectiveness of the fighting forces under their charge but each identified the manifestation of the threat in different ways. For Clark, nostalgia was a common emotion experienced by soldiers but magnified and perverted by some desperate individuals eager to shirk their duty. Mowris, on the other hand, considered nostalgia a "social infirmity" that could have a tangible effect on his weaker patients, sometimes resulting in lethal consequences. Despite these different views the decision by both men to include nostalgia in their regimental histories suggests each physician considered the condition an important part of the war experience.

Veterans other than medical personnel also mentioned nostalgia within their regimental histories.[50] Confederate Army officer Edwin Porter Thompson noted that feelings of homesickness were common amongst the men of the 1st Kentucky Brigade but often "a disease is developed which unnerves the man, and drags him, a lingering prey to his affections, to the

[49] J.A. Mowris, *A History of the One Hundred and Seventeenth Regiment, N.Y. Volunteers (Fourth Oneida) From Date of Its Organization, August, 1862 till that of its Muster Out, June 1865* (Hartford, Conn: Case, Lockwood and Company Printers, 1866), 81-82.

[50] Additional mentions of nostalgia can also be found in Fletcher W. Hewes, *History of the Formation, Movements, Camps, Scouts and Battles of the Tenth Regiment Michigan Volunteer Infantry* (Detroit: John Slater's Book and Job Printing Establishment, 1864), 106. and C.W. Boyce, *A Brief History of the Twenty-Eighth Regiment New York State Volunteers, First Brigade, First Division, Twelfth Corps, Army of the Potomac* (Buffalo, N.Y.: The Matthews-Northrup Co, 1896[?]), 65. The latter describes nostalgia as a "disease... often as fatal as other diseases and quite as painful and distressing."

grave." He recounted the confusion of one squad leader who could not understand why so many of his men were absent from duty:

> It will be remembered that much astonishment was expressed, during the early period of the war, at the singular term which so often occurred opposite the names of the sick, in the surgeon's notes. "Nostalgia!" said a wondering sergeant one morning in our hearing, upon seeing it written by his Esculapius against several names of his sick squad; 'what the plague is that?' "Home-sickness," said the surgeon, "is the plain English of that. It's a disease, sir."[51]

An extended and poignant discussion of the effect of nostalgia on an individual is found in the history of 10th Regiment of Vermont published by Chaplain Edwin Mortimer Haynes in 1870. He recalled for the reader how in October 1862 the regiment suffered numerous casualties from disease during a particularly difficult period of encampment near the Chesapeake and Ohio Canal in southern Maryland. "On the right [of the encampment] the troops were daily exercised in company and battalion drill," he wrote, "On the left there were some of them daily buried." Amidst these many fatalities the death of one soldier remained fixed in the mind of Haynes almost a decade later. He recounted, "These was one case, and it is said there were many similar cases about this time, such as I never heard of before. Medical records may furnish many such cases. One young man died whom the surgeons declared had not a single symptom of disease about him." This was the sad case of Frederic D. Whipple of H Company who, according to Haynes, presented himself at sick call one morning with no other complaint than the fact that he wanted to go home. The Chaplain reported that Whipple's "conduct was strange and pitiable" and when the soldier refused to perform his duty on account of his homesickness he was admitted to the hospital. Whipple refused treatment and instead "moan[ed] piteously all the time, 'I want to go home — I want to go home.'" The "poor fellow," Haynes reported, died after

[51] Thompson, *History of the First Kentucky Brigade*, 62.

only a few days and the regimental surgeon "declared that it was a clear case of nostalgia."[52]

The decision by these authors to include a mention of nostalgia within their histories of the war suggests that the condition warranted not only notice during the war itself but was important enough to be remembered after the war and recorded for the edification of later readers. While certainly not a central part of their war experience, the awareness of nostalgia and its effects on men and morale informed the construction of at least some veterans' memories of their time in military service. By including references to nostalgia within texts meant for a civilian audience they inserted the condition into the national memory as well.

Conclusion

By the start of the war in 1861, the medical field had started to make strides towards becoming the science-based profession that we recognize today. The same could not be said for the loose association of psychiatric practitioners. This absence of professional organization was aggravated by the general lack of a unified understanding about the cause and treatments of mental disorders. When the first soldiers stepped on the battlefields of the Virginia, they did so without the benefit of an organized military psychiatric response. Instead, they had to rely upon general surgeons with little familiarity with the principles of psychiatric thought or treatment.

The result was a disjointed response to those Civil War soldiers whom doctors felt displayed symptoms of mental distress. Sometimes these men received half-hearted treatment near the frontlines that ranged from sympathy to ridicule. In other instances, battlefield surgeons removed these men to asylums such as the Government Hospital for the Insane, where they

[52] Edwin Mortimer Haynes, *A History of the Tenth Regiment, Vermont Volunteers, with Biographical Sketches of the Officers who fell in Battle* (Lewiston, ME: Tenth Vermont Regimental Association, 1870), 20-25.

received more organized care. Despite this higher echelon of treatment, however, there was still no agreement among psychiatrists over how to label the suffering of these men, much less how to treat them. Whereas many surgeons working in the military camps, and the soldiers themselves, applied the term "nostalgia" as a blanket diagnosis for war-related psychological suffering, the mental community did not embrace the label with the same fervor. Instead, it worked within the paradigms of mental illness which its members understood; a trend which would continue over the next one hundred years.

In the period immediately following the Civil War, the professional discourse on nostalgia in soldiers ceased and little was done to better understand the condition. The publications of veterans continued to keep the condition within the public consciousness, creating a link between nostalgia and the Civil War. This was fortuitous because public and professional interest in the condition came about once more when U.S. troops embarked for the battlefields again at the end of the century.

CHAPTER TWO: THE SPANISH-AMERICAN WAR AND THE CHANGING DEFINITION OF NOSTALGIA

Observations by frontline military doctors during the Civil War perpetuated an idea that nostalgia was a disease largely exclusive to soldiers who were forced to leave their homes in wartime. While physicians who specialized in mental health did little to further the study of the condition, veterans affirmed these observations by regimental surgeons and brought them to the attention of the public in regimental histories, memoirs, and other texts published for popular consumption in the years following the war. Yet, by the close of the nineteenth century the definition of nostalgia remained malleable and if anything, had become more expansive. Whereas previous generations had spoken of nostalgia in terms of pathology, by the opening years of the 1900s the diagnosis became "demedicalized" and practitioners and public alike came to consider nostalgia as an emotion, not necessarily a disease. In his analysis of the social and cultural dimensions of nostalgia at the turn of the twentieth century, social scientist Stuart Tannock argued that broadly speaking, a feeling of nostalgia came to evoke "a positively evaluated past world in response to a deficient present world" and in that way nostalgia functioned as a "periodizing emotion" in which the individual or group is acutely aware of the past as it compares to the present. At the end of the nineteenth century the United States saw rapid changes in the form of industrialization, urbanization, migration and immigration, all of which challenged long-held social and cultural beliefs about race, gender, and civic identity. It is little wonder then that the use of the term nostalgia began to appear more frequently outside of

references to soldiers away from home. Americans overwhelmed by the pace of progress began to yearn for the "simpler times" of a pre-industrial nation.[1]

The public discussion of nostalgia that appeared in the popular media during the next major U.S. war demonstrates this expanding definition of the condition. The Spanish-American War reignited interest in the psychological well-being of America's fighting forces and in particular, the dangers of nostalgia. This time, however, the discourse on the psychological dangers of war developed mostly outside of the professional spheres dominated by military and civilian doctors and instead, took place within the popular media. What little professional discourse on nostalgia that did take place during the Spanish-American War appeared to occur in response to this national debate. This is not to say that the entire medical community was silent on the issue. Instead, for the first time the professional understanding of war-related mental illness intersected with a growing public awareness in the form of expert commentary in newspaper articles. As during the Civil War, however, these professional contributions came from non-specialists. Mental health practitioners did not make a concerted effort to shape public – or even medical – perceptions of the psychological trauma of war.

Mobilizing American Medicine for War

Thirty-three years after the conclusion of the Civil War the United States once again entered into a formal war. American forces came ashore in Cuba in the summer of 1898 after decades of tense mediation between the government of Spain and rebel forces seeking an

[1] Stuart Tannock, "Nostalgia Critique," *Cultural Studies* 9:3 (1995): 454-456. See also Michael Kammen, *Mystic Clouds of Memory: The Transformation of Tradition in American Culture* (New York, Vintage 1993), 295 quoted in David Anderson, "Dying of Nostalgia: Homesickness in the Union Army during the Civil War," *Civil War History* 56 (2010): 254-255.

independent Cuban nation. There were a variety of reasons that President William McKinley sought military intervention against Spain in the Caribbean, from deference to a public sympathetic towards the Cuban people attempting to throw off the yoke of an oppressive European nation, to a desire to fulfill the increasing national interest in outward expansion. The mysterious circumstances surrounding the sinking of the *USS Maine* in Havana harbor catalyzed the American people's desire for military action.[2]

Mobilization was a major concern for military planners. In the lead up to war the number of men in uniform compared to the entire U.S. population was at its smallest percentage since the Revolutionary War. On April 1, 1898 the authorized strength of the army was 28,747 officers and enlisted men. McKinley received authorization to raise that number to almost 63,000, but the War Department soon found that men were reticent to make the commitment required by joining the regular army. Ultimately, the bulk of the military forces that fought in Cuba and later in Puerto Rico and the Philippines were volunteers, almost 125,000 men from across the country.[3]

The nearly quarter-million men of the United States military who saw service in the tropical climes of the Caribbean or the Pacific were cared for by the Army Medical Department. Like the rest of the U.S. military forces, when war broke out against Spain the Medical Department was a mere shadow of what it had been during the Civil War. It could only offer up 192 medical officers and from those ranks only about one hundred were available for service in the field. The rest were needed to fill administrative roles or staff hospitals and supply depots in

[2] Surveys of the Spanish-American War include: Albert A. Nofi, *The Spanish-American War, 1898* (Pennsylvania: Combined Books, 1996).; Harvey Rosenfeld, *Diary of a Dirty Little War: The Spanish-American War of 1898* (Westport, CT: Praeger, 2000).; Ivan Musicant, *Empire by Default: The Spanish-American War and the Dawn of the American Century* (New York: Henry Holt and Company, 1998).; G.J.A. O'Toole, *The Spanish War: An American Epic 1898* (New York: W.W. Norton and Company, 1984).

[3] Musicant, *Empire By Default*, 235-249.

the United States. The Medical Department attempted to meet the demand for trained medical professionals by contracting 650 surgeons from across the country. Regrettably, these doctors had almost no training in military medicine, including the principles of camp sanitation necessary for the prevention of the most dangerous enemy of all nineteenth-century armies: disease.[4]

As in all previous American wars, disease posed a greater threat to military forces than any Spanish or Filipino bullet. Approximately seven soldiers died from illness for every one man who died from a combat-related wound in Cuba. This ratio was three times higher than the two-to-one ratio of Union losses during the Civil War, though Deputy Surgeon General Charles Smart assured concerned observers that this disparity was not the result of more disease in Cuba or a lack of adequate care on the part of the Medical Department. The reason, he explained, was much simpler though no less tragic: "the number of sanguinary battlefields of the Civil War" was much higher than those encountered by the soldiers in the Caribbean.[5]

The Spanish-American War presented unique challenges to military doctors including tropical diseases, extreme climates, and a supply chain that extended thousands of miles in the

[4] Vincent J. Cirillo, *Bullets and Bacilli: The Spanish-American War and Military Medicine* (New Brunswick: Rutgers University Press, 2004), 25-30. Despite this inauspicious start and what ultimately proved to be a less than exemplary record of service during the Spanish-American War, Cirillo argues that the Army Medical Department made two important advances as a result of its experience during the war. First, following a typhoid fever epidemic that wreaked havoc on U.S. troops in the early fall of 1898 it became evident to military leaders that surgeons needed more authority within the military hierarchy. Hindsight suggested that the epidemic could have been prevented had military surgeons – long considered by military officers to be simply advisors – had the authority to order line officers to maintain certain standards of camp hygiene. The second advance was the need for changes within the Department itself. These changes included the formation of a reserve nurse corps of trained female nurses, the creation of the Army Medical Reserve Corps to eliminate the reliance on poorly trained, contracted civilian doctors, and finally, the stock-piling of medical supplies in recognition that a military on a war-footing would be exponentially larger than a peacetime force. Cirillo, *Bullets and Bacilli*, 151-154. For a further discussion of American military medicine during this period see also Bobby A. Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917* (New York: Routledge, 2011), 121-156.

[5] Cirillo, *Bullets and Bacilli*, 31-33.

case of the forces stationed in the Philippines.[6] At the same time, however, the doctors also confronted many of the same scenarios as their predecessors during the Civil War, including soldiers suffering from the effects of mental illness. As in 1865, the Army Medical Department did not include amongst its ranks any specialists in mental health. Military psychiatrists would be a creation of the twentieth century. Soldiers suffering psychiatric distress were treated by the general military surgeon just as soldiers during the Civil War had been.

Whereas there were a few notable examples of military doctors writing about nostalgia in professional journals during the Civil War, no such conversation developed during the Spanish-American War. Much of the focus of the medical profession during the war remained on the development of surgical techniques and the treatment of tropical diseases as well as the common army afflictions of dysentery and venereal disease.[7] The most rigorous discussion of nostalgia and its effects on American soldiers in Cuba and the Philippines took place within the public sphere where it played out in some of the major newspapers of the day as well as smaller, local presses. This is not to say that the professional voice was absent from the national discourse on nostalgia and mental illness amongst soldiers. Both military and civilian physicians participated in the popular debates by contributing expert opinions on nostalgia to interested newspapers. This created a dialogue between a concerned public and medical practitioners who marshalled their professionalism in order to speak as authorities on the connection between soldiering and

[6] Mary C. Gillett, "Medical Care and Evacuation During the Philippine Insurrection, 1899-1901," *Journal of the History of Medicine and Allied Sciences* 42 (1987): 169-185 and Mary C. Gillett, "U.S. Army Medical Officers and Public Health in the Philippines in the Wake of the Spanish-American War, 1898-1905," *Bulletin of the History of Medicine* 64 (1990): 567-587.

[7] See for example David J. Doherty, "Medicine and Disease in the Philippines," *Journal of the American Medical Association* 24 (1900): 1526-1531.; J.M. Banister, "Surgical Observations in the Philippines," *Journal of the American Medical Association* 18 (1904): 1117-1121.; A.L.G. "A Philippine Evil," *Journal of the American Medical Association* 8 (1899): 467.; N. Senn, "Typhoid Fever in the Porto Rican Campaign," *Journal of the American Medical Association* 11 (1898): 599-604.; R.S. Woodson, "Special Sanitary Instructions for the Guidance of Troops Serving in Tropical Countries," *Journal of the American Medical Association* 22 (1898): 1266-1268.

mental illness. As during the Civil War, however, the psychiatric profession remained silent and instead, military surgeons and general physicians voiced the medical perspective, drawing from their experiences in either the last war or the fighting currently underway.

Public Interest in Nostalgia Casualties in Cuba

It is difficult to discern what triggered the sudden and intense national interest in nostalgia amongst soldiers of the Spanish-American War, but one possible catalyst was the death of Pvt. Harvey Atkins of Massachusetts. On July 28, 1898, only a few weeks after American troops landed in Santiago, the *Baltimore Sun* published a list of soldiers who had died as a result of diseases such as malaria, yellow fever, and typhoid. Nestled at the very bottom of the list under the heading of "Deaths Not Previously Reported" was the name of Pvt. Harvey Atkins of the Second Massachusetts Volunteers and next to Atkins's name was simply the word: nostalgia.[8] The day after *The Sun* published the casualty list an article appeared in *The New York Times* describing the death of Pvt. Atkins, accompanied by the eye-catching headline "A Death From Nostalgia, One of the Rarest Diseases." The information contained in the piece reflected many of the same sentiments expressed by physicians during the Civil War. Citing an unnamed "medical authority" the piece defined nostalgia as "a form of melancholy brought about by an unsatisfied longing for home or home surroundings." It goes on to list a variety of symptoms including "a deep feeling of sorrow," "impeded digestion," and a susceptibility to other, more serious illnesses. In a deviation from the discussions of the Civil War era, however, the article concluded that deaths from nostalgia were exceedingly rare and the reported death of Pvt.

[8] "Fever at Santiago," *The Sun,* Jul 28, 1898, 6.

Atkins, if true, "is a highly exceptional and most remarkable case." The reason for this being, the article argued, an American "cannot become a victim of nostalgia" because "the spirit of bustle and hustle here is such as to preclude any violent longing for home."[9]

Despite these reassurances, additional articles appeared across the nation to fan the flames of public concern about nostalgia, often with conflicting information. *The New York Times*, for example, ran an article only a week later that opened with the question "Is 'homesickness' epidemic at Santiago, and is the demoralization . . . attributable to the affliction of the entire army of occupation with 'nostalgia'?" The answer was a resounding affirmative if the observations of one Adjutant General were to be believed. "I have seen whole companies and regiments rendered helpless by it," he cautioned to the *Times*, "[Nostalgia] is not contagious, but it is epidemic." "Nostalgia is a contagious disease," wrote another military doctor to the *Chicago Daily Tribune*, spread not by germs but by the power of suggestion from soldier to soldier. He continued "the depressing effects of this common ailment have a decided influence increasing the rate of mortality of the sick and wounded and in impairing the effectiveness of the fighting line." *The Nashville American* took on the difficult task of trying to define a demarcation between nostalgia and simple homesickness. The latter was a sign of a "gentle mind" that demonstrated of a strong love of home and country, the author concluded. Nostalgia, on the other hand, "takes possession of a person" resulting in "untold misery and even death." In a more poetic turn of phrase *The Atchison Daily Globe* of Kansas described the effects of nostalgia such that “the young soldier droop[s] and wither[s] like a wild flower stuck in a dry vase.” In an article about the war, the popular magazine *Harper's Bazaar* simply concluded it was a "pitiful fact that soldiers actually die of heart-breaking, mortal homesickness."[10]

[9] "A Death from Nostalgia: One of the Rarest Disease," *The New York Times*, July 29, 1898, 12.
[10] "Shafter's Army Homesick?," *The New York Times*, Augst 6, 1898, 2.; "Death from Homesickness," *Chicago*

Despite this public concern about the number of casualties from nostalgia in the Cuban theater, the medical discourse largely ignored the condition. The only article to appear in the *American Journal of Insanity* about mental illness and the Caribbean was an 1899 piece that recounted Dr. G. Alder Blumer's tour of the domestic insane asylums located on the various islands. The article made no mention of the war or of American soldiers.[11] The *Journal of the American Medical Association* was equally quiet on the issue as was the *American Journal of the Medical Sciences.* The notable exception was an article published in the *Philadelphia Medical Journal* in August 1898 entitled "Death from Nostalgia." The piece was not a scientific article based on original research, but instead informed its medical audience of a recent report that two American soldiers had died of nostalgia in Santiago. The author also suggested a few points for readers to consider. First, that nostalgia and other "profound psychoses" often appeared in tandem with infections, particularly those caused by the typhoid and malaria that plagued U.S. troops. He recommended a careful screening of nostalgia patients for secondary illnesses that might explain the patient's psychological suffering. Second, the author noted that the two recent casualties served in the same Massachusetts regiment, leading him to posit that an element of "imitation or suggestion" had been at work, particularly if the young men in question had a highly susceptible nature. This supported his larger claim that nostalgia and similar conditions such as hysteria were the culmination of multiple factors. Like the research of Calhoun and

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Daily Tribune, August 22, 1898, 1.; "Homesickness: What It Really Is and a Possible Remedy For It," *The Nashville American,* August 22, 1898, 8.; "Homesick Soldiers," *The Atchison Daily Globe,* September 28, 1898.; "Untitled," *Harper's Bazaar,* August 20, 1898, 702. Additional mentions of nostalgia in Americans soldiers in the Caribbean can be found in "Fight with Nostalgia: Gen Grants' Humane Campaign in Porto Rico," *The Washington Post,* October 22, 1898.; "Homesick Soldiers," *The Sun*, October 21, 1898.; "Nostalgia Kills Soldiers," *The Milwaukee Sentinel,* August 28, 1898.; "Homesickness as a Disease," *The Sun,* August 16, 1898.; "Dying of Nostalgia," *The Milwaukee Journal,* August 16, 1898.

[11] G. Alder Bloomer, "The Insane in the Antilles," *The American Journal of Insanity* 55 (1899): 713-723. One possible explanation for the silence on the part of the medical community was because it was mired in an extended debate about the quality of care extended to soldiers in Cuba and Puerto Rico.

Peters before him – each of which the article mentioned as evidence of nostalgia's enduring presence during wartime – the author cited the patient's ethnicity and birthplace as potential factors in the cause of his illness, particularly if his birthplace was rural or mountainous. Reflecting the medical profession's growing certainty that inherent weakness of the body could cause weakness of the mind, the author also speculated that the soldier's predisposition to illness – mental or otherwise – made him particularly susceptible to nostalgia, stating "The enforced absence from home may simply act as an exciting cause; there may be deeper-seated causes, such as grave constitutional defects, that act as the real basis for the disease." Such thinking would come to dominate professional discussions of war-related mental illness during WWI.[12]

Interestingly, however, some medical professionals unknowingly contributed to the public conversation on nostalgia when newspapers quoted from – or in some cases, outright plagiarized – their journal articles. Though intended for an audience of their peers, the observations and opinions of these doctors helped to shape the public understanding of nostalgia. In one instance newspapers across the country reprinted an article about nostalgia originally published in the famous medical journal *The Lancet.* The piece made no mention of war or soldiers, but confirmed the stereotypes about nostalgia long-held in Europe, that education and especially race were the most frequent indicators of a mind at risk of nostalgia. "Nostalgia is righteously excluded from a list of the shocks that Anglo-Saxon flesh is heir to," the author concluded. The article appeared unmediated by editorial commentary or additional medical opinion in at least three newspapers, the popular *Christian Advocate* and the decidedly smaller *The Morning Oregonian* and *The Anaconda Standard* published in Anaconda, Montana. In Baltimore, *The Sun* also drew upon professional literature to inform its readers about nostalgia.

[12] "Death from Nostalgia," *The Philadelphia Medical Journal* 2 (August 13, 1898): 301-302.

In this instance the paper drew upon the editorial published in the *Philadelphia Medical Journal* and particularly, the editorial's references to the earlier research published by J. Theodore Calhoun that suggested a precedent for nostalgia during war. Whereas the decision by some editors to run *The Lancet* article furthered an antiquated – though perhaps patriotic— belief that white Americans were not susceptible to nostalgia, the latter article printed by *The Sun* added to the public dialogue by bringing to the attention of readers the fact that professionals were not only seeing nostalgia amongst soldiers fighting in Cuba, but in fact, Civil War doctors had encountered it a generation earlier.[13]

While some newspapers simply appropriated the work of physicians, others went to the doctors themselves and sought their professional opinion on cases of nostalgia in the military. Many of the doctors offering their opinions to the media relied on their Civil War experience as general surgeons, not their expertise in treating mental illness. Frequently these articles did little to assuage public concern and instead highlighted the dangers of nostalgia and its prevalence during the past war. *The Milwaukee Journal* quoted a Dr. Abbott, then the secretary of the Massachusetts State Board of Health but also a former army surgeon during the Civil War. Dr. Abbott commented on the number of nostalgic soldiers he encountered during his four years of service. Official reports had the number of casualties from nostalgia at around 5,000, he told the paper, but in his experience "there were a great many cases – very many more than 5,000 – that

[13] The author of *The Philadelphia Medical Journal* editorial actually took the argument one step further, suggesting that a dearth of American research into nostalgia did not indicate a surfeit of European cases over those in the United States, but instead critiqued American scientific inquiry, writing "to our mind it is rather an indication that they have greater literary activity among the curiosities of medicine." Ibid, 203. The original article in the *The Lancet* can be found in "Annotations – Nostalgia," *The Lancet* 153 (June 1899) 1727.; Reprinted in "Nostalgia," *Christian Advocate*, September 14, 1899.; "Homesickness: Considerations which Operate to the Promotion of Nostalgia," *The Morning Oregonian*, October 28, 1899.; "Homesickness," *The Anaconda Standard*, August 7 1899.; "Homesickness as a Disease," *The Sun,* August 16, 1898. *The San Francisco Call* also ran an article on nostalgia that amounted to a reprint of the editorial from the *Philadelphia Medical Journal*, but unlike *The Sun* it gave no credit to the original. Aside from changing the title, adding a few more paragraph breaks, and misidentifying DeWitt Peters as "Jeters" the articles are all but identical. "Soldiers Die of Homesickness," *The San Francisco Call*, September 4, 1898.

never got into reports." Abbott recalled that young soldiers were particularly susceptible to the condition, something that the author of the article found surprising given that youth was a time for "hopefulness, and hopeful natures are least subject to the malady." But the reporter conceded, "Dr. Abbott speaks from personal knowledge" and from the perspective of a medical professional, so there was little concern that the opinions of Dr. Abbott "will doubtless be confirmed" by those of his medical colleagues. The citizens of Milwaukee received equally dire information about nostalgia from Dr. Wallace Kempster "who saw nostalgia in its worst form during the Civil war." In an article published in the *Milwaukee Sentinel*, Kempster described the often tragic consequences of nostalgia and further highlighted the inability of medicine to address the condition with any success. "The science of medicine is powerless to circumvent nostalgia," he wrote. "When it takes a man the odds are against his living and all the medicines in the world would not avail against its progress." In his estimation Civil War doctors had achieved successes in battlefield medicine unheard of during previous wars but he admitted "we could not stay the dreaded nostalgia."[14]

Media Representations of Nostalgia in the Philippine-American War

Public interest in the "epidemic" of nostalgia among American troops continued even as the parameters of the conflict changed. In August 1898, after ten weeks of fighting, the United States and Spain agreed to a cease-fire, thereby ending the conflict between the two nations. On December 10, 1898 each country signed a formal peace treaty under which Spain ceded Puerto Rico and Guam to the United States, granted independence to Cuba, and sold the Philippines to

[14] "Dying of Nostalgia," *The Milwaukee Journal*, August 16, 1898.; "Nostalgia Kills Soldiers," *The Milwaukee Sentinel*, August 28, 1898. See also: "Homesick Soldiers," *The Atchison Daily Globe*, September 28, 1898.

the U.S. government for $20 million.[15] The legal acquisition of the Philippines did not, by any means, assure the goodwill and support of the Filipino people and by February 1899 the occupation forces of the United States military found themselves fighting to maintain their grip upon this newest U.S. territory. Alternately called the Philippine War or the Philippine Insurrection, this protracted guerilla-style war in the tropics of the Pacific Ocean lasted over three years and required the commitment of tens of thousands of American soldiers. President Theodore Roosevelt declared the end of the war in the Philippines on July 4, 1902, but only after American forces suffered approximately 7,000 casualties including 4,200 dead from wounds and disease.[16]

While Americans remained concerned about the number of soldiers afflicted with nostalgia the focus of the newspaper reports about soldiers in the Philippines with the condition shifted attention to the more tragic manifestations of the illness. More so than the discussions about nostalgia in Cuba, the public discourse on nostalgia in the Philippines portrayed a darker and more destructive illness linked not only to death, but also dangerous insanity and moral depravity. As in the public discussions about nostalgia during the recent invasion of Cuba, medical professionals also served as important sources of information. But instead of turning to veteran doctors of the Civil War, newspapers increasingly published first-person reports from military surgeons currently serving or having recently completed service in the Philippines.

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[15] O'Toole, *The Spanish War: An American Epic 1898*, 12-13. See also Musicant, *Empire By Default*, 586-630.

[16] O'Toole, *The Spanish War: An American Epic 1898*, 395. General histories of the Philippine War are surprisingly fewer than the many surveys that exist on the Cuban portion of the Spanish-American War. Some of the above mentioned histories of the Spanish-American War include a brief discussion of the Philippine War while others only mention it in the epilogue. Recently historians have attempted to address this historiographical gap. Three helpful texts include Brian McAllister Linn, *The Philippine War, 1899-1902* (Lawrence: University Press of Kansas, 2000).; David Silbey, *A War of Frontier and Empire: The Philippine-American War, 1899-1902* (New York: Hill and Wang, 2007).; and A.B. Feuer, *America at War: The Philippines, 1898-1913* (Westport, CT: Praeger, 2002).

Often these doctors contributed sensational reports instead of reassuring discussions about the nature and treatment of the illness.

An article published by the *Chicago Daily Tribune* in the spring of 1900 and entitled "Trace Madness to Nostalgia" opens with a frank assessment by a military surgeon recently returned from the Philippines. According to Surgeon C.E. Woodruff, the article reports, "many soldiers in the islands become insane," something that is "not startling to those familiar with the circumstances." The circumstances in this case being, the article continues, volunteer soldiers unfamiliar with the life of soldiering and the requisite months away from home. "Now the troops are settling down to the dull routine of garrisoning… they have more chance for homesickness, and when homesickness becomes chronic it is apt to induce insanity." Another article published shortly after proclaimed that the total number of American soldiers "invalided to the United States" from January to July 1900 amounted to 1,560 men, of whom 110 were deemed insane due to nostalgia. Newspapers also published reports of tragic suicides believed to have been brought on by nostalgia due to their service in the Philippines. The *Hartford Republican* of Kentucky quoted official military reports stating that seventy-two enlisted men and ten officers committed suicide in the Philippines between February 14, 1899 and April 14, 1902. The paper concluded that the cause of these suicides could only be nostalgia. "Nostalgia, or homesickness, prevailed largely among the men in the Philippines… undoubtedly nearly all who committed suicide were insane from this cruse [sic]." [17]

[17] "Trace Madness to Nostalgia," *Chicago Daily Tribune*, May 7, 1900.; "Our Army in the Philippines," *The Sun*, January 15, 1901.; Earlier *The Sun* had provided its readers with a short tutorial on how to properly pronounce the word "nostalgia," suggesting the frequency with which the word was now appearing in conversation. "Answers to Queries," *The Sun*, February 1, 1899.; "82 Soldier Suicides," *The Hartford Republican*, August 1, 1902. Specific examples of soldier suicides blamed on nostalgia can be found in "Naval Chaplain Ends Life," *The Washington Post*, September 12, 1902. The piece describes the death of Army Chaplain William F. Morrison who shot himself after being sent back to the States after "suffering from an attack of nostalgia." and "Suicide of a Soldier," *The Washington Post*, August 25, 1902. This article reports the death of Pvt. John Calhoun who "lost his reason through

Perhaps no other newspaper was as dedicated in its coverage of the psychological plight of Americans in the Philippines as *The Atlanta Constitution*. Over the course of the war it frequently ran articles with sensational titles about rampant insanity afflicting the troops overseas. In January 1901, the paper published the account of military surgeon Dr. Perry Lancelot Jones in a piece called "Nostalgia *Cause* of Their Insanity" [emphasis in the original]. The lengthy article includes a faded picture of Dr. Jones with the caption "The Army Surgeon who Attributes Insanity Among Troops to Homesickness" as well as an assurance of his credentials as a man who "stands high in his chosen profession" not to mention his qualities as a an "educated American, alert, aggressive, and imbued with all that is implied by the modern spirit of expansion." Dr. Jones, the paper reported, spent much time with the American soldiers serving in the Philippines and from these observations he was able to conclude that though reports of insanity amongst the troops had been exaggerated, "it was not to be denied that the malady prevailed to an abnormal degree." Indeed, he sadly recounted that on his ship from the Philippines to San Francisco there were no fewer than eleven insane soldiers on board whose situation he could only call "indescribably pathetic."[18]

Dr. Jones described to the reader how, in his estimation, many of the afflicted U.S. soldiers ignored the health regulations put in place by military doctors and gave "full rein to their baser nature" to include too much sun and too much alcohol. "Excess in this and other respects soon debilitate their system" and the soldiers became "weak-minded" or "a little off" before succumbing to a "melancholia that deepens into lunacy." From there, he concluded, the soldiers were put under guard before being shipped back to the United States and likely,

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suffering from nostalgia" and was sent from his home in Los Angles to the Government Hospital for the Insane were he hanged himself.

[18] "Nostalgia *Cause* of their Insanity," *The Atlanta Constitution,* January 5, 1901. [Emphasis in the original] *The Nashville American* reprinted portions of the interview with Jones on January 13, 1901.

institutionalization. "What a home-coming for the home-sick khaki hero!," lamented the newspaper.

One year later the *Atlanta Constitution* again alerted its readers to the epidemic of insanity plaguing U.S. soldiers in the Pacific. "Homesickness Troubles Philippine Soldiers" announced one article in August 1902. Some soldiers, it suggested, were suffering from a "certain temporary aberration of the mind" that manifested itself in "mild delusions" brought on by nostalgia. A few months later a second article about nostalgia appeared under a Boston, Massachusetts dateline. It bore the sensational headline, "Troops Crazed by Nostalgia – Homesickness is Destroying our Army in the Philippines" and proclaimed that a "Surgeon now in Island [sic] Writes that Thousands of Men are Becoming Incapacitated by Reason of Nostalgia – Many Go Insane." The paper went on to report that, according to the anonymous Boston surgeon, "every returning transport… brings hundreds of soldiers insane from nostalgia."[19]

Each newspaper article attempted to offer some explanation for the mental suffering of the soldiers. Many often pointed to the dangerous heat and tropical conditions the men were forced to endure. "It is a well known fact," one paper reported, "that extreme heat and extreme cold are very likely to produce cases of nostalgia." Similarly, the general privations of military service were also thought to be a cause, including the distance from home, the lack of good food, and the short supply of letters from loved ones. [20] But in a discussion unique to the troops

[19] "Homesickness Troubles Philippine Soldiers," *The Atlanta Constitution*, August 22, 1902.; "Troops Crazed by Nostalgia," *The Atlanta Constitution*, November 16, 1902.

[20] "Homesickness Troubles Philippine Soldiers," *The Atlanta Constitution*, August 22, 1902. Most popular newspapers were quite content to perpetuate the popular image of deprivation experienced by American soldiers in the Philippines. The one interesting exception to this was *The New York Times*. In an article published in February 1899 it stated quite emphatically that "despite all of the stories, the health of the troops is excellent, the food… is above the average, and the percentage of sickness is small for such a large body of men. The lurid yarns about the sufferings endured by our soldiers are without foundation." The article further states that were it not for nostalgia, "service here is nowise worse than at many an army post in the United States." A second article from the *Times* again emphasizes the inaccuracy of media reports of inadequate food for Americans in the Philippines, arguing

fighting in the Philippines, as opposed to the interest directed towards the soldiers stationed in Cuba, the newspapers also frequently mentioned the role of alcohol as perhaps another reason for the spike in cases of nostalgia or as an explanation for the condition's severity in American soldiers.

In particular, the papers cited American soldiers' taste for *vino*, a strong alcohol distilled from the sap of a tree native to the Philippines and said to be five times stronger than any American whiskey available to troops overseas. The *Chicago Tribune* proclaimed both the dangers and the appeal of *vino* in a long article complete with pencil drawings of American soldiers imbibing *vino* from the barrels of their rifles and one tragic soldier hung by his neck from the bars of his window in an apparent *vino*-induced suicide. "American Soldiers Crazed by a Filipino Drug" shouts the headline, "Three Drinks of Which are Sufficient to Make the Most Hardened Whiskey Drinker Insane." Perhaps in an effort to explain the popularity of such a seemingly dangerous pastime to readers back home, the author of the article opened the piece with an immediate connection to nostalgia. "There is a cure for nostalgia to be had in the Philippines," the author announced, "It is called *vino*, and two drinks of the dangerous nepenthe will drive dread homesickness and everything else out of the victim's head, except a hellish desire to do evil." The article continues with a litany of frightful observations about the drink, not the least of which being that the native Filipinos refused to drink it for fear of its negative effects. Despite the dire rhetoric of the article the author assured the reader that he was only highlighting the most extreme examples of the effects of *vino* on a small percentage of American

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instead that some men in the Pacific "have never been fed so well in their lives." Food was not the most significant issue affecting the soldiers, contended the author of the article; instead, "the chief and main trouble with the men is that they suffer from nostalgia." It is interesting to note that even the attempts by one media outlet to assuage public concerns about the conditions of war in the Philippines still contained dire warnings about the effect of nostalgia. "Cause of Manila War," *The New York Times*, February 22, 1899.; "The Philippine Problem," *The New York Times*, March 5, 1899.

soldiers and with the exception of sailors, "our men are sensible." However, the piece closes with a parting reminder from the author that commanding officers in the Philippines were forced to declare the consumption of *vino* illegal because of its likelihood to cause acute insanity, thereby suggesting that the problem might have been more widespread than the author was willing to concede. Another reporter highlighted the dangers of *vino* while at the same time attempting to assuage public concern about the number of reports of drunk or insane soldiers. A correspondent of the *Army and Navy Journal* tried to correct a "line of prevarication [that] is very common with our home papers" that drunkenness was pervasive in the military in the Philippines. In the opinion of the reporter, "there is not more of this than follows in the wake of any army" and the only drunkards were "bad characters" who had sought refuge in the military. Similarly, he argued, when concerned citizens read about "an immense number of officers and men being sent home insane" they should rest assured that it was simply these few "bad characters" drunk on *vino* and temporarily maddened.[21]

For all of the speculation about the causes of nostalgia in the popular press, mental health professionals and medical experts did not develop a rigorous discussion of their own. One possible reason this did not occur during the fighting in Cuba could be because the conflict only

[21] "American Soldiers Crazed by Filipino Drug," *Chicago Daily Tribune*, February 9, 1902. "Misconceptions Concerning Our Army in the Philippines," *Los Angeles Times*, January 27, 1901. See also "Use of Vino Prohibited," *The Washington Post*, December 5, 1901. "The Seductive Vino: Alarming Effect on American Soldiers Receives Prompt Attention," *Los Angeles Times*, April 19, 1899. The extent to which alcoholism was truly a significant issue in the Philippines or just the product of sensational media reports is unclear. On the one hand, the Surgeon-General reported that alcoholism in 1900 was lower than it had been during the "pre-Spanish war decade." But there must have been enough of a problem present because alcoholism or alcohol consumption in general amongst military forces overseas and garrisoned in the United States was a source of concern and controversy at the end of the nineteenth-century. Military and government officials studied the issue fairly closely, spurred in part by the provocative media reports circulating about soldiers in the Philippines but also motivated by Victorian ideals of temperate behavior. They ultimately decided that the best way to curb excessive drinking was by re-establishing the military "canteen" where alcohol would be served but in moderation and under close supervision. The hope was that by making alcohol available to soldiers they would be less likely to drink in secret or, in the case of the Philippines, drink locally sourced alcohol. For a summary of the Surgeon-General Report see "The Health of the Army," *Journal of the American Medical Association* 37 (1901): 1041. For a brief summary of the canteen controversy see "Praise for the Canteen," *Special to The New York Times* in *The New York Times*, January 11, 1903.

lasted for ten weeks and there was simply not enough time for physicians to study, compose, and publish new research on the subject. The three years of the Philippine-American War provided more opportunity and indeed, the *Journal of the American Medical Association* offered up a handful of articles concerning nostalgia in the Philippines. However, instead of contributing to a professional understanding of nostalgia in the form of research or medical studies, the articles that appeared in *JAMA* were reactionary pieces to both the reports put forth by the Office of the Surgeon General and the deluge of media coverage. In October 1900 the editors of the journal addressed what they considered to be unnecessary concern on the part of the public created by an incendiary press. "According to some of the sensational journals of the day, it would appear that the American army serving in the Orient was being decimated – if that is the word – by mental disorder." These "thrilling statements" the piece continues, "have caused serious distress to friends and some concern to well-wishes of our soldiers generally." The brief statement concludes with statistics drawn from a recent report by the office of the Surgeon General of the Army which stated that there were only 84 reported cases of insanity in U.S. forces in the Philippines. "Though from newspaper accounts there ought to have been ten times as many," the *JAMA* editors noted with a hint of derision. Similarly, they drew attention to the Surgeon-General's conclusion that few of these reported instances of insanity were caused by excessive alcohol consumption, which they remind their readership, "has a bearing also on another frequently repeated scandal." Relying solely on the information provided by the military the *Journal of the American Medical Association* discounted the media reports of an epidemic of nostalgia.[22]

[22] "Alleged Insanity in the Army Abroad," *Journal of the American Medical Association* 35 (1900): 1033.

Further evidence that some in the medical community gave little credence to the media fervor surrounding nostalgia was evident in the next issue of *JAMA* when the editors published a letter from frequent contributor Deputy Surgeon General Dr. Charles Smart. Smart often served as the voice of the military medical establishment in *JAMA*, commenting on a variety of issues raised by the journal from the quality of rations to the quality of medical care. In this particular letter, entitled "Alleged Insanity in the Army," Smart sought to address the "sensational paragraphs" about the soldier insanity that not only dominated the news media but had started to elicit a response in the professional literature as well. In order "to clear up this matter" Smart attempted to add context to an official report recently released by the Surgeon General on the status of the Army in the Philippines. While the report circulated amongst the media only "touches lightly on the question," the full report, Smart asserted, offered a more complete picture of the mental health of American soldiers and the results were more positive than the situation suggested by the data and anecdotal evidence put forth in civilian newspapers. According to the information received by the Surgeon General of the Army, 1.8 per 1000 soldiers were admitted for mental illness in 1898 and that number fell slightly to 1.78 per 1000 a year later. In comparison, he noted that the average was stable at around 1.7 from 1888 to 1897. Smart argued that the small increase was likely due to the increased number of men in the military and as it was "well understood by army medical officers" the military always attracted "more mentally unsound men than among a similar number of civilians of the same age and physical development." Such men, he contended, could not always be screened out during the initial recruitment process and sometimes even "excitable men" who were not necessarily mentally ill at the time of their enlistment could "lose their equilibrium under conditions of stress in the field." It was also "to be expected" that mental health casualties should appear with greater

frequency amongst soldiers serving overseas because of the likelihood of depression due to the separation from friends and family. But equally important to Smart was the number of these psychiatric casualties who made swift recoveries. He observed that many such casualties, after being "properly recorded on the monthly reports of sick and wounded as cases of insanity" and sent home to the United States for treatment, quickly recovered. As proof of this claim Smart turned to statistics gathered from the Government Hospital for the Insane. He reported that between 1898 and 1899 there were 347 cases of insanity in the United States Army of which 202 were admitted to the Government Hospital. One-hundred and thirty-five of these cases recovered in approximately four months. He also noted that only 32 of the 202 soldiers admitted to the Government Hospital during this period came from the Pacific Theater of operation. On the weight of these statistics Dr. Smart concluded "it is not deemed necessary to do more than present these official figures to silence the sensational newspaper paragraphs which have been published during the past year relative to the unusual number of cases of insanity which have been returned to the United States from our troops operating in the Philippines." [23]

As during the Civil War, the medical professionals who were most vocal about the negative effects of nostalgia on the individual soldier and the entire army were those doctors working in the field. However, whereas Civil War doctors published their concerns about nostalgia in medical journals, thus engaging primarily with their fellow medical professionals, military doctors during the Spanish-American War took their concerns directly to the media. Following Dr. Smart's letter to *JAMA*, the only other mention of insanity among soldiers in the Philippines that appeared in the journal was in a brief editorial comment on another report by the Surgeon General on the state of the army. After again being reminded by the report that

[23] Charles Smart, "Alleged Insanity in the Army," *Journal of the American Medical Association* 35 (1900): 1098-1099.

nostalgia remained a concern for the continued well-being of the soldiers serving overseas, the editors concluded that calling nostalgia a form of insanity was a misnomer. The condition, they argued was at best a form of neurasthenic depression "hardly deserving of the name insanity." With that, they concluded their discussion.[24] The dismissal of the potentially serious nature of nostalgia by the mouthpiece of the American Medical Association in the face of so many caustic reports by military physicians in the popular press suggests a profession divided not only in opinion but in experience with and understanding of the condition. The result was a dearth of professional exploration into the potential causes and symptoms of nostalgia that stunted professional conversation not just about nostalgia but about the psychological consequences of war.

The differences of opinion that existed within the medical profession is perhaps no more apparent than in an article published by a military doctor that appeared shortly after the above piece published by *JAMA*. Whereas the editors of that prestigious journal had concluded that nostalgia barely warranted the label of insanity, Dr. Henry C. Rowland argued passionately in the popular *McClure's Magazine* for the dangerous consequences of nostalgia both physical and spiritual for the soldier fighting in the Philippines. Rowland was an "Acting Assistant Surgeon in the United States Army" and he published his article, "Fighting for Life in the Philippines," in 1902. According to the introduction preceding the article, throughout his service Rowland traveled the island extensively either as a surgeon attached to various field hospitals and during extended periods aboard one of the hospital ships that worked its way up and down the coast collecting patients. The introduction further informs the reader that Rowland's work "brought him into the most intimate personal contact – the relation of doctor and patient – with men

[24] "The Health of the Army in the Philippines," *Journal of the American Medical Association* 36 (1901): 512.

representing all the different types of the American soldier," and it was from these contacts that he was able to "obtain an excellent understanding of the real sentiment of the soldier, and to discover a reasonable explanation for many conditions which the stay-at-home American does not understand." After thus establishing Rowland's professional as well as experiential authority to speak on American soldiers and the medical situation in the Philippines, the introduction concludes with the allusion to the real focus of Rowland's piece. It was Rowland's experience with soldiers suffering from nostalgia that drove his writing of the following article. On his return trip to the United States, much like the *Atlanta Constitution*'s Dr. Jones, Rowland encountered soldiers being sent back to the United States for severe melancholia brought on by nostalgia. "A study of these cases, following former observations of their earlier stages in the field and in the hospital, served to emphasize the impressions conveyed in his article," concluded the author of the introduction.[25]

Dr. Henry Rowland's article is a rich document that depicts the myriad issues he saw confronting American soldiers fighting an insurgent force in a tropical climate. Rowland's purpose in composing the lengthy article was to address the accusations of atrocities perpetrated by American soldiers then circulating in the popular press and to do so from the perspective of a man who not only served in the Philippines but as someone in the position of a medical authority.[26] He did not, however, deny that such atrocities took place. Indeed, he admitted that

[25] Henry C. Rowland, "Fighting Life in the Philippines," *McClure's Magazine*, July 1902, 241.

[26] The supposed link between nostalgia and intemperance perpetuated by the media, combined with the stigmatization of nostalgia-induced insanity did more than just suggest to the public that American soldiers serving in the Pacific were at risk from a very dangerous disease. It also contributed to a growing anti-war narrative that developed within the United States. As the war moved into the second and third year anti-imperialists became increasingly vocal in the newspapers about the U.S. conduct of the war, particularly unofficial policies against taking prisoners, retaliatory actions against civilians who supported rebel forces, and the hiring of mercenary forces from marginalized Filipino ethnic groups. They charged that these native soldiers were "prone to 'murder, burn, and rob' and were difficult to keep 'within the lines of civilized warfare.'" Daniel B Schirmer, *Republic or Empire: American Resistance to the Philippine War* (Cambridge: Schenkman Publishing Company, Inc., 1972), 227. See

his article was predicated on three beliefs: American officers ordered the execution of Filipino natives without trial; that officers ordered the torture of natives; and finally, that subordinate soldiers carried out these orders without complaint or question. In the face of this, Rowland explained, "The difficult task for us is the conception of an obedient fulfillment of cruel and savage orders by exactly such men as we see about us every day."[27]

For Rowland the explanation for why soldiers committed atrocities was complex. On one hand it would be easy to blame extreme climactic conditions but, he admitted, "history is full of such cases." He argued it would be equally difficult to find justification within the rigors of military discipline and conclude that such soldiers were simply following the orders put forth by their superiors. Rowland rejected this explanation, asserting that the American soldier was unique in his ability to consider an order and then act independently. "He is supposed to think," wrote Rowland, "it is required . . . he is expected to use his head." Such thoughtfulness bred American soldiers capable of ingenuity on the battlefield and, he theorized, soldiers able to consider the morality of an order and act accordingly.[28]

Given such mindfulness on the part of the soldier, Rowland believed that left only one explanation for the alleged atrocities against the native population, that "the orders to kill are carried out by the men, not in blind obedience, but because such orders seem to them as good." Rowland recognized that this provocative and chilling conclusion would be difficult for the

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also "Prof. Worcester and the Two Defamers of American Manhood" *The New York Sun* reprinted in *The Los Angeles Times,* June 17, 1899. Some news stories about nostalgia helped fuel antiwar sentiment at the same time they raised concern for U.S. soldiers. One newspaper suggested that the focus of the media and the military on nostalgia was distracting from the real issues of morale plaguing U.S. troops overseas and the direction of the war. As the paper colorfully put it, "'Nostalgia' is the latest fine word employed to butter the Philippine parsnip" and through its employment the public was diminishing the truth that soldiers were simply "disgusted, indignant, weary, [and] exasperated" by difficult tropic conditions and an elusive enemy. "How to Make the Troops Happy," *New York Evening Post* reprinted in *The Atlanta Constitution,* March 30, 1902.

[27] Rowland, "Fighting Life in the Philippines," 241.

[28] Rowland, "Fighting Life in the Philippines," 241-242.

average civilian to understand, particularly those who had friends or loved ones currently serving in the Philippines. "The factors in the production of such a state of mind cannot be distinguished at a range of 12,000 miles," he explained, "An intelligent comprehension of them demands either a personal experience or an accurate reproduction."[29]

Using the hypothetical soldiers of "Tom, Dick, and Harry," Rowland attempted to create the "accurate reproduction" that he felt the public needed in order to understand how seemingly average – meaning civilized – American men could act so far outside of the bounds of civilized behavior. Through the remainder of the article Rowland traced the experiences of the three fictional men, paying special attention to their mental state as well as their encounters with soldiers suffering from nostalgia. For it was nostalgia, Rowland felt, that fed "the sluggish ulcer of discontent [that] gnaws at their hearts." It was "the solution from which may crystalize insanity" that often lurked "unexpected" only to "smolder along until it finally bursts into a flame of suicidal, or homicidal, mania." It was, in Rowland's opinion, a key component behind the destructive behavior of American soldiers.[30]

The article is laden with anecdotes "witnessed" by Tom, Dick, and Harry of violent, crazed soldiers, but in actuality, as a footnote indicated, drawn from the personal observations of Rowland. These stories included soldiers attacking natives in fits of confusion or rage, soldiers mysteriously abandoning their posts only to reappear days later, and one man whose nostalgia led him to try and drown himself in a river. Most disturbing however, were the sad fates of Tom, Dick, and Harry with which Rowland concluded the article. The men and their fictional unit go on a march in search of the elusive guerilla forces they have been tasked with pacifying. While

[29] Rowland, "Fighting Life in the Philippines," 242.

[30] Rowland, "Fighting Life in the Philippines," 242-243.

in the jungle two Americans soldiers go missing only to be discovered later by their comrades, dead and dismembered. In a foreshadowing of events that would become all too familiar to a public trying to understand atrocities in another American war in Asia seventy years in the future, the unit of Tom, Dick, and Harry brutally executed a number of Filipino prisoners of war in retribution for the deaths of their friends. The piece ends with Tom shooting three prisoners in the head, shouting "This is for Dick!" "This is for Harry!" and with the final prisoner who tried to flee, "This is for *me*!"[31]

Rowland's article and his depictions of soldier violence are unique when compared to the other articles dealing with mental illness and nostalgia in American soldiers in the Philippines. First, its literary style and tone do little to soften the harsh reality of war. The brief articles that appeared in national newspapers alluded to extreme climate and the differences that marked life in the Philippines from life in the United States. Few of these articles, however, offered extended descriptions of what characterized fighting an insurgent force. Rowland drew attention to facets of the war that journalists had been largely ignoring, including the frustration soldiers felt at fighting a war of pacification that required them to take and retake the same piece of land over and over, the fear they experienced when confronting an unseen guerilla force, and the tedium of garrison life in a tropical climate.

By linking this harshness to nostalgia and the attendant mental breakdown he identified in soldiers such as the fictional Tom, Rowland added complexity to the condition that did not exist prior to the war in the Philippines. While he still highlighted the tell-tale longing for home that had always characterized nostalgia– the hypothetical friends experienced "the gnawing pain of a heartaching [sic] homesickness" when "one by one their letters have ceased to arrive" –

[31] Rowland, "Fighting Life in the Philippines," 247.

Rowland determined a more sinister consequence of nostalgia than debilitating depression which the soldier directed inward to a debilitating or even fatal extent. Instead, nostalgia fed a destructive insanity in which the soldier turned his violence outward on his comrades or, more likely, the native population. Rowland described this phenomenon:

> [When] the last transport brought no tidings [from home], and at their lack, the cold chill of disappointment has proved as hardening as a pail of water on glowing steel. They have long since ceased to look upon friendly natives with a kindly toleration; no longer do they play with the brown babies and chat with the soft-eyed mothers in the market-place…A native's life assumes in their eyes an equal value to that of a sheep-killing collie. The sight of a trench full of dead insurgents awakens no more feeling than the wreck of a cattle train. They ponder among themselves, and decide that the only chance of pacification lies in a wholesale cataclysm; an inundation of human blood that will purge the islands of treachery.

This hardening of the heart brought on by nostalgia, Rowland argued, led to a dehumanization of the enemy by American soldiers, in turn triggering atrocities such as the actions of Tom, an otherwise ordinary American who shot three unarmed men in the head. American soldiers of Rowland's piece were not heroes, nor were they truly victims. As the author pointed out early in the piece, in his estimation American soldiers were capable of restraining their actions and rationally considering their orders. What force would be capable of overcoming military training as well as ingrained social mores about the proper conduct of war and the value of human life? In Rowland's opinion that force was nostalgia, tempered with the conditions of war that brought about not just feelings of homesickness but also frustration, fear, and hatred for one's enemy.[32]

A similar sentiment had appeared the previous summer in *The Sun*. After listing the casualty statistics from the Philippines, including those suffering from insanity, the paper listed nostalgia-induced melancholia as the primary cause. However, it also included an enumeration

[32] Rowland, "Fighting Life in the Philippines," 244.

of additional causes of soldier insanity, including "the isolation of the troops, their enforced confinement to the towns they garrison and the constant nervous strain incident to continued preparation against attack by the enemy."[33] Such language did not appear in the earlier accounts of nostalgia in Cuba and though perhaps implied, were also not directly stated with regards to Civil War soldiers either. Even the *Journal of the American Medical Association*, at the same time it discounted the connection between nostalgia and insanity, had to admit that the mental strain suffered by troops in the Philippines was due in part to "the assassinating methods of the insurgents." Such articles suggested that more than simply the separation from home could induce nostalgia and subsequent mental break down in a soldier. It was becoming increasingly clear that where a soldier was – war – could be equally detrimental to his psychological health as where he was not – home.[34]

The war in the Philippines marked an expansion of the definition of nostalgia. By linking the condition with debilitating insanity, newspapers stressed the severity of the disease among soldiers in the Philippines. Whereas reports from Cuba and even some of the descriptions by veterans of the Civil War seemed to depict death by nostalgia as a tragic culmination of physical and spiritual weakness due to longing for home, accounts from the Philippines suggested to the public that nostalgia could drive soldiers towards a dangerous mania that resulted in violence and death. By linking nostalgia with alleged atrocities against natives or personal failings such as alcohol abuse, newspapers further demonized the mentally ill soldier by suggesting his moral depravity.

[33] "Our Army in the Philippines," *The Sun*, January 15, 1901.

[34] "The Health of the Army in the Philippines," *Journal of the American Medical Association* 36 (1901): 512.

These discussions of nostalgia contrast to a concurrent discussion about the illness that developed in the press during the Spanish-American War. At the same time that newspapers reported sensational stories about soldiers driven to the brink of insanity by nostalgia, they published pieces about civilians afflicted by the illness. These pieces, however, reflected a decidedly different tone more reminiscent of the discussions about nostalgia during the Civil War. They also expanded the definition of nostalgia beyond the popular understanding that soldiers were the individuals most at risk.

Take, for example, the story of one New York widow. In August 1899 *The New York Times* published an article about Nora Legro, a widow who left Brooklyn to follow her new husband to California. Only a few short weeks after her arrival on the West Coast Mrs. Legro was dead of an apparent suicide. "Homesickness was responsible," announced the article, while also conceding, "though the physicians declared alcoholism to be the direct cause of death." Citing a friend who claimed Legro's last words to her were "I wish I was in New York or dead!" *The New York Times* was satisfied, per its headline for the story, that this was a case of "fatal nostalgia" in a woman who "could not live away from New York."[35]

Only a few months earlier *The Washington Post* ran an article about another possible victim of nostalgia, the state of Texas. Asking "is Texas getting homesick?" the editors of the *Post* appropriated the popular diagnosis of nostalgia as a means of discussing the more serious issue of whether some in Texas were agitating for the state's annexation from the United States. The editors concluded that in fact it was "only the *Houston Post* that is suffering from an attack of nostalgia," which was a relief because "it will be easier for that newspaper to get cured than it

[35] "Fatal Nostalgia: Woman Died Because She Could Not Live Away from New York," *The New York Times*, August 7, 1899, 7.

would be for that great and glorious State to be remediably [sic] treated."[36]

The *Chicago Daily Tribune* took an equally tongue-in-cheek approach to nostalgia with its article claiming that Chicagoans vacationing away from the Windy City could prevent or cure the illness by taking the city with them in the form of a pill. Following a recent "perfume concert" in New York, the *Daily Tribune* proclaimed that "anti-homesickness pills" smelling of such famous Chicago scents as the stockyard, garbage, and "an especially fine imitation of a Ninth Ward alley in April" would become a requisite for every traveler. "Every Chicagoan traveling abroad can carry his favorite brand of odor," the article assured, "and when nostalgia overcomes him [he] can release the perfumes and dream of home, sweet home."[37]

Such articles suggest the expansion of the popular understanding of nostalgia and even, perhaps, of the definition of the illness and even of the word itself. Coverage still maintained that soldiers remained among the most susceptible in the population to the dangers of nostalgia, but the popular media's attention shifted to other victims as well. In these instances the media suggested that nostalgia was a serious, if not always fatal condition. Perhaps more importantly, these public discussions seemed to increasingly imply that the condition might just be a mere inconvenience or only a minor discomfort experienced by many people in a variety of benign situations.[38]

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[36] "A Victim of Nostalgia," *The Washington Post*, April 8, 1899, 6.

[37] "Odor Capsules May Come: Perfume Concert Opens Field for New Industry," *Chicago Daily Tribune*, September 11, 1902, 8.

[38] The *Oxford English Dictionary* entry for "nostalgia" supports this late-nineteenth century expansion of the word from a medical condition on par with dementia or psychosis to a description of a broader, nonfatal feeling of sentimental longing for home. The *OED* notes that beginning in 1900, mentions of the word nostalgia in popular media as well as academia perpetuated a notion of nostalgia as a general "evocation of the past" more so than a medical diagnosis. "Nostalgia," Entry, OED: The Oxford English Dictionary, last modified December 2003, http://www.oed.com.libproxy.lib.unc.edu/view/Entry/128472. See also Janelle L. Wilson, *Nostalgia: Sanctuary of Meaning* (Lewisburg: Bucknell University Press,005), 21-23. A social psychologist, Wilson says of the definition of nostalgia at the end of the nineteenth-century, "Nostalgia during this time was de-medicalized… [it] has moved from a pathology to an emotion."

This was not the case when the media discussed nostalgia among soldiers, particularly those men who fought in the Pacific later in the war. Their nostalgia, the media seemed to imply, was different from the nostalgia that could be jokingly cured with an imaginary pill smelling of home. Within the popular discourse the affliction experienced by soldiers was of a darker sort and seemed more likely to lead to insanity and even uncontrollable violence, not to mention death by suicide. A stark difference existed between the descriptions of soldiers whose nostalgia left them with a "hellish desire to do evil" such as the *Chicago Daily Tribune* attributed to nostalgic soldiers drunk on *vino* or the "homicidal mania" described by Rowland, and joking concern over the hypothetical sadness felt by the state of Texas.

This difference suggests two things about the public understanding of nostalgia at the end of the Spanish-American War. On the one hand, the definition had expanded so far that something of a spectrum of nostalgia came to exist. At one end a New Yorker vacationing in Paris could feel a faint longing for home during his travels, in the middle of the spectrum an immigrant could pine for her homeland to the point of chronic depression, and on the very extreme end, a soldier could be driven to execute an unarmed man. On the other hand, the contrast generated between tongue-in-cheek appraisals of nostalgia and the public concern over the manifestations of the condition in soldiers could also suggest a growing public recognition of the inadequacy of the diagnosis when it came to giving a name to the psychological suffering of men at war. This can be seen in the efforts made Henry Rowland to describe the nostalgia he witnessed in soldiers during his service. In his view the soldiers certainly suffered because they were away from home, but more importantly, the conditions under which they fought and the enemy they faced played an equally significant, if not more important, role in the deterioration of their mental well-being. Such an opinion would become increasingly popular in the twentieth

century.

Conclusion

The media discussion about nostalgia that took place during the Spanish-American War leads to two interesting conclusions regarding the evolution of the public and professional interest in the psychological trauma of war. The first is the important interaction that took place between medical experts and the public. During the Civil War, doctors talked about nostalgia among themselves, but national interest in the condition forced them to expand the discourse to include the public as well. Medical practitioners responded to the public desire for information with newspaper interviews, often containing information drawn from their own experiences as battlefield doctors in either the Civil War or the present fighting in Cuba and the Philippines. Additionally, the professional discourse indirectly informed the public through the media's reference to professional journal articles and earlier research conducted during the Civil War.

This interaction between medicine and civilian interest was not perfect, however. The medical community explicitly discounted what it considered to be public hysteria over a minor health issue among the many afflicting U.S. soldiers in Cuba and the Philippines. Regardless of whether the public was justified in its alarm or the media amplified a nonexistent issue simply for the sensational headlines, the newspaper articles circulating around the country forced the public to confront psychological suffering in American soldiers. The public did so without the benefit of an organized response from mental health professionals to assuage or confirm its worry. Americans without medical training were left to parse journal articles published in their local papers without expert commentary or to try and decipher meaning from quick quotes from

military doctors. The Civil War was marked by a similar lack of useful communication between psychiatrists and non-professionals. It was not until World War I that the mental health profession would make a concerted effort to inform the public about mental illness in soldiers, though even then it would do so by attempting to limit aspects of public discourse.

A second conclusion we can draw about the popular and professional understanding of war-related psychiatric suffering during the Spanish-American War regards the expanding meaning of nostalgia. When the definition of nostalgia grew from a strictly pathological explanation to include a non-fatal longing for home experienced by almost anyone, it forced the public as well as the medical community to begin to consider – albeit in a limited way – alternate causes for the breakdown of soldiers in battle or the psychological symptoms from which they suffered, as well as seek more specific nosology. In this way the public redefintion of nostalgia sparked interest in a larger question about the effects of war on the psyche.

CHAPTER THREE: THE EFFECTS OF PROGRESS: NEURASTHENIA, RAILROAD SPINE, AND THE PROFESSIONALIZATION OF AMERICAN PSYCHIATRY BEFORE WORLD WAR I

The mental health community that existed during the Civil War and persisted through the Spanish American War was profoundly different from the profession that mobilized to assist American forces during World War I. From the period beginning in the late 1800s and lasting into the new century, psychiatry underwent a process of professionalization that divided practitioners of mental health care at the same time that it modernized the field and expanded the definition of mental illness. During these decades came new ideas about the origins of mental disorder and particularly, the role of trauma in causing psychiatric distress. At the same time, psychiatrists formed new professional organizations, worked to standardize psychiatric education, and incorporated scientific experimentation into their explorations of mental health.

The professionalization that occurred during this period was key to the successful mobilization of the psychiatric profession during World War I. In the previous two major wars, mental health practitioners lacked both the organization of men and the ideas necessary to provide the American military with a unified response. Similarly, this lack of cohesion prevented the larger medical community from offering a coherent response to public concerns regarding psychiatric casualties. But even if psychiatrists during the Civil War and the Spanish-American War had the professional networks and training they would come to have during WWI, none of it would have mattered if the paradigms of thought surrounding the understanding

of mental illness did not allow for psychiatrists to consider the role of trauma in causing psychological distress. These professional paradigms began to shift in the 1880s and the 1890s as European psychiatrists and eventually their American counterparts began to study trauma more closely, sparking the beginning of a psychiatric discourse that would endure into the next century.

Professionalization and the Rise of Scientific Inquiry in Psychiatry

Spurred by the same spirit of innovation and injection of capital that generated the rapid industrialization of the United States and Europe, the last half of the nineteenth-century witnessed profound and important changes to the study and practice of medicine. Foremost among these was the rise of laboratory science that strengthened the understanding of healthy and diseased bodies through the application of chemistry, vivisection, and microscopic investigation. While doctors working in hospitals focused on the observation and treatment of patients, the laboratory provided the opportunity for a growing number of physicians to experiment and often change their understanding of medicine and the function of the human body.[1] Some of the important discoveries of science and medicine born out of late nineteenth-century laboratories included the refinement of the germ theory of disease based on the research of France's Louis Pasteur, Robert Koch's application of germ theory to study the role of bacteria in the causation of diseases like tuberculosis, and the increased safety of surgical procedures resulting from the research of English surgeon Joseph Lister into the relationship between

[1] Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: W.W. Norton & Company, 1999), 320.

microorganisms and post-operative infections.[2] These discoveries and others like them would form an important foundation for medicine in the twentieth-century and beyond. By the early 1900s, the laboratory and the application of its discoveries in clinical practice or to further medical research had become an integral part of how doctors — and increasingly, the public — viewed the role of the physician. William Osler, a professor at Johns Hopkins, remarked that hospital laboratories became "to the physician just as the knife and scalpel are to the surgeon."[3]

An increased focus on science did more than improve the practice of medicine, it also contributed to its professionalization, particularly in the United States. For a time, medicine in America lagged behind its counterparts in France, Germany, and Great Britain, in large part because of the lack of rigorous, standardized medical training. Many American physicians received their education or conducted research at teaching-hospitals in Paris or laboratories in Berlin. However, by the dawn of the new century a small number of institutions located in Pennsylvania, New York, Baltimore, and Ann Arbor began to take steps to increase the level of medical training in the United States. In 1890 a consortium of these and other medical schools formed the Association of American Medical Colleges (AAMC) which advocated for increased medical education grounded in scientific methods and exploration. They recommended a minimum of three years of training and a requirement that students familiarize themselves with laboratory work in histology, chemistry, and pathology. The recently formed Johns Hopkins University took reform a step further by becoming the first American medical school to require its applicants to hold a college degree. In 1904 the American Medical Association created the Council on Medical Education which worked to set nationwide standards in medical education,

[2] Robert P. Gaynes, *Germ Theory: Medical Pioneers in Infectious Diseases* (Herndon, VA: American Society for Microbiology Press, 2011), 143-171.

[3] Osler quoted in Porter, *The Greatest Benefit to Mankind*, 347.

medical school curriculum, and physician licensing.[4]

In the face of such transformations in medicine, practitioners of mental health care worried that their field would stagnate or become marginalized if they could not find a way to incorporate scientific methods into psychiatry. As historian Gerald Grob notes, "In the emerging world of scientific medicine… institutional psychiatry appeared to be the vestigial remnants of a premodern age." Contemporaries were acutely aware of the growing chasm between psychiatry and science. In 1870, the *American Journal of Insanity* chastised its members by paraphrasing a quote by famed French physician and early medical researcher Marie François Xavier Bichat, "as far as the general medical profession is concerned; [psychological medicine] is 'an incoherent assemblage of incoherent opinions; it is perhaps of all the sciences, the one which shows most plainly the contradictions and wanderings of the human mind—a shapeless conglomerate of inexact ideas, of observations often puerile, and of illusory remedies.'" In the opinion of many within the field, the practice as well as the practitioners of psychiatry needed to be reinvented to both stay relevant in the new century and to better meet the needs of their patients.[5]

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[4] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 114-119.; Porter, *The Greatest Benefit to Mankind*, 319, 335-336.; Ronald L. Numbers, "The Rise and Fall of the American Medical Profession," in *Sickness and Health in America: Readings in the History of Medicine and Public Health,* ed. Judith Walzer Leavitt and Ronald L. Numbers, 3rd ed. (Madison: University of Wisconsin Press, 1997), 225-236. See also: James A. Schafer, Jr., "Fighting for Business: The Limits of Professional Cooperation among American Doctors during the First World War," *Journal of the History of Medicine and Allied Science,* 70 (2014): 165-194. Schafer situates his article within a growing historiographic debate that challenges the narrative of professional unity amongst physicians and allied professionals at the turn of the century. He and like-minded historians contend that economic self-interest and individualism had a larger impact on professional cohesion than scholars initially recognized. Schafer argues, "what emerged from the era of medical professionalization was by no means a unified corporation of homogenous professionals, but rather a tenuous alliance of disparate professional subgroups with distinct economic interests, political motivations, and social identifications." Schafer, "Fighting for Business," 174. This more nuanced view of medical professionalization brings it closer in line with the trajectory of professionalization within the field of psychiatry where political infighting, generational divides, and conflicting views on new therapies and research led to schisms between psychiatrists and neurologists, asylum directors and university researchers, and individuals in private practice and directors of large state hospitals. Though the field of mental health, like the broader study of medicine, eventually embraced overarching standards of training, education, and treatment, the process did not reflect a unified march towards professionalization.

[5] Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 31.;

The rise of the subfield of neurology was one reaction to what some nineteenth-century physicians saw as a lack of scientific inquiry into mental illness. Like most medical advancements during this era, neurology began in Europe when doctors sought to understand the connection between the structure and function of the body. However, it took on a new form when a handful of American doctors used their experiences treating wounds in the Civil War to more closely examine damage to nerve tissue. In a few short years the interests of neurologists expanded to include disorders of the mind, from organic conditions such as paralysis and hematomas to those mental illnesses whose origins were less clear — insomnia or general feelings of unhappiness or depression. The "younger sister of psychiatry" and its practitioners were the most ardent reformers of the field of mental health in America at the end of the nineteenth century.[6]

William A. Hammond, the former Surgeon-General of the Union Army during the war years and the author of the seminal *A Treatise on Diseases of the Nervous System* (1871), was one of the founding members of the field of neurology in the United States and one of its most vocal supporters. Over time, Hammond and other neurologists began to challenge the hegemony of asylum superintendents when it came to the care and treatment of the mentally ill. Many neurologists in the late-1800s opened private practices where they consulted with physicians and treated more affluent clients. Few, if any, neurologists had experience with the patients who filled the private and state institutions still dominating mental health care during this era.

"Clinical Teaching and Pathological Investigations in Insanity," *American Journal of Insanity*, 26 (April 1870): 408. The original Bichat quote can be found in Pierre-Victor Renouard, *History of Medicine: From Its Origin to the Nineteenth Century, with an Appendix, Containing a Philosophical and Historical Review of Medicine to the Present Time* (Philadelphia: Lindsay & Blakiston, 1867), 600.

[6] William Malamud, "The History of Psychiatric Therapies," in *One Hundred Years of American Psychiatry*, ed. J. K. Hall et al. (New York: Columbia University Press, 1944,) 291. See also: Grob, *Mental Illness and American Society, 1875-1940*, 50-52.

However, as Grob notes, neurology's familiarity with the anatomy and function of the brain did imply some legitimacy in the claim of neurologists to contribute to the treatment of mental health. While neurologists might have lacked exposure to severely ill psychiatric patients, the new subfield offered a chance for psychiatry to find a firmer scientific footing at a time when medicine was turning to the biological sciences to explain disorders of the body.[7]

Psychiatrists remained hesitant to align themselves with neurologists, despite the fact that neurologists and psychiatrists had very similar ideas about mental illness — particularly the connection between pathology and mental health — or that neurology offered a way to demonstrate the possible scientific legitimacy of psychiatric exploration. To the old guard of asylum superintendents and state hospital directors, the upstarts of neurology lacked experience with real patients, preferring instead the sterile environment of laboratories or the comfort of main street offices. Not surprisingly, a period of professional conflict developed between the two fields in which neurologists attacked the efficacy of asylums and challenged the scientific acumen of psychiatrists. In the opinion of some neurologists, the psychiatrist who absconded to the isolated asylum was more businessman than he was a scientist, and therefore, a relic of an earlier, darker age of medical inquiry.[8]

No incident highlighted the tensions between psychiatrists and neurologists more than the speech delivered by S. Weir Mitchell at a meeting of the American Medico-Psychological Association on the occasion of the Association's fiftieth anniversary. Mitchell had served as a

[7] Grob, *Mental Illness and American Society, 1875-1940,* 50-55. General histories of the origin and development of neurology can be found in F.R. Freemon, "American Neurology," *Handbook of Clinical Neurology* 95 (2010): 605-612.; Edward M. Brown, "Neurology's Influence on American Psychiatry: 1865-1915," in *History of Psychiatry and Medical Psychology: With an Epilogue on Psychiatry and the Mind-Body Relation,* ed. Edwin R. Wallace IV and John Gach (New York: Springer, 2008): 519-531.

[8] Malamud, "The History of Psychiatric Therapies," 291. See also: Grob, *Mental Illness and American Society, 1875-1940,* 50-52.; Jacques M. Quen, "Asylum Psychiatry, Neurology, Social Work, and Mental Hygiene: An Exploratory Study in Interprofessional History," *Journal of the History of the Behavioral Sciences* 13 (1977): 3-11.

physician during the Civil War and had since become a leading figure in the neurology movement. He was a controversial choice, which Mitchell wryly noted at the beginning of his speech, "[When I was asked] to be your speaker on this important anniversary, I declined. It is customary on birthdays to say only pleasant things and this I knew I could not altogether do." After being assured that his presence was welcome, Mitchell used the opportunity to unleash a scathing critique of the field of psychiatry. Chief among his complaints was the isolation of asylum directors, both physical and professional, which he argued, has "done us and you and many of our patients lasting wrong." He emphasized the lack of scientific inquiry pursued by the superintendents, complaining that any request by neurologists and physicians for meaningful dialogue about psychiatry was met with "odd little statements, reports of a case or two… sandwiched among incomprehensible statistics and farm balance sheets." Finally, Mitchell challenged the validity of the asylum system as it presently existed and questioned whether it truly served to help the mentally ill. "Upon my word," he charged, "I think asylum life is deadly for the insane."[9]

Institutional care was already being called into question at the end of the nineteenth century when progressive reformers such as Dorothea Dix publicized the conditions in some American institutions. In fact, the psychiatric profession had itself already begun to question its continued reliance on the asylum structure to care for America's mentally ill. Whereas early mental health professionals had touted their effectiveness at curing their patients — aided in no

[9] S. Weir Mitchell, "Address Before the Fiftieth Annual Meeting of the American Medico-Psychological Association," *The Journal of Nervous and Mental Disease* 21 (1894): 414, 422, 426. For a complete biography of S. Weir Mitchell, including his Civil War service and the development of his famous "rest cure" see Nancy Cervetti, *S. Weir Mitchell, 1829-1914: Philadelphia's Literary Physician* (University Park, PA: Penn State University Press, 2012).

small part, they believed, by the structured care provided by asylums — psychiatrists now called these optimistic views into question at the close of the century. In the 1870 and 1880s, a founding member of the Association of Medical Superintendents of American Institutions for the Insane conducted a retrospective review of some of the early statistics asylum directors used to demonstrate their success at curing their patients. His evaluation led him to conclude that the claims of "cured" patients had been grossly exaggerated and often reflected flawed or even dishonest record-keeping. This news, combined with the reality of an ever-increasing patient population characterized by chronic or degenerative mental disorders, led many psychiatrists to reevaluate the primacy of the asylum in the care and treatment of the mentally ill.[10]

As to Mitchell's other charges about the isolated and unscientific nature of psychiatry, the field was already taking small steps towards change. Though, like any large organization, progress was incremental and drawn out. Some changes were broad, such as the foundation of the Pathological Institute of the New York State Hospitals in 1890, which served to unite the disparate and haphazard scientific enterprises then being undertaken at the many state hospitals in the New York area.[11] More often, scientific methodology was introduced gradually by individual practitioners who recognized the value of the discipline on the field of mental health. Dr. Alfred Meyer was at the forefront of inserting scientific inquiry into psychiatric institutions. At the Illinois Eastern Hospital in Kankakee, Illinois he insisted that his medical staff undertake research in anatomy, pathology, and studies of the nervous system in addition to their usual duties caring for the hundreds of patients housed at the hospital. Meyer and his staff would then

[10] Gerald Grob, *Mental Illness and American Society, 1875-1940,* 50-52, 39.

[11] C.R. Bardeen, "Scientific Work in Public Institutions for the Care of the Insane," *American Journal of Insanity* 55 (1899): 468-469.

meet twice weekly to discuss their findings and possible applications to patient care. In his 1895 report on the hospital, Meyer wrote that the intention of these meetings was to create, "a livelier interest in the purely medical questions of the work and a systemic review of what to look out for in the examination of patients." Furthermore, the interchange between the doctors "furnished mutual instruction and formed a fair start in a movement that is not generally recognized yet by outside neurologists, but which will grow steadily and rapidly." Meyer left Kankakee hospital shortly after and instituted similar changes at the state hospital in Worcester, Massachusetts.[12]

Despite the professional differences that threatened to disrupt breakthroughs in understanding mental illness, the profession did see remarkable growth at the turn of the century. The effect of this growth, however, was not limited to the practitioners alone. As the field of psychiatry expanded beyond the walls of isolated state hospitals and into universities and private practices in the late nineteenth-century, laypersons and the public began to take a rising interest in mental illness. The result of greater contact between psychiatrists and the public nurtured a symbiotic relationship in which each group worked together — officially and unofficially — to craft definitions of normal and abnormal behavior.

One example of this interaction was, of course, the public concern over the psychological well-being of American fighting men in Cuba and the Philippines. Through the medium of newsprint and magazines, American's expressed their interest and concern over the impact of nostalgia on individual soldiers and the overall strength of the American military. The medical community responded, albeit begrudgingly, with information about the effects of nostalgia. On the one hand, some of the information was reassuring, while sometimes their comments led to

[12] Meyer quoted in. Bardeen, "Scientific Work in Public Institutions for the Care of the Insane," 466. Adolf Meyer would later be elected President of the American Psychiatric Association and would serve as a founding member of the Henry Phipps Psychiatric Clinic at Johns Hopkins Hospital.

bleak headlines about insanity and suicide that only fanned the flames of public concern.

While nostalgia in soldiers made for sensational reading, it was not the only psychiatric condition to capture the attention of medical professionals and laypersons alike. As the century drew to a close, both the public and the mental health profession —neurologists and psychiatrists — began to attempt to define what it meant to be psychologically healthy or, put another way, what it meant to be "normal." From this discourse arose the construct of neurasthenia.

Neurasthenia and the Growing Public Interest in Mental Health

The definition of neurasthenia is as elusive in the twenty-first century as it was to doctors and patients at the beginning of the twentieth. As one historian observed, "neurasthenia was used to characterize practically every nonspecific emotional disorder short of outright insanity." Recall that until the post-Civil War era, the etiology of mental illness was limited to a few diagnostic labels such as melancholia or psychosis. Within these labels there was very little room for specificity and ultimately, all patients were considered to be insane. The introduction of neurasthenia did little to add to the diagnostic lexicon of doctors or patients; however, it suggested the possibility that individuals could suffer from a mental disorder without necessarily requiring hospitalization or extreme forms of treatment. Most importantly, it suggested that mental illness could exist on something of a spectrum. As one physician assured anxious readers of *Harper's Bazaar,* "Insanity or loss of mind is never caused by neurasthenia."[13]

[13] F.G. Gosling, *Before Freud: Neurasthenia and the American Medical Community, 1870-1910* (Urbana, IL: University of Illinois Press, 1987), 9.; Graeme M. Hammond, "Nerves and the American Woman," *Harper's Bazaar*, July, 1906, 590. The historical study of neurasthenia and its place within American medicine and Victorian culture is quite large. The history of neurasthenia is often discussed in conjunction hysteria, given that the two terms were used nearly interchangeably by contemporaries. Works focused almost exclusively on neurasthenia include: Gosling, *Before Freud*.; David G. Schuster, *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1869-1920* (New Brunswick, N.J.: Rutgers University Press, 2011). See also: George Frederick Drinka,

The condition entered the medical consciousness in the years immediately following the Civil War when it was first proposed by a young neurologist named George Beard. Beard had briefly served as a doctor in the U.S. Navy during the Civil War, though he did not complete his medical degree until after the war ended and his interest in the nervous system led him to the new field of neurology. Like many in his profession, Beard was a firm believer in the principles of science and its ability to offer answers to some of medicine's most difficult questions, among them, the causes of insanity. When he began to encounter patients with vague, undefined symptoms such as irrational fear, anxiety, and depression he proposed the existence of an underlying cause capable of being identified and treated through scientific inquiry. Whereas psychiatrists and even other neurologists might have labeled such patients hysterical or nervous, Beard suspected an underlying pathology driven by a depletion of nervous energy which he labeled neurasthenia.[14]

The symptoms of neurasthenia varied from patient to patient and often depended on the whims of the diagnosing psychiatrist or neurologist. George Beard worked hard to apply the principles of science to the study of neurasthenia in an effort to create a professional understanding of the condition. In the Preface to his foundational work *A Practical Treatise on Nervous Exhaustion (Neurasthenia)*,(1880), Beard outlined goals that included describing "with thoroughness, if not exhaustively, the symptoms of neurasthenia," demonstrating the interdependence of these symptoms and distinguishing neurasthenic symptoms from those associated with other common conditions such as hysteria and hypochondria. Despite these

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The Birth of Neurosis: Myth, Malady, and the Victorians (New York: Simon and Schuster, 1984), 184-209.

[14] Charles E. Rosenberg, "The Place of George M. Beard in Nineteenth-Century Psychiatry," *Bulletin of the History of Medicine* 36 (1962): 245-249.; George Beard, "Neurasthenia, or Nervous Exhaustion," *The Boston Medical and Surgical Journal* 80 (1869): 217-221.

efforts, Beard's list of symptoms remained broad and still left room for reinterpretation by different psychiatrists and neurologist. The symptoms he identified included headaches, dilated pupils, frequent blushing, "deficient mental control," dry skin, back pain, and tooth decay, among dozens of others. Perhaps even more disconcerting to patients and doctors was Beard's assertion that, ultimately, nervous exhaustion was "compatible with the appearance of perfect health."[15]

As the diagnosis gained popularity, neurasthenia appeared in the medical literature and in the popular media of the day under a variety of names, including "nervous exhaustion," "nervousness," or simply "nerves." Such diagnostic labels reflected the continued belief of mental health professionals in the somatic nature of psychiatric disorders. Led by Beard's research, a consensus developed among physicians that neurasthenia resulted from the weakness of the nerve force, that the nerves of the body could become depleted through a variety of physical and psychological means, resulting in the many symptoms that fell under the broad heading of neurasthenia.[16] While physiological origins remained the mainstay of psychiatric thinking, lifestyle and environment continued to play a role in how doctors viewed the origins of mental disorders. In the case of neurasthenia, observers linked the rapid growth and

[15] George M. Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Symptoms, Nature, Sequences, Treatment*, ed. A.D. Rockwell (New York: E.B. Treat, 1888), 13, 117. See Chapter 2, "Symptoms of Nervous Exhaustion," for Beard's entire list and a detailed explanation of symptoms. Beard, *A Practical Treatise on Nervous Exhaustion*, 23-117.

[16] Charles E. Rosenberg, "The Place of George M. Beard in Nineteenth-Century Psychiatry," 249-250. Beard stated very succinctly, "nervousness is a physical not a mental state, and its phenomena do not come from emotional excess or excitability or from organic disease but from nervous debility and irritability." George M. Beard, *American Nervousness: Its Causes and Consequences A Supplement to Nervous Exhaustion (Neurasthenia)* (New York: G.P. Putnam's Sons, 1881), 17. Historian Charles Rosenberg labeled neurasthenia and similar conditions as "striking" in part because of the "relentlessly somatic etiologies that legitimated these innovative diagnoses." He argued that given the etiological culture of the late nineteenth century, it was only by including a somatic basis for neurasthenia that medical professionals and the public would accept the condition as legitimate. Charles E. Rosenberg, "Body and Mind in Nineteenth-Century Medicine: Some Clinical Origins of the Neuroses Construct," *Bulletin of the History of Medicine* 63 (1989): 194-195.

industrialization of the United States to decreased psychic health. In the opinion of some in the medical community as well as the public, neurasthenia was a distinctly "American illness" that resulted from a national drive towards improvement, success, and superiority.[17] George Beard even titled the follow-up to *A Practical Treatise on Nervous Exhaustion (Neurasthenia)* simply *American Nervousness* (1881). He argued that the prevalence of neurasthenia in America was chiefly caused by "dryness of the air, extremes of heat and cold, civil and religious liberty," and most perhaps most significantly, by "the great mental activity made necessary and possible in a new and productive country."[18]

The relentless pursuit for international dominance had profound effects on the social and economic fabric of the United States, and for some concerned citizens, neurasthenia represented just one of the negative consequences to come from this new modern era. Newspaper headlines reiterated the definition of neurasthenia as the "American Disease" or "American Nervousness." These contemporaries were sometimes less inclined to see neurasthenia as the consequence of a nation steadily improving, but instead, considered it an unfortunate side effect of the accumulation of wealth and the concurrent growth in leisure time. One sanitarium owner, commenting on his experiences to a *New York Times* reporter, cautioned that neurasthenia would cause the decline of the "American race." Only a year before the *Times* posed a question to its readers, "Has the American reached the level of his endurance?" Dr. I.L. Nasher of the Fordham University School of Medicine responded in the affirmative. "The American's ambition," he wrote, "to go to the limit of physical ability, to reach the goal he has set for himself, has carried

[17] Schuster, *Neurasthenic Nation,* 2-4. Schuster also notes that while neurasthenia might have been an "American illness," medical professionals in other countries had also linked similar symptoms together in their own versions of neurasthenia. George Drinka argues that to Europeans, for instance, the condition was "more complex, troubled." Drinka, 210-238. See also, Arthur Kleinman, *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China* (New Haven, C.T.: Yale University Press, 1986).

[18] Beard, *American Nervousness,* vii.

him to the limit of human endurance."[19]

By grouping symptoms such as indigestion, headaches, and fatigue under the category of mental illness, the pool of potential psychiatric patients rapidly grew. This had the effect of expanding interest in mental illness beyond the cloistered offices of asylum superintendents or the backrooms of private family homes and into the sphere of the wider public. While individuals with more extreme psychiatric symptoms still found refuge in large hospitals, now patients with more minor complaints could receive an official diagnosis to legitimize their symptoms. Even more significant to the evolution of the relationship between mental health practitioner and patient, the afflicted individual could find assistance in an out-patient clinic, often run by a neurologist or in an often luxurious sanitarium.

Historian David Schuster refers to neurasthenia as a "formal diagnosis often informally applied." Indeed, it became almost fashionable to claim a neurasthenic complaint. In 1894, one newspaper labeled neurasthenia the "Malady of the Age" and warned of a grim future dominated by a "race of nervous men." Ten years later the *Christian Advocate* reiterated the popularity of neurasthenia, referring to it as "the disease of the century." In 1908, a *Chicago Daily Tribune* headline proclaimed "'The Blues' More Fashionable this Year than Appendicitis." The article alerted readers to the "distinctly fashionable" nature of the condition, evidenced by the fact that six society women had already committed suicide during the current winter social season.[20]

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[19] "Money Madness is Ruining Our Race," *New York Times*, January 7, 1912. "Has the American Reached the Limit of His Endurance?," *New York Times,* October 15, 1911.

[20] "The Malady of the Age: Conjectures as the Future of a Race of Nervous Men," *Maine Farmer*, February 1, 1894.; "Neurasthenia: The Disease of the Century," *Christian Advocate,* September 1, 1904.; Frances Barnes, "'The Blues' More Fashionable this Year than Appendicitis," *Chicago Daily Tribune,* May 17, 1908. In an article entitled "Great Men in Sanitariums," the *New York Times* reported that one doctor had encountered in a single sanitarium "six men at a time who were leading lights in as many vocations, all millionaires or near millionaires, and all familiar names in the richest churches, in the oldest business houses, as well as in the newspapers." "Great Men in Sanitariums," *New York Times*, February 27, 1910.; See also: "Is the World Going Crazy, and is Liquor Doing It?" *New York Times*, May 21, 1911.; "Fashionable Laziness: 'Neurasthenia' is the Medical Name for It," *Chicago Daily Tribune,* May 17, 1888.

Sufferers included such famous persons as Jane Adams, Edith Wharton, William James, and Alexandra, Empress of Russia.[21]

This is not to say, however, that neurasthenia was an illness free of stigma. The diagnosis was as much tied to social and cultural considerations as it was to medical theories. When presented with a potential neurasthenic patient, the treating psychiatrist or neurologist would first look to the patient's background and lifestyle in an attempt to identify the origin of the illness. The observations and connections made by the clinician were often tied to commonly held beliefs about class, gender, and moral behavior. For example, women were considered to be more at risk for neurasthenia than men based on a simple weakness of biology. Similarly, doctors tended to cast blame on their poor or immigrant patients, while they labeled wealthier patients as unfortunate victims. In their opinion, the former, in embracing vices such as alcohol or immorality, brought the neurasthenia on themselves, while the latter were exhausted by their labors at work and the demands of the new industrial America.[22]

Interestingly, the popular media sometimes argued the reverse, highlighting the diversity of opinion about the nature and etiology of neurasthenia that existed among the public. In 1906 the *Los Angeles Times* sought to remind readers that the poor could also fall victim to nervous exhaustion. Whereas neurasthenia was "usually supposed to be the disease of the rich and lazy… brought on by excess in one form or another — by irritation of the nerves and a life void

[21] Schuster, *Neurasthenic Nation*,2-3.; "Czarina's Mind Affected: A Special Cable to the New York Times," *The New York Times*, November 30, 1909.

[22] Gosling, *Before Freud*, x-xi.; In 1911 the *New York Times* published a commentary on an article drawn from the British medical journal *The Lancet* which claimed that "physical training" for high school girls could lead to "the worst type of neurasthenia." Physicians recommended dancing as a cure of any psychological issues created by "athletic angularities." "Blames Athletics For Women's Unrest", Special Correspondence, *The New York Times*, February 12, 1911. Dr. Graeme M. Hammond, Professor of Mental and Nervous Diseases at the New York Post-Graduate School wrote a lengthy article for *Harper's Bazaar* in which he counseled female readers to avoid unnecessary stress and frequent excitement. Among his recommendations he suggested avoiding excessive bridge-playing and "offending [your] digestion with what is known as 'light refreshments.'" Graeme M. Hammond, "Nerves and the American Woman," *Harper's Bazaar*, July 1906, 590.

of any useful, satisfying occupation," the article posited that the poor were not only susceptible to neurasthenia, but perhaps at an even greater risk for the condition due to "overwork or mental worry" depleting nerve strength. Similarly, an unnamed doctor speaking to the *New York Times*, who "knew whereof he spake," painted an acerbic picture of the rich clients crowding private sanitariums with the diagnosis of neurasthenia. When asked if these men were "really crazy," the doctor responded, "for the time being, yes," but he added, "here is where publicity ends and rich man's privacy begins." In his observation, among these wealthy patients their symptoms would often be labeled "'nervous breakdown,' 'overwork,' 'strain of business care,' or whatever his friends may fancy." However, he confided, "the cause, as a general rule, is found to be whiskey. It is the high-ball craze or the cocktail mania… [and] the result of high living" that really brought the scions of great families to the care of popular sanitariums.[23]

The medical profession and the public contested and debated the etiology and nosology of neurasthenia at the turn of the twentieth-century, further strengthening the developing dialectic that would shape the recognition and legitimization of mental disorders in the United States during the next hundred years. Public fascination with neurasthenia also indicated growing popular interest in — and even acceptance of — the prevalence of mental illness among a large swath of the population. While still stigmatized, discussions around neurasthenia occurred more openly than previous public conversations surrounding mental illness, with the possible exception of nostalgia. Furthermore, professional interest in the condition did more

[23] "Nervous Prostration: Not a Disease of the Rich But Prevails Among the Poor as Well," *Los Angeles Times*, October 26, 1906.; "Great Men in Sanitariums," *The New York Times*, February 27, 1910. Famed author O. Henry expressed similar sentiments in his satirical short story *Adventures in Neurasthenia: Let me Feel Your Pulse.* The psychiatrists and patients that populate the story are compelling caricatures of the individuals described within the popular press. The patients are characterized as rich, insipid individuals searching for vague rest cures that include fine cuisine, golf, and artistic expression at cloistered, luxurious sanitariums. Meanwhile, Henry's psychiatrists are unauthoritative and easily bent to the whims of their patients, often failing to conduct an examination and simply taking the client at her word when she states that she has neurasthenia. O. Henry, *Adventures in Neurasthenia: Let me Feel Your Pulse* (New York: Doubleday, Page, and Co, 1910).

than just demonstrate the influence of neurology on mental health at the end of the nineteenth century. Professional definitions of mental illness were expanding, as were the potential causes of these conditions. Neurasthenia was only one of the growing class of neuroses that captured the attention of mental health practitioners during this period. Just as neurasthenia challenged psychiatrists to think about the relationship between mind, body, and environment, another condition of the late nineteenth-century would cause them to consider the role of trauma in mental illness.

Railway Spine and Traumatic Neuroses

One of the first neurologic conditions to be tied to a traumatic event was the aptly-named railway spine. Once again it seemed to some as though modernity was exacting a stiff cost on a nation of hardworking citizens. As thousands of miles of railroad tracks crisscrossed the industrializing United States and as more and more individuals took to the rails for business or pleasure, the number of railway accidents increased. In addition to the expected injuries of broken and crushed bones, lacerations, and head wounds, doctors and railway surgeons began to observe a curious phenomenon. Some survivors, even weeks after the accident, reported sudden paralysis, headaches, and sleeplessness. Doctors were especially baffled when such symptoms occurred in individuals who had seemed previously unscathed by the accident.[24]

Interest in railway spine was not limited to the United States. One of the first mentions of the condition came in the form of a series of lectures by British physician John Eric Erichsen in 1866. Erichsen published the lectures soon after in a short treatise entitled *On Railway and*

[24] Thomas Keller, "Railway Spine Revisited: Traumatic Neuroses or Neurotrama?" *The Journal of the History of Medicine and Allied Sciences* 50 (1995): 507-524.

Other Injuries of the Nervous System (1866). He reissued the lectures a decade later, with additional research, in a longer book called *On Concussion of the Spine: nervous shock and other obscure injuries of the nervous system in their clinical and medic-legal aspects* (1875). Erichsen was a well-respected English surgeon and Professor of surgery at University College Hospital in London. His name has largely been lost to the history of psychiatry despite his importance to some of the first explorations of the effect of trauma on mental well-being. As historian Eric Michael Caplan observed, Erichsen's lectures did little to advance the science of railway injuries. Instead, Erichsen was important for the interest and debate that developed in professional circles after the publication of his research. Within thirty years of their publication, one noted American neurologist labeled Erichsen's lectures "epoch-making."[25] Erichsen's observations about the somatic causes of railway spine served as the catalyst for the first serious discussions in the medical profession about the possibility that a traumatic event could alter the brain in such a way that mental illness resulted.

As a surgeon, Erichsen approached the topic of railway spine from a strictly somatic perspective. In his opinion, a railway or other accident had the potential to cause a "Concussion of the Spine." While reasonably convinced that Concussion of the Spine was not limited to railway incidents, Erichsen did admit that the number of spinal injuries associated with train accidents required special examination by medical professionals. "It must be obvious to you all," he remarked to his colleagues,

> That in no ordinary accident can the shock be so great as in those that occur on Railways. The rapidity of the movement, the momentum of the person injured,

[25] Michael Trimble, *Post-Traumatic Neurosis: From Railway Spine to the Whiplash* (New York: John Wiley & Sons, 1981), 9.; Eric Michael Caplan, "Trains, Brains, and Sprains: Railway Spine and the Origins of Psychoneuroses," *Bulletin of the History of Medicine*, 69 (Fall 1995): 390-391.; Charles D. Dana, "The Traumatic Neuroses: Being a Description of the Chronic Nervous Disorders That Follow Injury and Shock," in *A System of Legal Medicine*, vol. 2, ed. Allan McLane Hamilton and Lawrence Godkin (New York: E.B. Treat, 1894), 299, quoted in Caplan, "Trains, Brains, and Sprains," 390.

> the suddenness of its arrest, the helplessness of the sufferers, and the natural perturbation of mind that must disturb the bravest, are all circumstances that of a necessity greatly increase the severity of the resulting injury to the nervous system, and that justly cause these cases to be considered somewhat exceptional from ordinary accidents.[26]

Erichsen contended that the "external violence" of a train crash, large or small, could result in a "shake or a jar" to the spinal cord and, as a result, the spine's "intimate organic structure may be more or less deranged, and by which its functions are certainly greatly disturbed." Erichsen also noted that such injuries were possibly "independent of, and usually, but not necessarily, uncomplicated by any obvious lesion of the vertebral column." In other words, survivors with no obvious signs of injury to their spines — such as a laceration or a dislocation — might still be victims of concussion of the spine. According to Erichsen, the physiological effects of a concussion to the spine included "molecular changes in its structure," inflammation, and "retrogressive organic changes" such as softening of the spine and "interference with its nutrition."[27] He identified symptoms of concussion of the spine or railway spine that included paralysis, numbness and tingling, but also melancholy, confusion, and anxiety. Perhaps the most important characteristic of the symptoms associated with the condition, he argued, were their tendency to be delayed. In *On Railway and Other Injuries of the Nervous System* Erichsen observed, "There is great variation in the period" during which the symptoms of spinal concussion can appear. "In some cases they do so immediately after the occurrence of the injury,

[26] John Eric Erichsen, *On Railway and Other Injuries of the Nervous System* (London: Walton and Maberly, 1866), 9. Also quoted in Caplan, "Trains, Brains, and Sprains," 392. Interestingly, Erichsen is reported to have called the label Railway Spine an 'absurd appellation' given that he had found instances of the condition among so many individuals unassociated with railway injuries. Trimble, *Post-Traumatic Neurosis: From Railway Spine to the Whiplash,* 14.

[27] John Eric Erichsen, *On Concussion of the Spine: Nervouse Shock and Other Obscure Injuries of the Nervous System in their Clinical and Medico-Legal Aspects* (London: Longmans, Green, and Co. 1882), 15. See also: Trimble, 12-13.

in others not until several weeks, I might perhaps even say months, had elapsed." He reiterated this point in *On Concussion of the Spine,* saying, "Nothing is more common than that the symptoms of spinal mischief do not develop for several days after heavy falls on the back."[28]

In his lectures, and later in his books, Erichsen highlighted the physical symptoms of his patients and in some instances, their psychological suffering as well. Like his medical colleagues in both the surgical and psychiatric professions, Erichsen sought pathological reasons for the psychic suffering evident in some of his patients. In his opinion, there were occasions when Concussion of the Spine, "in its clinical history, in its symptoms, and probably in its pathology," could be connected with hysteria, especially in cases of railway spine.[29]

Erichsen's views on hysteria appear to have evolved between the publication of his first book, *On Railway Spine* (1866) and the revision and republication of the same lectures in *On Concussion of the Spine* (1882). In each work he stressed his uncertainty over hysteria as a diagnostic label, considering it to be too broad and he feared physicians were in danger of applying it too easily and, as a consequence, missing a more apt diagnosis. Erichsen spoke derisively of the hysteria diagnosis, referring to it as a "word which serves as a cloak to ignorance" that "simply means a group of symptoms all subjective and each one separately

[28] Erichsen, *On Railway and Other Injuries of the Nervous System*, 96-97.; Erichsen, *On Concussion of the Spine,* 77. To highlight his observations about the symptoms and prognosis of the condition, Erichsen included just over fifty case studies of concussion of the spine observed by himself and others in *On Concussion of the Spine*. As the case studies indicated, railway accidents were not the only causes of spinal concussions. Erichsen also identified falls from horses and injuries from athletic exercises and sports as the sources suffering in some individuals. Almost every example involved some sort of blow or other physical trauma to the head or back, though not all. Some cases resulted in only the partial recovery or even death of the patient, as in the case, labeled as "Crush of the Finger," which led to "Progressive Disease of the Nervous System" and, ultimately, the death of the patient. Trimble, *Post-Traumatic Neurosis: From Railway Spine to the Whiplash,* 13.

[29] Erichsen, *On Concussion of the Spine,* 173.

common to many morbid states."[30] However, by 1882, Erichsen seemed more willing to concede that hysteria might play an important role in understanding the effects of concussion of the spine and railway spine in particular. It is unclear why Erichsen's views on hysteria and railway spine expanded, though it is reasonable to assume that his thoughts evolved as the professional discourse on traumatic neuroses developed at the end of the century.[31]

In *On Concussion of the Spine*, Erichsen linked hysteria caused by railway accidents to "nervous shock." In his research he identified two forms of nervous shock that existed on a

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[30] Erichsen, *On Concussion of the Spine,* 174.

[31] Erichsen never explicitly stated that his opinion on hysteria had progressed; it is evident, however, in subtle changes between the two texts. For example, in *On Railway Injuries* Erichsen wrote,

> To me, I confess, the sight of a man of forty-five, rendered 'hysteria,' not for a few hours or days even, by some sudden and overwhelming calamity that may for the time break down his mental vigour, but permanently so for months or years, would be a novel and a melancholy phenomenon, and is one that I have neither seen described by any writer with whose works I am acquainted, nor witnessed in a hospital experience of twenty-five years. (Erichsen, *On Railway Injuries,* 127)

Compare the above to the same paragraph that appeared, revised, in *On Concussion of the Spine.* The emphasis is mine.

> To me, I confess, the sight of a man of middle age, previously strong and healthy, active in his business and in all the relations of life, suddenly rendered 'hysterical,' not merely for a few hours or days, by some sudden and overwhelming calamity that may for the time break down his mental vigor, but continuously so, for months and even years, *is* a most melancholy spectacle, and is a condition that certainly to my mind is an evidence of the infliction in some way of a serious, and, for the time, disorganizing injury of the nervous system.

Writing in 1866, Erichsen held the opinion that physicians often confused concussion of the spine for hysteria, something that "has always appeared extraordinary to me, that so great an error of diagnosis could so easily be made." He did not contend that railway accidents were devoid of psychological consequences. "That mental emotion is occasionally manifested by an unfortunate individual who has been seriously injured by an accident which tends to shake his whole nervous system, can scarcely be matter of surprise." He labeled such a reaction "natural enough." However, he argued, "it certainly appears to me that the term 'hysteria,' elastic as it is, can scarcely, with any regard to trust or justice, be strained so far as to embrace those feelings that naturally spring from the contemplation of so gloomy a prospect as [a railway injury]." Erichsen, *On Railway Injuries,* 128. By 1882, however, Erichsen identified hysteria — "for want of a better name," he conceded —as a "condition of the nervous system that occasionally occurs as a result of spinal concussion." Erichsen, *On Concussion of the Spine,* 194. Erichsen's writing on hysteria demonstrates the fluid nature of professional understanding of the condition and the rapid change of medical views on the mind-body connection were undergoing during this era. For further discussion of Erichsen's attempts at incorporating a more psychological perspective see: Ralph Harrington, "The Railway Accident: Trains, Trauma, and Technological Crises in Nineteenth-Century Britain," in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930,* ed. Mark S. Micale and Paul Lerner (New York: Cambridge University Press, 2001) 47-48.

spectrum of severity. The first, he argued, was "mental or moral," while the second was strictly physical in nature. Either form could exist outside the other, but sometimes, he observed, the two "may co-exist" in a single patient. Significantly, Erichsen noted that mental or moral nervous shock "may occur without the infliction of any physical injury, blow, or direct violence to the head or spine." Most commonly, he observed, sufferers only experienced "a general shock or concussion to the system." Furthermore, even when the shock rendered the patient unconscious, Erichsen noted that the individual never displayed "those after phenomena indicative of real or organic lesions of the brain, the cord, and their membranes, which so commonly result from physical shock."[32]

For a surgeon interested in the physiological or pathological origins of a disordered mental condition, Erichsen was left with the challenge of explaining how mental or moral shock, and its subsequent hysteria, could come about absent organic evidence. To bridge this gap, Erichsen relied on the same understanding of the nervous system that underlay the contemporary understanding of the cause of neurasthenia. Nervous shock due to railway accident was caused by a depletion of the nervous system and, he argued, in this instance the depletion was "probably dependent upon the influence of fear." More specifically, Erichsen contended that the unique nature of train accidents made this fear more intense and its subsequent effects more acute, particularly in male patients. He wrote,

> It must be remembered that railway accidents have this peculiarity, that they come upon the sufferers instantaneously without warning, or with but a few seconds for preparation, and that the utter helplessness of a human being in the midst of the great masses in motion renders these accidents peculiarly terrible… The crash and confusion, the uncertainty attendant on a railway collision, the shrieks of the sufferers, possibly the sight of the victims of the catastrophe, produce a mental impression of a far deeper and more vivid character than is occasioned by the

[32] Erichsen, *On Concussion of the Spine,* 194-195.

more ordinary accidents of civil life.[33]

Erichsen was firmly convinced that the physiological as well as the psychological symptoms he witnessed in patients and other survivors of railway crashes were connected to some sort of damage to the spinal column. In many instances, though not all, he was able to trace the source of that damage to a blow or a fall, but often, physical evidence of the injury was unclear. This left Erichsen to assume that some sort of concussive force acted upon the spine, causing, for example, its molecular structure to change in a way not visible to a surgeon. When he revisited his research for the republication of his lectures, Erichsen made greater efforts to fit hysteria into his thinking about spinal injuries, particularly in relation to train accidents. He remained convinced, however, that physical factors outweighed the psychological when it came to explaining the suffering of accident victims and he concluded that spinal concussion could cause a severe depletion of the nervous system, resulting in hysterical symptoms.[34]

Perhaps not surprising given their popularity, Erichsen's theories met with critics, particularly those who argued that he neglected to appropriately consider the influence of psychological factors such as fear in generating nervous ailments. One of the sharpest critiques came from Herbert Page, a physician and fellow of the Royal College of Surgeons. His 1883 text, *Injuries of the Spine and Spinal Cord Without Apparent Mechanical Lesion,* took issue with Erichsen's central premise, that the collection of symptoms commonly found in railway accident survivors were necessarily caused by a physical injury to the spine. Drawing on his own study of over two hundred and thirty case histories, Page argued that "the spinal cord itself is very

[33] Erichsen, *On Concussion of the Spine,* 195.

[34] Erichsen, *On Concussion of the Spine,* 194.; Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995),16.; Trimble, *Post-Traumatic Neurosis: From Railway Spine to the Whiplash*, 25.

securely protected from injury." This caused him to conclude that "cases where there has been unquestionable lesion either of the central or more peripheral parts of the nervous system are few and far between."[35]

In discounting Erichsen's hypothesis, Page suggested his own to account for the collective suffering of so many accident victims. He argued for the concept of nervous shock, in which he contended that fear alone could inflict a serious enough shock on the nervous system to cause the broad symptoms found in accident survivors. "Medical literature abounds," he wrote, "with cases where the gravest disturbances of function, and even death or the annihilation of function, have been produced by fright and fright alone." Page posited that nervous shock induced by fear explained not only the immediate symptoms but also "those after-symptoms which may be almost as serious as… those which we meet with shortly after the accident has occurred." Whereas Erichsen sought to explain how psychological symptoms could derive from a physical injury to the spine or spinal column, Page argued the opposite, that a state of mental distress brought on by acute fear could lead to physical symptoms. He wrote, "The incidents indeed of almost every railway collision are quite sufficient – even if no bodily injury be inflicted – to produce a very serious effect on the mind, and to be the means of bringing about a state of collapse from fright, and from fright only." Thus, he concluded, only "purely psychical causes" could explain why some victims developed symptoms of the so-called railway spine, regardless of whether or not they suffered a physical injury.[36]

By introducing a psychological explanation for the symptoms produced by a traumatic

[35] Herbert W. Page, *Injuries of the Spine and Spinal Cord Without Apparent Mechanical Lesion* (London: J. & A. Churchill, 1883), 116, 117.

[36] Page, *Injuries of the Spine and Spinal Cord*, 147, 148.; Harrington, "The Railway Accident: Trains, Trauma, and Technological Crises in Nineteenth-Century Britain," 50-52.

event such as railway crash, Page's monograph expanded the discourse on traumatic injury to include neurologists.[37] Perhaps the most famous to take up the question was French neuropsychiatrist Jean-Martin Charcot. Charcot made a name for himself in Western medicine as a neurologist and by the 1880s was one of the most famous physicians in France. His most important contributions to the understanding of psychological trauma came in the form of a series of case studies he compiled from 1878 to 1892 at the renowned Salpêtrière hospital where France sent many of its mentally ill citizens. Importantly, these case studies were not all derived from railway accidents, but from a wide-range of what might be considered traumatic events, including workplace accidents and an attempted assault. To these twenty or so cases Charcot applied diagnoses such as "*nérvose traumatique*," "*hystérie traumatique*," "*hystéro-traumatisme*," and "*hystéro-neurasthénie traumatique*." Historian Mark S. Micale argues that Charcot's adoption of these diagnostic categories "created a wholly new diagnostic entity," traumatic neurosis, and it was because of Charcot's prominence within the field of Western psychiatry that traumatic neurosis became "a distinct subcategory of hysteria" with a "high medical profile."[38]

Like the vast majority of mental health practitioners in the late-nineteenth century, Charcot viewed the etiology of mental illness to be a combination of hereditary susceptibility and an environmental trigger. The constitution of that trigger was the source of much debate for Charcot and others within the field. For Erichsen, it was somatic in nature, such as a physical

[37] Historian Eric Caplan notes, however, "Rather than ushering in a new age of medical consensus, Page's work simply shifted the domain of the previously existing conflict from the realm of surgery to that of neurology." Eric Caplan, "Trains and Trauma in the American Gilded Age," in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930,* ed. Mark S. Micale and Paul Lerner (New York: Cambridge University Press, 2001), 63.

[38] Mark S. Micale, "Jean-Martin Carcot and *les névroses traumatiques:* From Medicine to Culture in French Trauma Theory of the Late Nineteenth Century," in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930,* ed. Mark S. Micale and Paul Lerner (New York: Cambridge University Press, 2001), 121, 116.

accident like a railway crash leading to damage of the spine or nerves. Charcot noted physical trauma in his patients as well. But just as Erichsen increasingly conceded the potential influence of psychological factors, Charcot also gradually came to accept the argument put forth by Page, that emotion or fear could play a role in producing neurosis, writing in 1889, "The nervous shock or commotion, the emotion almost unavoidably inseparable from an often life-threatening accident, is sufficient to produce the neurosis in question."[39] In particular, Charcot accepted that a sudden nervous shock could serve as the catalyst towards the realization of a hereditary disposition towards mental illness.[40] Charcot served as an influential voice at an important moment in the evolution of the professional understanding of psychic trauma. As Micale notes, "Charcot was a transitional figure" between the nineteenth-century mental health professionals who focused their attention on the somatic or pathological and the later psychiatrists of the twentieth century whose work revolved solely on the role of emotion and experience in the shaping of the psyche.[41]

It is important to note, however, that Charcot's voice was just one of many during this time and not all agreed with his theories. One of his critics was German neurologist Hermann Oppenheim, whose interest in neurosis led to a correspondence with Charcot while Oppenheim was researching at a Berlin training hospital. Oppenheim conducted patient observations similar to those of Charcot from 1883 and like his French mentor, Oppenheim concluded that the etiology of traumatic neurosis included both a physical and mental component. Where the younger German neurologist disagreed, however, was in the classification of traumatic neurosis.

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[39] Charcot quoted in Micale, "Jean-Martin Carcot and *les névroses traumatiques:* From Medicine to Culture in French Trauma Theory of the Late Nineteenth Century," 123.

[40] Micale, "Jean-Martin Carcot and *les névroses traumatiques,*" 125.

[41] Micale, "Jean-Martin Carcot and *les névroses traumatiques,*" 123.

Charcot purposefully designated traumatic neurosis as a subcategory of hysteria – sometimes referring to the condition as "traumatic hysteria" – because its symptoms so closely mirrored those of the female hysterics he encountered in his work. Oppenheim argued that traumatic neurosis was a discreet diagnosis separate from hysteria and governed by its own causes and outcomes. He warned against doctors placing too much emphasis on a patient's thoughts and emotions while neglecting to give attention to the traumatic event that contributed to the patient's condition. Oppenheim agreed with Charcot's assertion that a patient's experience of fear should inform the practitioner's understanding of traumatic neurosis, but Oppenheim believed that linking the condition to hysteria belied the importance of pathology when considering the condition. These disagreements of nosology would continue into the next century and would characterize much of the professional discourse on traumatic neurosis during World War I.[42]

Finally, any discussion of the theories surrounding the psychology of trauma at the end of the nineteenth-century must include a mention of Sigmund Freud. Like Oppenheim, Freud was an acolyte of Charcot's and he studied with the famous French neuropsychiatrist in Paris in the early 1880s. As a young neurologist, Freud worked with Charcot on his studies of hysteria, including the latter's research into the role of trauma. Whereas Charcot argued that a traumatic event could trigger a patient's predisposition to mental illness, Freud, however, came to believe that trauma itself could be the cause of psychic distress. He explored this hypothesis in *Studies in Hysteria* (1895), his first major work based on his observations of a series of female patients he diagnosed with hysteria. In the text, Freud described how the hysterical symptoms displayed by the women were connected to traumatic events early in their lives, especially during their

[42] Paul Lerner, "From Traumatic Neurosis to Male Hysteria: The Decline and Fall of Hermann Oppenheim, 1889-1919," in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, ed. Mark S. Micale and Paul Lerner (New York: Cambridge University Press, 2001), 143. See also Micale, "Jean-Martin Carcot and *les névroses traumatiques*," 116; Caplan, "Trains and Trauma in the American Gilded Age," 66-67.

childhoods. In particular, he focused on incidents related to sexuality. For Freud, these moments led to a repression of the unconscious, which he considered to be traumatic to the mind. This repression would then fester in the patient until it eventually manifested in mental illness such as the hysteria he observed in his female cases. As Micale explains, "Freud elevated the medical idea of trauma from secondary to primary etiological status." In this way, Freud expanded on Charcot's ideas about the psychological effect of trauma on the mind.[43]

Charcot, Oppenheim, and Freud's theories on traumatic neuroses built on the conclusions of others such as Erichsen and Page. As anthropologist and trauma scholar Allan Young noted in his research of this period, "There is no 'turning point' in the history of the traumatic memory. One looks in vain for a key discovery, or a paradigmatic experiment, or even a prophetic figure." What scholars find instead is a rigorous debate of ideas slowly moving towards what Micale describes as a "process of psychologization" in which the medical community and especially mental health professionals began to look away from the body and instead turned towards psychological processes within the mind to understand psychiatric suffering caused by trauma.[44]

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[43] Louis Breger, *Freud: Darkness in the Midst of Vision* (New York: John Wiley & Sons, 2000), 74-85, 111-117.; Micale, "Jean-Martin Carcot and *les névroses traumatiques*," 128-129. Historians must carefully contextualize Freud's role in shaping professional ideas about traumatic neurosis on the eve of World War I and during the conflict itself. Freud's theories about trauma were only just starting to take shape at the start of the new century and his international popularity – and that of psychoanalysis – would not come about until the interwar years. As historian Ben Shephard put it, "Freud had little directly to do with the war." Only after the war did Freud and others begin to draw connections between his theories on trauma, hysteria, and the war neurosis encountered by military psychiatrists during the war. Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2000), 104. Breger, *Freud: Darkness in the Midst of Vision,* 233-268. Mark Micale has an excellent historiographical discussion that challenges the primacy of Freud in the history of trauma studies, particularly during World War I. See Micale, "Jean-Martin Carcot and *les névroses traumatiques*," 134-136.

[44] Young, *The Harmony of Illusions,* 39.; Micale, "Jean-Martin Carcot and *les névroses traumatiques*," 123.

Conclusion

The approximately five decades between the end of the Civil War and the mobilization of U.S. forces for World War I witnessed dramatic changes in the practice of mental health in the United States. The field undertook a move towards professionalization, including new standards in education, training, and clinical practice. Young men eager to use new scientific principles to unlock the secrets of mental illness began to replace the isolated asylum superintendents of a generation earlier. This transition was not smooth and schisms erupted, most prominently in the rise of the subfield of neurology. But on the eve of World War I, American mental health practitioners were better prepared to meet the challenges of military mobilization as a result of these rapid – albeit sometimes disruptive – efforts at professionalization.

Additionally, while tensions may have existed between psychiatrists and neurologists, the post-Civil War period saw important advances in the professional understanding of mental illness, in part because of the explorations into the mind-body connection conducted by neurologists. Whereas psychiatric diagnoses were limited during the Civil War, as American soldiers prepared to fight in Europe the professional and even popular debates surrounding conditions like neurasthenia and traumatic neuroses had begun the process of expanding the definition of what it meant to be mentally ill and where the causes of those illnesses might derive. Significantly, the mental health community began to explore the psychological consequences of a traumatic event. While some psychiatrists and neurologists emphasized a somatic basis for any psychological sequelae, others such as Charcot and Oppenheim suggested a dual-pathology that encompassed the physical and the mental. Their perspectives on trauma were reflected a larger paradigm shift that began at the end of the nineteenth century when

psychiatrists – and increasingly the public– incorporated psychology and emotion into their understandings of mental illness. The popular discussions of nostalgia during the Spanish-American War exemplified this trend as well.

Despite the new attention to the psychological effects of trauma however, mental health professionals reached few conclusions. The lack of consensus on the nosology of traumatic neurosis would be apparent when psychiatric casualties during WWI brought the condition to the forefront of professional discussion and public concern once again. Psychiatrists from Europe and the United States would have to grapple with the role of trauma in psychiatric breakdown as they confronted thousands of soldiers presenting symptoms of psychological distress. Just as they did in the debates that emerged the effects of railway accidents on the brain, mental health practitioners would have to examine their long-held beliefs in the connections between mind and body.

CHAPTER FOUR: TRANSATLANTIC LEARNING: EARLY BRITISH OBSERVATIONS ON SHELL SHOCK AND THE AMERICAN EFFORT TO LEARN FROM THE EUROPEAN EXPERIENCE

Within the first few months of World War I, European medical professionals began to encounter an almost overwhelming number of psychiatric casualties. While mental breakdown was not unfamiliar or unexpected by these physicians, the number of casualties presenting with similar symptoms suggested to them that something new was at work. As early as January 1915, military doctors and a growing number of military psychiatrists began to quietly discuss the phrase "shell shock." Early British observations of shell shock reflected current professional beliefs surrounding traumatic neurosis that had begun in the previous decades when the profession examined the survivors of railway incidents and other traumatic events. Then as now, they emphasized a dual pathology – somatic and psychological – and argued for the role that predisposition played in whether or not a person developed a traumatic neurosis.

As the war continued, this professional discourse grew and interest in shell shock or war neurosis spread from France and Great Britain to the United States. Though America remained neutral for the time being, the mental health profession in the U.S. closely followed the developments overseas. A process of transatlantic learning developed as American psychiatrists undertook informal – and later, formal – observations of Allied military psychiatric practices to better prepare for an eventual U.S. mobilization.

This transatlantic exchange of ideas led psychiatrists and neurologists in the United States to three conclusions that shaped their profession's response to shell shock during WWI. First, war neurosis was a serious condition that could potentially have disastrous effects on the strength of the U.S. military overseas. Thus, the United States military needed an organized military psychiatry apparatus to respond. Second, while mental health practitioners disagreed on the role of psychological trauma in the development of shell shock, there was wide agreement that predisposition was related to the condition. This was in line with their existing belief about the etiology of traumatic neuroses. Their observations of shell shock throughout the war did little to challenge this belief. Indeed, it played a key role in the third and final conclusion that American psychiatrists reached through their careful review of the European experience.

Neuropsychiatrists in the U.S. came to believe that the failure of Europeans to adequately screen their recruits had contributed to the high number of psychiatric casualties that the French and British militaries now faced. To avoid this same mistake, they argued, the American military would need to adopt a rigorous screening procedure to identify and exclude men at risk of developing mental illness.

This chapter addresses the first two of these three conclusions. It describes the development of early ideas about shell shock in Great Britain and how these theories evolved into a larger professional discourse. Wartime exigencies then spurred American interest in this debate and led to U.S. mental health professionals undertaking their first organized effort at military psychiatry. Due in large part to the widespread professionalization that had occurred over the last few decades, American neuropsychiatrists were finally positioned to coordinate the kind of response that had eluded them during the Civil War and the Spanish American War.

Charles Myers, Frederick Mott, and Early Theories of Shell Shock in Great Britain

The death of Austrian Archduke Franz Ferdinand from an assassin's bullet set off a cascade of alliances and treaties among the great powers of Europe during the summer of 1914. The fighting, in what contemporaries referred to as the Great War, lasted from 1914 until the signing of an armistice on November 11, 1918. For four years, battles unfolded across Europe, Africa, the deserts of the Middle East, the waters of the North Sea and the Indian Ocean, and even the skies over European towns. Arguably, however, the most demanding fighting developed along the over four-hundred-mile-long front that bisected Western Europe. The Western Front was characterized by a series of muddy trenches where the combatants were sometimes separated by no more than a few dozen yards. Soldiers engaged in trench warfare encountered artillery barrages that could last for days or even weeks, snipers, barbed wire, and attacks across "no man's land" that tested the courage of the most hardened individuals. The hardships of the war were not limited to peril inflicted by the enemy. Men were also subjected to mud-filled trenches, exposure to the elements, diseases, and crushing boredom.[1]

It was evident early in the war that the fighting would be brutal. During 1914, Germany recorded more deaths per month on the Western Front than during any other point in the war. Forty thousand Frenchmen died between August 20 and August 23, 1914 in fighting near the Belgian border. Twenty-seven thousand of those deaths occurred on a single day. From the outset, military doctors on both sides confronted a wide array of challenges that included everything from controlling the spread of disease and implementing rules of sanitation, to

[1] There is a vast body of historical literature on World War I. For a good overview see Hew Strachan *The First World War*, vol. 1, *To Arms* (Oxford: Oxford University Press, 2001).; Hew Strachan, *The First World War* (New York: Viking, 2004). There are numerous histories of WWI that describe life in the trenches. An excellent example is John Ellis, *Eye Deep in Hell: Trench Warfare in World War I* (Baltimore: Johns Hopkins University Press, 1989).

establishing lines of supply and evacuation for casualties. They performed these duties in addition to the important medicals tasks of treating the wounded that arrived at hastily established dressing stations and hospitals. Doctors confronted bodies riddled by shrapnel from high velocity shells, limbs torn off by machine gun fire, and eventually lungs burned by gas. Even the earth men dug into or piled around themselves in desperation to escape the reach of the enemy proved deadly. The farming fields of France and Flanders, where so much of the fighting took place, were laced with bacteria-rich manure. While no battlefield is sterile, British military doctors were unprepared for the number of cases of tetanus, septicemia, and especially gas gangrene that resulted from the microbe-laden dirt working its way into wounded bodies.[2]

Medical officers confronted more than just physical illness and wounds. Within months of the opening battles of the war, military leaders and doctors faced a growing number of men presenting symptoms of mental distress. In December 1914, the Director General of the Army Medical Services in London received a report that suggested nearly ten-percent of officers and three-percent of other servicemen in the hospitals near Boulogne, France suffered from mental breakdowns. Alarmed, the Army Medical Services responded by dispatching a London neurologist to investigate. Dr. Alden Turner reported back about patients seemingly paralyzed as

[2] Strachan, *The First World War*, 164.; Strachen, *The First World War,* vol. 1, *To Arms*, 230.; Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 27-32. There is a dearth of comprehensive studies of military medicine during World War I. As Harrison notes, the historiography is fragmented by smaller studies of particular medical issues, with shell shock being the most dominant. His book stands out for its comprehensive approach to the evolution of the Royal Army Medical Corps during World War I and the challenges encountered by an infant medical service in the face of mechanized warfare. Emily Mayhew's *Wounded: A New History of the Western Front in World War I* (2014) offers an interesting look at the experiences of British medical workers, chaplains, volunteers, and wounded soldiers during WWI. She describes her book as an "unconventional history," as opposed to a volume seeking to create "a comprehensive overview of the planning and process of medical care." Emily Mayhew, *Wounded: A New History of the Western Front in World War I* (Oxford: Oxford University Press, 2014), 2. The single best source for American military medicine in WWI remains the fifteen volume official history of the war published by the Surgeon General of the United States in the 1920s, *The Medical Department of the United States Army in the World War*.

a result of shell fire. He was unable to stay in France and research the problem further, but he recommended another psychologist, Charles Myers, continue in his stead. Myers was a fortuitous recommendation. Not only was he a well-respected psychologist, but he also had a familiarity with the symptoms witnessed by Turner. In fact, Myers had recently written a piece for the *Lancet* discussing his early experiences with the disorder, which he called "shell shock."[3]

Contemporaries and historians agree that Charles S. Myers popularized the term shell shock.[4] Myers, a Cambridge educated British psychologist, embodied many aspects of the

[3] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2000), 21.; Charles S. Myers, *Shell Shock in France* (Cambridge: Cambridge University Press, 1940), 14-15. It is difficult to determine the exact number of British shell shock casualties during the war because of the unorganized way in which the military and medical profession applied the diagnosis. The compilers of the official medical statistics for Great Britain tentatively reported 80,000 cases of shell shock in army hospitals and approximately 30,000 men sent to institutions as a result. Officials in charge of military pensions after the war placed the number closer to 200,000 but even they suggested the number of actual cases was likely higher. Martin Stone, "Shellshock and the Psychologists," in *The Anatomy of Madness: Essays in the History of Psychiatry* vol. II, ed. W.F. Bynum, Roy Porter, and Michael Shepherd (New York: Tavistock Publications, 1985), 249. Peter Leese summarizes the challenge of gathering accurate statistics on shell shock in Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (New York: Palgrave Macmillan, 2002), 9-10.

[4] Tracey Loughran, "Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories," *Journal of the History of Medicine and Allied Sciences* 67 (2012): 105. Myers believed himself to be the originator of the term, writing after the war "I must have been one of the first to use the term 'shell shock,' which has since deservedly received adverse criticism." Charles S. Myers, *Shell Shock in France*, 12-13. There is a substantial literature on shell shock and Great Britain during World War I. Examples include: Martin Stone, "Shellshock and the Psychologists," 242-271.; Peter Leese, "'Why Are They Not Cured?' British Shell-Shock Treatment During the Great War," in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age 1870-1930*, ed. Mark S. Micale and Paul Lerner (New York: Cambridge University Press, 2001), 205-221.; Peter Leese, *Shell-Shock: Traumatic Neurosis and the British Soldiers of the First World War* (London: Palgrave, 2002).; Tracey Loughran, "Shell Shock and Psychological Medicine in First World War Britain," *Social History of Medicine* 22 (2009): 79-95. For discussions that contextualize the British experience within the larger history of shell shock, see Shepard, *War of Nerves*, 1-169.; Loughran, "Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories," *Journal of the History of Medicine and Allied Sciences* 67 (2012): 94-119. Other scholars have used shell shock, and psychological trauma more broadly defined, as a window through which to better understand the British experience for the First World War. See, for example, Paul Fussell, *The Great War and Modern Memory* (Oxford: Oxford University Press, 1975).; Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (Chicago: University of Chicago Press, 1996). I used this rich historiography to explore the professional understanding about shell shock in the years before U.S. involvement in WWI. Just as neuropsychiatrists in the United States built on the work of their European colleagues to craft the American response to shell shock, I extend some of the historical arguments about the British experience – particularly those made by Tracey Loughran – to examine the evolution of American ideas about the psychological trauma of war. The historiography of the

scientific turn of the mental health profession prior to the start of war. Though he was a doctor he rarely saw patients. He instead directed his attention to science and the education of future mental health professionals. He helped run the psychology department at the University of Cambridge, produced the well-received *Textbook of Experimental Psychology*, and personally paid to outfit a Cambridge laboratory with the latest in scientific equipment. When the war began, patriotism called him into service, though at the age of forty-one he was "politely informed" by the War Office that his services were not needed. As an administrator at Cambridge he was renowned for his networking skills and through his social connections he was able to gain a posting at a hospital in France sponsored by a wealthy British noblewoman. Thus in October 1914, Myers found himself near the thick of the fighting in the earliest months of the war. Shortly after his arrival, he toured the Salpêtrière hospital where he encountered French soldiers with functional disorders such as paralysis and mutism. After returning to his hospital, British soldiers began to arrive presenting a similar cluster of symptoms. Myers observed these men during the winter of 1914 and submitted an article to *The Lancet* describing some of his initial findings. He eventually wrote a series of articles on shell shock, the first was published in the February 13, 1915 issue, while the final appeared in the same renowned journal after the war ended in January 1919. His initial article, partly because of its release early in the war, quickly acquired a wide-ranging influence on his colleagues, as well as future scholars of the First World War. [5]

The phrase "shell shock" was in circulation before Myers's first piece appeared. Indeed, the title of the article: "A Contribution to the Study of Shell Shock," suggests that Myers

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American experience with shell shock is not nearly as extensive as the body of scholarship about the British perspective. In this way, the transatlantic learning must continue.

[5] Myers, *Shell Shock in France*, 2-4, 12-13.; Ben Shepard, *A War of Nerves*, 21-22.

believed his medical audience would have some familiarity with the term. One month before Myers's article, British surgeon Gilbert Barling of the Royal Army Medical Corps published in the *British Medical Journal* a description of the war wounds he encountered at the 1st Southern Hospital. In his tally of patients, Barling noted "only one case of shell shock has come under my observation." The man in question was a Belgian officer who, after surviving a shell blast without any sign of physical injury, lost control of his lower extremities. Barling struggled to treat the man and eventually had him transferred to another hospital. He warned that "unless proper provision is made for the treatment of such cases" that recovery for men like the Belgian officer might be impossible.[6] Other doctors drew connections between shells, concussions, and functional disorders, though they did not employ the phrase "shell shock." At a November 1914 meeting of the Medical Society of London, a military physician described the case of a marine who was buried by a shell blast and reported to a field hospital unable to speak or hear. The doctor discovered no physical injury. Doctors at another British hospital reported "several cases of concussion of nerves," including a man whose face became paralyzed when a shell exploded nearby. They also noted a soldier who presented with total memory loss beyond his name and the name of his regiment despite having no physical injuries. They concluded the man "had had some severe shock."[7]

Myers was not the first doctor to suggest shell shock or a link between traumatic injury and functional disorder. But he – or at least his article – was among the first to single it out for

[6] Gilbert Barling, "Surgical Experiences at the 1st Southern General Hospital, Birmingham," *British Medical Journal* 1 (January 1915): 192.

[7] "The Surgical Experiences of the Present War," *British Medical Journal* 2 (November 1914): 891-892.; "Home Hospitals and the War," *British Medical Journal* 2 (December 1914): 992-993. See also Loughran, "Shell Shock, Trauma, and the First World War," 105. The fact that Myers met with French neuropsychiatrists at the Salpêtrière hospital to observe symptoms of functional disorders in soldiers suggests that other military psychiatrists were engaging with the condition early in the war as well.

special consideration among the broader concerns of military medicine during WWI. The February 1915 piece presents the cases of three soldiers whom Myers felt showed a "remarkably close similarity." Each of the men survived a nearby shell blast, either thrown some distance by the explosion or buried by the resulting debris. One patient described the blast to Myers as feeling "like a punch on the head, without any pain after it." Myers catalogued a number of symptoms in the men, ranging from sleeplessness and memory loss to physical symptoms such as the loss of taste, smell, and sight. It was the last that interested Myers perhaps the most. The article contains graphs and charts tracing changes in the men's visual acuity as he treated their condition with hypnotism. He also discussed experiments in which he exposed one of the men to strong smells and tastes such as peppermint and carbolic acid to study whether or not the substances could invigorate the soldier's missing senses. The results were mixed, but Myer's dutifully noted them all for his reader. [8]

In addition to testing for physical responses, Myers explored his patients' psyches as well. He applied techniques of hypnosis and "treatment by suggestion" in an effort to both uncover and treat the soldiers' hallucinations and memory loss. Over the course of multiple sessions, Myers and his associates used hypnosis to encourage the men to remember their war experiences. He tracked the recollections of the patients and recorded gradual increases in memory restoration as well as better quality of sleep. Observed over a century later, the processes Myers described in "A Contribution to the Study of Shell Shock" serve as an excellent

[8] Charles S. Myers, "A Contribution to the Study of Shell Shock," *The Lancet* 185 (February 1915): 316-320.

example of the intersection between science and the practice of mental health care that characterized much of the profession at the start of the war.[9]

Despite all of his testing, a ready answer to his patients' suffering failed to present itself. Myers refrained from offering any firm conclusions or recommendations based on these cases aside from suggesting that rest and hypnotism led to "gradual improvement." He also stopped short of categorizing the cases as either physical or psychological in nature. To Myers, the data seemed contradictory. He noted that shell explosions were loud and dusty, but mostly odorless; yet, his patients lost their sight and sense of smell while their hearing was only marginally impaired. "It is therefore difficult to understand," he wrote, "why hearing should be (practically) unaffected, and the dissociated 'complex' be confined to the senses of sight, smell, and taste (and to memory)." This ambiguity prompted Myers to tentatively suggest a psychological component. "The close relation of these cases to those of 'hysteria,' appears fairly certain."[10]

Myers's frustration and uncertainty would be shared by his colleagues. The professional discourse on shell shock and war neuroses that developed during WWI was rife with conflicting views on the cause of the condition and the best forms of treatment. In this way, Myers was also a trailblazer, though certainly an unwitting one. His article anticipated the tension between the two opposing viewpoints: those who searched for a somatic explanation to the symptoms and those who sought answers by looking to the mind – particularly the role of fear, emotion, and trauma. The views of the latter would eventually prevail in shaping the professional

[9] Myers, "A Contribution to the Study of Shell Shock," 316-320.

[10] Myers, "A Contribution to the Study of Shell Shock," 316-320.

understanding of the psychological trauma of war during WWI, both in the final years of the war and in the following decades. But even this simple dichotomy included additional caveats and disagreements, particularly about the role of predisposition, which prevented mental health professionals from fully examining the impact of trauma on mental well-being.[11]

An early example of the somatic explanation can be found in the research and publications of Frederick Mott. Mott, like Myers, was an advocate for the professionalization of mental health practitioners. He was an early member of the British Psychological Society, lobbied for accreditation programs at English universities and encouraged scientific exploration to explain psychiatric disorders. He gained early prominence for his pioneering research into the effects of syphilis on the brain, an insight he gained through dissecting the brains of asylum patients in London. When confronted by shell shock casualties at the Maudsley Hospital in Great Britain in 1915, Mott looked immediately to the brain in order to understand the condition.[12]

In 1916, the Medical Society of London asked Mott to deliver the annual Lettsomian Lectures. In a series of talks entitled "The Effects of High Explosives on the Nervous System," Mott laid out his belief that exposure to shelling physically altered the nervous system and produced the symptoms of some forms of shell shock. He argued that the central nervous system of the human body existed within a carefully pressurized system of cerebro-spinal fluid that served "as a perfect protective mechanism" for the brain and other bodily functions controlled by nerves. This delicate balance was at risk, however, when exposed to artillery shelling. "When

[11] Loughran, "Shell Shock and Psychological Medicine in First World War Britain," 87.

[12] Edgar Jones, "'An Atmosphere of Cure': Frederick Mott, Shell Shock, and the Maudsley," *History of Psychiatry* 25 (2014): 412-413, 418.; Tracey Loughran, "Shell Shock and Psychological Medicine," 86.; Shephard, *A War of Nerves*, 30.

large quantities of these high explosives are detonated an enormous aerial compression is instantly generated," he stated. Mott believed this compression "may be transmitted to the fluid about the base of the brain and cause shock," negatively affecting the functions of the brain, the lungs, and the heart. Mott referred to this as "commotion from aerial compression." He theorized that one effect of the change in pressure was to "liberate nitrogen suspended in the blood and transform it into bubbles of gas" that were then driven through the body and resulted in "instant death."[13]

In addition to "commotion," Mott drew on a previous research interest into the dangers of carbon monoxide poisoning to suggest another possible threat from proximity to shelling: poisoning as a result of burial. "These high explosives generate considerable quantities of CO," he warned. The odorless gas posed a special risk to men trapped in enclosed spaces during shelling, either in trenches or worse, buried as the result of a nearby explosion. The soldier, unconscious or conscious but pinned under the weight of dirt and debris, would breathe in the noxious gas as it seeped into the ground and hung in the air around him. Mott argued that the symptoms of shell shock resembled those of carbon monoxide poisoning, including headaches, ringing in the ears, hallucinations or blindness, "mental confusion," and memory loss. When he examined the brain of a soldier designated as a "fatal case of shell shock with burial," he found histological changes similar to those of the brain of a woman who committed suicide by carbon monoxide inhalation. The resulting similarities led him to recommend soldiers reporting

[13] Frederick W. Mott, "The Effects of High Explosives Upon the Central Nervous System: Lecture I," *The Lancet* 187 (February 1916): 332.; Frederick W. Mott, "The Effects of High Explosives Upon the Central Nervous System: Lecture II," *The Lancet* 187 (February 1916): 448.

symptoms of shell shock after burial have their blood tested for elevated levels of carbon monoxide.[14]

Historian Tracey Loughran refers to Frederick Mott as the "champion" of physical theories of causation in the professional debates about shell shock during WWI. She argues that Mott "would become the leading proponent" of such models and contends that "Mott's writings played a vital part in convincing other doctors of the validity of physical theories of causation." Loughran cites numerous examples of British neuropsychiatrists who themselves cited Mott in their own somatic explanations of shell shock. As we shall see, Mott's work also reverberated across the Atlantic with American psychiatrists, psychologists, and neurologists trying to comprehend the shell shock phenomenon. However, Loughran does not discuss the extent to which Mott also embraced psychological explanations for shell shock.[15]

A review of Mott's lectures clearly suggests his firm belief that explosions caused by artillery shells could negatively affect the physical processes of the body. This was a position that Mott held long after the war ended and after most others in the profession had embraced a psychological etiology for shell shock. But he also saw ways in which the same shelling could

[14] Mott, "Lecture I," 332.; Mott, "Lecture II," 441-442.; Mott, "The Effects of High Explosives Upon the Central Nervous System: Lecture III," *The Lancet* 187 (March 1916): 547. 549.

[15] Loughran, "Shell Shock and Psychological Medicine," 86. A more complete discussion to include Mott's interest in the psychological would have served as further evidence to Loughran's argument that, in the early years of the war, the medical discourse on shell shock reflected a belief that physical and psychological damage were present in most cases of the disorder. Instead, she argues that Mott's adherence to the physical is part of a response by the medical community to find more defined explanations for war neuroses once it was clear that "shell shock" – both the label and the condition – was too vaguely defined. She identifies 1916 as a key year in which this transition occurred, in part because Mott's publications, stating that "a trend towards differentiation of psychological and physical disorders was now apparent." Loughran, "Shell Shock and Psychological Medicine,", 85-86. But a close reading of Mott suggests that might not have been the case. Shephard's discussion of Mott's theories is limited to only a few sentences, but he does identify Mott's interest in the psychological as well as the physical. Shephard, *A War of Nerves,* 29-31. Edgar Jones attempts a more complete analysis of Mott in his article, "'An Atmosphere of Cure': Frederick Mott, Shell Shock, and the Maudsley." Jones challenges the view of Loughran and others that Mott was only interested in the physical explanations for shell shock. He frames Mott's views within the neurologist's larger body of research and describes Mott's methods of treatment as a window into latter's views on neurology. For Jones's analysis of other historians views on Mott, see Jones, "'An Atmosphere of Cure,'"413.

lead to a psychological response that could also contribute to symptoms of shell shock. Early in his first lecture he noted that "apart from the effects produced by direct material injury to the central nervous system," doctors needed to be cognizant of the "moral effect" caused by high explosive shells. The "moral effect" resulted from "continued anxious tension of what may happen… combined with the terror caused by the horrible sights of death and destruction." Mott argued such a state of fear and anxiety "tends to exhaust and eventually even shatter the strongest nervous system." He reiterated this point in his final lecture, stating "it is a fact that trauma accompanied by horrifying circumstances, causing profound emotional shock and terror, has a much more intense effect on the mind than simple head injury would cause." He pointed to the terrifying dreams of shell shock victims and instances of hysterical mutism as evidence of the impact of psychic trauma.[16]

For Mott, the physical and the psychological were closely linked in the etiology of shell shock. He believed that iterations of the condition should be viewed as a form of neurasthenia, arguing that except in the most severe cases of shell shock, the symptoms "accord in the main to those of the two common types of functional neurosis, hysteria and neurasthenia." Recall that many doctors believed neurasthenia resulted from an exhaustion of nervous energy, though they often debated the causes of the depletion of nerve strength. Mott maintained that the harshness of war or the effects of high explosive blasts could be precipitating factors of a neurasthenic state. He posited that trench-life in combination with "fearful tension and apprehension" could "lower the vital resistance of the strongest nervous system" and theorized that some symptoms of shell shock such as "weariness" and "mental fatigue," resulted from the soldier "drawing on the

[16] Mott, "Lecture I," 331.; Mott, "Lecture III," 545.

reserve of neuro-potential." The condition was compounded when the sufferer was kept awake by nightmares and anxiety, preventing the "automatic renewal of nervous energy."[17]

Mott did not blame environmental factors alone. He also argued strongly for the role of predisposition in marking men as more likely victims of shell shock. Mott's definition of predisposition was broad, however, and extended beyond simply hereditary nervous weakness. He categorized the physical and psychological states of his patients at the moment of "shock" into two classifications: "inborn" and "acquired." His research at Maudsley Hospital led him to conclude that soldiers with "an inborn timorous or neurotic disposition" were "more liable" to develop the symptoms of shell shock. He considered men with an inherent "psychopathic taint" less able to withstand not only the psychological stress of war, but the physical strain as well.[18]

Mott claimed, however, that there was an additional, smaller group of sufferers whose susceptibility could not be explained by a hereditary condition. These men, Mott theorized, were debilitated by an acquired weakness of the nervous system. He suggested alcohol or syphilis as possible catalysts, but that did not explain the patients who claimed perfect health before succumbing to shell shock. Mott attributed their symptoms to mental exhaustion caused by the war itself. "A neuro-potentially sound soldier in this trench warfare may from the stress of prolonged active service acquire a neurasthenic condition," he said. This was a "cumulative effect," he argued, that resulted from "repeated and prolonged exposure to shell fire and projectiles containing high explosives." Mott believed that the experience of surviving war created a pre-existing condition in some soldiers in much the same way that hereditary predisposition weakened the nervous systems of others. He reiterated that this was not the case

[17] Mott, "Lecture II," 448.; Mott, "Lecture I," 336.; Jones, "'An Atmosphere of Cure,'" 414-415.

[18] Mott, "Lecture II,"448.; Mott, "Lecture I," 331.; Mott, "Lecture III," 545.; Jones "'An Atmosphere of Cure,'" 415.

for the majority of sufferers and that most often, a heredity weakness could be identified. Nonetheless, this theory allowed him to explain to his audience why healthy soldiers could be victims of shell shock.[19]

The research conducted by Charles Myers and Frederick Mott into the etiology of shell shock reflects the uncertainty that characterized the professional understanding of the condition in Great Britain during the early years of the war. Despite the mental health profession's embrace of scientific processes, no easy explanation appeared to account for the suffering of thousands of soldiers. Instead, specialists like Mott suggested etiologies that moved between physical and psychological catalysts. Even Myers, who eventually supported a psychological explanation of shell shock, admitted that early on, he was persuaded that physical causes played a role. When he reflected on his famous *Lancet* articles almost twenty-five years later, Myers argued that even in his original theories he emphasized that shell shock was a psychological and not a physical malady. In perhaps a bit of professional pique, he asserted that unlike Frederick Mott, he never believed that the condition was caused by lesions or physical injury to the brain. "I attributed [shell shock]…. to mental 'repression' and 'dissociation;" he wrote in 1940. But, he admitted, "I was at first by no means convinced that all cases of 'functional dissociation' arose *solely* from mental causes." He conceded that he was "inclined to lay some emphasis on the physical shock produced by the bursting of a shell as a prime cause of the 'dissociation.'" At least initially, Myers, like Mott, sought the cause of shell shock in physical alterations to the body and theories reflected an interaction between the psychological and the physical.[20]

[19] Mott, "Lecture I," 331.; Mott, "Lecture II," 448.

[20] Myers, *Shell Shock in France,* 12-14 [emphasis in the original]. For Myers's belief in the role of emotion and fear in causing war neuroses, see Myers, *Shell Shock in France,* 36.

Myers was just one of many British mental health professionals and physicians who embraced a psychological explanation of shell shock. Indeed, by the time Mott gave his lectures in early 1916, observers in Great Britain were inclined to give credence to fear and trauma as the causative factors of the condition. One such example of this can be found in a December 1915 article published by British physician David Forsyth. The piece, which appeared only two months before Mott's Lectures were recorded in the same publication, encouraged the study of psychological trauma over physical trauma in order to explain the etiology of shell shock.

While Forsyth's thoughts on shell shock and war neurosis did not receive the same attention in professional circles as those of someone like Charles Myers or Frederick Mott, his article remains interesting to historians for a number of reasons. First, the piece explores the nature of the condition by contextualizing it within the professional understanding of railroad spine and traumatic neurosis, suggesting that Forsyth saw shell shock as part of an ongoing professional dialogue to understand "the nervous effects of intense emotional strain." Unlike his counterparts who sought the cause of shell shock in the uniqueness of modern war, Forsyth defined the impetus more broadly by linking shell shock sufferers to civilians who developed similar symptoms following work place accidents, fires, or collisions. If Forsyth saw war as offering any sort of special circumstance, it was the opportunity it provided for psychiatrists and neurologists to undertake the study of a large group of patients – what he referred to as a "surplusage of material – presenting similar symptoms.[21]

In addition to contextualizing shell shock within the larger professional discourse on psychological trauma, Forsyth made a number of observations and asked questions that foreshadowed many issues and concerns medical professionals, traumatologists, and historians

[21] David Forsyth, "Functional Nerve Disease and the Shock of Battle: A Study of the So-Called Traumatic Neuroses Arising in Connexion with the War," *The Lancet* 186 (December 1915): 1400.

debate a hundred years later. For example, while he reiterated the psychological damage that resulted from "the ghastly sights of carnage" caused by modern war, he expanded his definition of trauma to include any life-threatening event. He wrote, "At the time of trauma, whether it is concentrated into a few moments or spread over days and weeks, the situation to be met derives its psychical importance from the fact that it involves the risk of death." Nearly one hundred years later, the American Psychiatric Association would list a person either being exposed to – or threatened by – death as the first criterion of Post-Traumatic Stress Disorder in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (2013). Among his prescient questions, Forsyth pondered why two individuals who experienced the same trauma developed different symptoms or sometimes none at all. He also asked whether a person's state of mind at the moment of trauma affected the severity of the resulting neurosis. He had no good answers to these questions in 1915 and scholars continue to examine them in the twenty-first century.[22]

The medical discourse in Great Britain on the etiology of shell shock in the early years of the war reflected the continued professional debate over the cause of traumatic neurosis. However, by 1917, theories that linked shell shock to emotion and not pathology dominated British medical literature. There was no one observation that led the profession to coalesce around this opinion and some, like Mott, continued to emphasize physical factors. But even Mott admitted that psychological trauma could have a profound impact on the mind.[23]

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[22] The 2013 definition of PTSD can be accessed at PTSD: National Center for PTSD, DSM-5 Criteria for PTSD, https://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp, accessed 9/4/2017.; For a good summary of recent debates in traumatology see Nigel C. Hunt, *Memory, War, and Trauma* (Cambridge: Cambridge University Press, 2010), 50-60.

[23] Loughran, "Shell Shock and Psychological Medicine," 87. For an excellent example of how the theories of British psychiatrists and neurologists about shell shock reflected a combination of physical and psychological explanations see: Frederick Mott, "Special Discussion on Shell Shock Without Visible Signs of Injury," *Proceedings of the Royal Society of Medicine* 9 (1916): i-xliv. Frederick Mott presented some of his ideas on the causes of shell shock before the Royal Society of Medicine in January 1916, followed by discussion from those in

As the war continued and the number of psychiatric casualties increased, the scope of the conversation about the condition expanded to include military leaders, the public, and members of the British government. Despite all of the interest, however, there were few clear answers. Medical professionals disagreed on the causes of shell shock, its symptoms, its treatments, and even its name. For American psychiatrists and neurologists watching these developments from across the Atlantic, the only certainty was that if the United States became involved in the war – a possibility that seemed increasingly likely to many observers – then American soldiers would fall victim to this condition as well. With that in mind, American professionals entered the fray.

American Psychiatrists Examine the Allied Experience

On August 4, 1914, as the British government officially announced its declaration of war on Germany, President Woodrow Wilson made a declaration of his own: the United States would remain neutral in the developing conflict. America at the start of the twentieth century had political and economic relationships with belligerents on both sides. Wilson was also the leader of a country swelling with first and second generation immigrants, many of whom still had ties to their European country of origin, whether that was England, France, or Germany. Perhaps most of all, Wilson saw the rapidly unfolding events of the summer of 1914 as a failure of diplomacy and he was not eager for the United States to join the rush to war. While he

attendance. The transcript reveals that Mott's colleagues concurred with some of his theories surrounding the physical antecedents of shell shock, but many also stated strong support for the role of emotion and even trauma as the foundation of the condition.

undertook efforts to restore peace in Europe, Wilson implored Americans "to act and speak in the true spirit of neutrality."[24]

Neutral or not, American politicians, military officials, and eager citizens closely followed developments in Europe and generally with an anti-German bias. The medical and mental health communities were no exception. Professional medicine was still in its youth in America in the 1910s and many practitioners maintained close ties with colleagues and institutions overseas. The advent of war all but halted the interchange of psychiatric research with Germany and Austria, and nationalist sentiment among the American medical community even caused some psychiatrists to question the validity of any early research conducted by German psychiatrists. This tendency accelerated when the United States joined the Allied Powers in 1917. In his Presidential Address at the Seventy-Fourth Annual Meeting of the American Medico-Psychological Association in July 1918, Dr. James V. Anglin, a Canadian psychiatrist from New Brunswick, openly lambasted German doctors and psychiatrists. Against the backdrop of a service flag — a gift from the host city of Chicago — decorated with nearly one hundred stars to honor some of the Association's members serving in the military, Anglin declared that, for all its horror and destruction, at least the war would bring about the decline of "the tendency to Pan-Germanism in medicine." He accused German researchers of fraudulent work and charlatanism. "On a slender basis of achievement," he proclaimed, "they have contrived to impress themselves as the most scientific nation. Never was there greater imposture." Anglin reserved his harshest rebuke for his own profession. "It is especially in mental science that the reputation of the Germans is most exalted and is least deserved." He

[24] 63 Cong. Rec. S14042 (daily ed. August 20, 1914)(statement of the President); Jennifer D. Keene, *World War I: The American Soldier Experience* (Lincoln: University of Nebraska Press, 2011), 5.; "President Wilson Proclaims Our Strict Neutrality; Bars All Aid to Belligerents and Defines the Law," *New York Times,* August 5, 1914.; "President Moves for Mediation," *New York Times,* August 6, 1914.

continued, "Alienists have been infatuated with German pseudo-discoveries. Novelty of terminology has been taken for originality of thought and their works on insanity have been accorded undue authority. We ignored the substance in our own and the Motherland, and chased the mirage on the Continent." Anglin argued that now was the time for American doctors and psychiatrists, "with no misgivings as to [their] qualifications for leadership," to create "a center of medical activity" in the United States. "If we learn to know ourselves, great good will come out of this war," he concluded. In a review of Anglin's address in the *American Journal of Insanity*, the Editors labeled the speech a "stirring appeal to patriotism" that roused the audience to "a high pitch of enthusiasm." For the first time, the American mental health community was organized and applying their collective knowledge to the aid of America's fighting men.[25]

Though American psychiatrists turned their backs on their German colleagues, they closely monitored the experiences in England and France. In the decades before the professionalization of medicine in the United States, American doctors traveled back and forth to Europe for education and training. While the war limited interactions between U.S. and German psychiatrists, the interchange of ideas between American and other European doctors continued apace. If anything, the shared discourse intensified as U.S. psychiatrists watched with growing horror the increasing number of psychiatric casualties overseas. Despite President Wilson's protestations of neutrality, Americans at the end of 1915 had begun to realize that U.S. involvement in the war was likely inevitable. While many citizens held out hope that American

[25] James V. Anglin, "Presidential Address," *American Journal of Insanity*, 75 (July 1918): 7-9.; "Notes and Comment," *American Journal of Insanity* 75 (July 1918): 187. The editors of the *Journal of the American Medical Association* announced in January 1919 that the war – "notwithstanding the censor and the U-boat" – had had limited impact on their ability to gather foreign journal articles during 1918. As a result they would be able to provide their usual index to their members. However, they noted, "of course" no entries would appear from Germany and Austria, though there would be a handful of articles published in German. The editors assured their readers that the pieces actually reflected work conducted by Swiss scholars and some research exchanged with physicians located in Japan. "Our Foreign Exchanges in 1918," *Journal of the American Medical Association* 72 (1918): 197-198.

participation could be limited only to economic or materiel support, the country began to slowly prepare for a military confrontation in Europe.[26]

Much like the military, the American psychiatric community also undertook the study of its enemy in order to formulate the best strategy for victory. Though, in the case of the medical profession, there is, perhaps, a better analogy, as the editors of the *Boston Medical and Surgical Journal* wryly reminded their readers, "As in preventative medicine, one of the often effective methods of averting an evil is to take intelligent measures for meeting it." The APA history of the war put it more bluntly. "It was imperative," psychiatrist Edward Strecker wrote in 1944, "that we learn what there was to be learned from the neuropsychiatric experiences of our Allies."[27]

American psychiatrists and neurologists had a variety of mechanisms for following the mental health crisis unfolding during the war underway in Europe. They could read about it in French and British medical journals that traveled across the Atlantic or in the articles from European journals that were subsequently reprinted in American journals. Sometimes American doctors and psychiatrists summarized European research and offered some comments for their colleagues. E.E. Southard, for example, wrote a review of Frederick Mott's Lettsomian lectures for *Mental Hygiene*, a respected medical journal within the mental health community. Southard was a prominent neurologist and Director of the Psychopathic Hospital in Boston. He wrote that Mott's lectures "contain much of interest" and presented a detailed recounting of Mott's theories

[26] Michael S. Neiberg has an excellent discussion of the changing American attitude toward U.S. involvement in WWI. He considers late-1915 as the moment when the public position on the viability of neutrality began to shift towards reluctant acceptance of some form of U.S. intervention. Military build-up started as early as 1916, coinciding with the increased interest of American psychiatrists in military psychiatry. See Michael Neiberg, *The Path to War: How the First World War Created Modern America* (New York: Oxford University Press, 2016), 39-66, 122-150.

[27] "Preparation for War," *Boston Medical and Surgical Journal* 176 (February 22, 1917): 283.; Edward Strecker, "Military Psychiatry: World War I," in *One Hundred Years of American Psychiatry,* ed. J. K. Hall et al. (New York: Columbia University Press, 1944), 385.

on predisposition, the physical causes of shell shock, and Mott's belief that "modern trench warfare" could incite a neurasthenic reaction in an otherwise healthy soldier. Southard did not offer an opinion on Mott's research, merely presenting it along with some descriptions of treatments employed at Maudsley. Southard recommended the reader consider the British publication *Shell-Shock and Its Lessons* by G. Elliot Smith and T.H. Pear's as "an interesting foil" to Mott's lectures.[28]

George Kirby was more forthright in his critique of Mott's views on shell shock. Kirby, the Director of Clinical Psychiatry at Manhattan State Hospital, wrote in a review published in the *Psychiatric Bulletin of the New York State Hospitals* that he found Mott's "presentation of the subject of shell shock … disappointing." He argued that Mott's attempts to tie functional neuroses to physical changes to the central nervous system "leads the author into a highly speculative field." Furthermore, Kirby charged, Mott "fails to furnish any new facts tending to support his contention." Most of all, however, Kirby disagreed with Mott's broad definition of what constituted a shell shock case. "The author apparently classes under shell shock all the various groups of nervous symptoms which arise from exposure to forces generated by the detonation of high explosives," he wrote. Kirby contended that Mott's large diagnostic umbrella meant that "cases of a totally different nature have been brought together for no apparent reason except that they have all been exposed to shell fire and present 'no visible signs of injury.'" The result, he felt, was a false equivalency between a soldier who died as a result of partial asphyxiation due to temporary burial and the soldier with "definite hysterical attacks developing during exposure to high explosives." Would the post-mortem findings of the former be truly

[28] E.E. Southard, "The Effects of High Explosives Upon the Central Nervous System: A Review of Mott's Lettsomian Lectures, 1916, and G. Elliot Smith's 'Shell-Shock and Its Lessons,'" *Mental Hygiene* 1 (1917): 397-405.

characteristic of the latter, Kirby asked; and what important research into the neuroses were lost by spending time studying what – to Kirby at least – was clearly physical trauma? Kirby's critique of Mott reflected his own professional bias towards a psychological approach to mental illness versus Mott's neurological. But his review also demonstrates that the debate over the physical or psychological etiology of shell shock took place in the United States as well.[29]

The American medical community was also informed by its members who traveled overseas and informally reported back their experiences. Henry Viets was one such observer. After graduating Harvard Medical School in 1916, Viets found himself in Great Britain as a Mosely Travelling Fellow, just as the magnitude of the psychiatric crisis was becoming apparent to military physicians. Fortuitously for Viets, as a part of his fellowship he was assigned to William Osler, the famous British clinician who was intimately involved with the British medical response to the war. While with Osler, Viets was able to witness British military medicine firsthand and report back to his American colleagues back home. The *Boston Medical and Surgical Journal* touted Viets as "our Special Foreign Correspondent" and published his observations of British war hospitals. He depicted a carefully controlled chaos, peppered by vivid details such as "a whole piazza full of amputation cases sunning their flap-less, open stumps." Amidst these descriptions, Viets tried to impart some observations of the more unique conditions encountered by British physicians. Chief among them was shell shock, which Osler told Viets was "one of the great problems of the war."[30]

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[29] George Kirby, review of "The Effects of High Explosives upon the Central Nervous System," Lettsomian Lectures by F.W. Mott, *Psychiatric Bulletin of the New York State Hospitals* 2 (1917): 393-397.

[30] "Obituary: Henry R. Viets, M.D.," *Medical History* 13 (Oct 1969): 394.; Henry Viets, "London War Hospitals," *The Boston Medical and Surgical Journal* 176 (Feb 1917): 222.

To better understand the condition, Viets visited Frederick Mott's Maudsley Hospital. He noted especially the modern equipment and laboratory found in the hospital and declared it "compares favorably" to hospitals back in the United States. But what caught his attention most of all were the patients, "perhaps the most interesting and remarkable cases which the war has produced." Mott accompanied Viet on his tour of the hospital and described some of the patients currently under treatment at Maudsley. Viet did not suggest his own views on shell shock in his report, except to say that "the whole question of 'shell shock' is yet to be elucidated." He did, however, describe Mott's views on the causes of shell shock, a combination of psychological exhaustion and physical changes to the body brought on by proximity to a shell blast. Viet did not go into great depth on Mott's theories and encouraged readers to review Mott's *Lancet* articles for a more complete understanding. He ended his observations on shell shock with an optimistic note, that in most cases the sufferers seemed to recover.[31]

Viets remained interested in the problem of shell shock and in October of 1917, presented a paper entitled "Shell-Shock: A Digest of the English Literature," before a staff meeting of the Boston Psychopathic Hospital. His lecture stemmed from the same period of research and observation covered in his initial piece for the *Boston Medical and Surgical Journal.* This time, however, Viets attempted to unravel – or at least fully describe – the "question of shell shock" that he found so difficult to articulate earlier in the year. For him, this lecture was no mere intellectual exercise. "In the last three years," he stated, "the neurologists and psychiatrists of the United States have viewed with interest the reports that have come to us from abroad regarding the remarkable war neurosis, shell-shock." These papers "excited our interest," Viets continued, but now that American soldiers were at risk, what had once been a mere curiosity was now a

[31] Henry Viets, "London War Hospitals," 223.

"problem … that demanded our serious attention." American doctors "ought to be fully acquainted with the data already accumulated by foreign workers in the three years of war," he announced as a way of framing his lecture. He summarized some of the findings of prominent British neuropsychiatrists – though he relied heavily on Mott – and delineated symptoms and treatments. He emphasized the growing consensus that predisposition to mental illness made a man more likely to fall victim to shell shock.[32]

On the issue of etiology, however, Viets was more circumspect; he never defined the cause of shell shock. Indeed, he admitted with some frustration, "it can be readily seen that the term 'shell-shock' is a blanket diagnosis to cover all the traumas disorders of the central nervous system without visible injury, occurring in modern warfare. The term is a poor one." But Viet's lecture suggested that he, like many by 1917, believed that the psychological trauma of war served as an important catalyst. He reiterated Mott's claims that CO poisoning could account for "a very small part of the vast number of cases" of shell shock, for example. But he also stated that "most neurologists" believed gas poisoning to be an "exceptional cause" of the condition. He underscored Mott's assertion that psychological stress wore down the nervous system and featured extensive quotations from David Forsyth's 1915 article in the *Lancet* that emphasized the horror of war and psychological trauma. Viets referred to the latter's article on shell shock as "one of the best" on the subject.[33]

The articles and informal observations overseas laid bare for the American mental health community the scope of the challenge they would confront when U.S. troops entered the war. Similar to their British colleagues, American psychiatrists viewed the etiology of shell shock in

[32] Henry Viets, "Shell-Shock: A Digest of the English Literature," *Journal of the American Medical Association* 69 (1917): 1779-1786.

[33] Henry Viets, "Shell-Shock: A Digest of the English Literature," 1780, 1783-1784.

light of their present understandings of mental illness and the role of trauma in psychological breakdown. Mental health professionals in the United States, like those overseas, struggled to define the causes of war neuroses as they considered both psychological and physical factors in relation to the condition. Regardless of this professional debate, American neuropsychiatrists recognized the severity of shell shock and its potential to wreak havoc on America's ability to wage a successful campaign in Europe. They also accepted that an effective response to this challenge would require more than passive observation. The mental health community needed to view firsthand the effects of shell shock on the mind and on the military. Only then could they create an organized military psychiatric effort to confront the looming threat.

To form a new system of medicine within the military, the psychiatrists turned to an existing professional organization. The National Committee for Mental Hygiene (NCMH) was founded in New York in February 1909 with an ambitious agenda. Its members – a combination of laymen, wealthy investors, and mental health professionals – sought to protect the mental health of the public. Reflective of the desire of the psychiatric field to move out of the asylums, the NCMH and the larger mental hygiene movement focused on preventing mental illness among the wider public. It was, historian Gerald Grob describes, "a broad-based crusade to create a better society." Or, as one of the movement's founding members put it, "attacking insanity, as such, is a small part of our work. Protecting *sanity* is the prime object." The NCMH undertook surveys of the conditions of institutionalized persons, published information regarding laws surrounding insanity, and worked to create uniform standards for statistical reporting of mental illness. When war broke out in 1914, the NCMH provided a professional, administrative, and financial framework on which to begin constructing the first military psychiatry apparatus.[34]

[34] Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 144-178. Clifford Beers quoted in Grob, *Mental Illness and American Society, 1875-1940*, 154. Emphasis in the

In its first step, the NCMH, at the request of the Surgeon General, began to oversee the effort of mobilizing the psychiatric profession, including the formal exploration of Allied procedures overseas and the current state of psychiatric state of psychiatric treatment in the U.S. military. Thomas W. Salmon was one of the leaders of these early examinations of American military psychiatry. Born in 1876 in a small town near Albany, New York, Salmon's father had been a country doctor and British naval surgeon. He followed in the path laid out by his father and graduated from Albany Medical College in 1899. He further attempted to emulate his father by opening his own country medical practice. The venture proved unsuccessful and to support his young family, Salmon took up a position as a bacteriologist at a psychiatric institution outside of Syracuse. His work garnered positive attention and helped him to secure a job with the New York State Health Department and the responsibility of overseeing bacteriology at all New York mental hospitals. His government service continued with a position with the U.S. Public Health Service and posting to Ellis Island. By 1904, he was overseeing mental health assessments for the thousands of new immigrants who passed through the famous landmark every year. This influx of new immigrant helped to fuel the national mental hygiene movement; thus, it was no surprise that Thomas Salmon came to the attention of Clifford Beers and the new NCMH. Salmon was a firm believer in the humane treatment of the mentally ill. While with the NCHM, he oversaw many efforts to improve psychiatric care and the treatment of sufferers. In 1915, while war raged overseas and psychiatric casualties mounted, Salmon was the medical director of the NCMH. In this position he divided his time between research and promoting the mental hygiene movement among wealthy donors and the general public. As medical director, his

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original. For a contemporary perspective on the goals of NCMH see Lewellys F. Barker, "The Wider Work of the National Committee for Mental Hygiene," *Mental Hygiene* 1 (1917): 4-6.

salary was paid by the Rockefeller foundation, a testament to Salmon's efficacy as a fundraiser and advocate for mental health issues in the United States at the start of the century.[35]

The formal partnership between the American mental health community and the military began with a March 1917 meeting between Surgeon General of the Army William Gorgas and Salmon, along with two of Salmon's NCMH colleagues, Stewart Patton and Pearce Bailey. Gorgas, like the psychiatric profession, had closely followed developments in Europe, including the high instances of mental breakdown among soldiers. He agreed with American neuropsychiatrists that preparation would be the key to limiting psychiatric casualties among U.S. forces. He encouraged the NCMH to continue its examination of the European experience and requested reports and recommendations on how best to formulate the American response to the mental health challenges they would likely face both at home and abroad.[36]

At the behest of the Surgeon General and with the support of the NCMH, the three men undertook an April 1917 tour of the medical facilities of U.S. Army installations along the Mexican border. Their inspection illuminated the current state of unpreparedness. They reported to Surgeon General Gorgas that incidents of mental illness among American soldiers along the border were three times higher than those reported among civilians in New York during the same period of time. "The excess among soldiers is still higher under war conditions," they warned and reminded Gorgas that rates of insanity in the Army had risen during the Spanish-American War versus the peacetime force. Drawing on this data, they theorized that if the army raised a force of 500,000 men and subjected them to combat conditions

[35] Manon Parry, "Thomas W. Salmon: Advocate of Mental Hygiene," *American Journal of Public Health* 96 (October 2006): 1741.; Shephard, *War of Nerves,* 123-124.

[36] Pearce Bailey, Frankwood E. Williams, and Paul O. Komora, "Organization," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 5.

similar to those on the Mexican border, military doctors could expect at least 4,500 psychiatric casualties per year. To put this in perspective for Gorgas, they stated that such a figure would likely exceed the number of patients institutionalized in the state of California in a given year. Privately, Salmon expressed his concern more overtly. He wrote to the Rockefeller Foundation that the military doctors along the Mexican border were "entirely unprepared to deal with the large number of serious mental and nervous cases coming to them." He was encouraged by the enthusiasm among medical officers for more organized psychiatric care for their patients, but he reiterated "some special provisions are urgently needed." What Salmon witnessed in the south did not fill him with confidence for the efficient or effective implementation of American military psychiatry in the more chaotic European theatre.[37]

The NCMH, and particularly Thomas Salmon, wanted a more systematic study of Allied military psychiatric operations. Salmon felt that the lack of preparation by British neuropsychiatrists prior to their entry into the war had led to the "formidable" problem they now confronted and he was determined that the United States should not make the same mistake. He sought the opportunity to study what the British and French had learned in the intervening years and hopefully build a better, more effective system for the United States. Almost immediately upon his return from the Mexican border, he petitioned the Rockefeller Foundation for $2,500 to fund a two-month trip to investigate Allied practices in Britain and France. "There is need of more accurate knowledge than can be gained by indirect means regarding the prevalence of mental disorder in military forces," he wrote in his letter of appeal. "Insanity is such a heavy

[37] Report to Major General W.C. Gorgas from Pearce Bailey, Stewart Patton, and Thomas Salmon, April 12, 1917, in "Appendix," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 489.; Letter to Edwin R. Enbree from Thomas Salmon, April 13, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL. For more about the American army's efforts along the Mexican border see Julie Irene Prieto, *The Mexican Expedition, 1916-1917,* The U.S. Army Campaigns of World War I (Washington, D.C.: United States Army Center of Military History, 2016).

affliction upon individuals and communities in time of peace that it is imperative to consider any addition to this burden which war may bring," he continued.[38]

Salmon proposed a dual purpose for his trip. First, to understand what he labeled "clinical matters." This would be a study of shell shock and neurasthenia in soldiers, as well as "any special methods of treatment which have proved useful." If there was time, Salmon also wanted to explore drug addiction, alcoholism, and suicide rates among Allied soldiers as well as the civilian population. The second goal of the trip was to examine the structure of French and British military psychiatric operations. The Surgeon General's Office had already accepted the NCMH's recommendation to incorporate psychiatry under the umbrella of military medicine in the United States, including the construction of designated psychiatric hospitals and units. Now, Salmon needed to figure out how to build a new military medical system from its very foundation, and the pressures of mobilization were intense. His European trip, therefore, would include careful observation of screening techniques of new recruits, evacuation and transportation of psychiatric casualties from the frontlines to rear echelon hospitals, the provisioning of these hospitals, and how the French and English militaries compiled statistics and communicated with medical professionals. He also wanted to examine more sensitive issues such as the legal status of psychiatric casualties housed in civilian institutions, the role mental illness played in disciplinary hearings, and the process by which a psychiatric casualty was deemed fit to return to his unit. Salmon admitted that it would be "manifestly impossible" to fully explore any one of these complex issues in only two months. But he was confident that any information he gained "would be of great practical value in dealing with issues which are already coming to our attention in this country." Within days, the Executive Committee of the

[38] Letter to the Rockefeller Foundation from Thomas Salmon, May 1, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL.

Rockefeller Foundation responded to Salmon's request with hearty support and an appropriation of $2,500 to the NCMH, specifying that some of the money go towards the purchase of a life insurance policy "for the benefit of Dr. Salmon's family." Shortly after, Salmon departed for Europe.[39]

It was a whirlwind trip in which Salmon visited military hospitals, consulted with British and French doctors and psychiatrists, and met with American medical personnel already in place overseas. Excerpts from a letter dated London, June 1, 1917 reveal Salmon's astonishment at the scope of the psychiatric crisis unfolding in Europe. "The extent of these casualties is almost beyond belief," he wrote. "I have not yet had access to the official records but apparently the neuroses constitute one of the most formidable problems of modern war." His personal observations and his consultation with Britain's Dr. Mott led him to an important conclusion: American military psychiatrists would have to be prepared to treat two different kinds of patients: those with organic nervous diseases or preexisting mental health disorders and those who developed nervous conditions once in combat. It was the latter that caused Salmon the most concern, which he stated quite plainly in his letter. "The neuroses greatly outnumber the strictly mental cases," he wrote, and worse yet, he had seen "innumerable instances showing how ineffective ordinary treatment is in these cases."[40] The Americans must do better, Salmon concluded and to that end, he drafted a report for the Surgeon General detailing just how the newest branch of American military medicine would meet this challenge. Salmon's report, with

[39] Letter to the Rockefeller Foundation from Thomas Salmon, May 1, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL.; Letter to Thomas Salmon from Edwin Enbree, May 3, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL.

[40] "Extracts from letter dated London, June 1, 1917, from Dr. Thomas W. Salmon, Medical Director, The National Committee for National Hygiene," undated, Thomas Salmon Papers, Box 2, Folder 3, ODL. Salmon's entire letter is not preserved nor is the recipient of this original letter clear. The document referenced above consists of only a series of typed extracts and appears to be part of a larger report either for members of the NCMH or the Rockefeller Foundation.

its careful statistical analysis and keen observations, would become one of the classic documents in the history of American military psychiatry; for contemporaries, it was a foundation upon which they could organize their treatment of the psychiatric casualties of war.[41]

In his report, Salmon described the challenges faced by the mental health professionals attached to the British Expeditionary force and delineated recommendations for how American doctors could avoid them upon their activation into military service. For Thomas Salmon, like Pearce Bailey, the most important lesson he took from his time observing British and French soldiers overseas was the need for careful screening of military recruits. The construction of an "exclusion policy" by the U.S. Army and instituted by trained psychiatrists would reduce the burden on mental health professionals in France, increase military efficiency, and hopefully, save the government millions of dollars in veteran's pensions. For the first time, soldiers would be examined for their psychological as well as their physical fitness for military duty. [42]

While the need for careful screening constituted Salmon's foremost recommendation to the Surgeon General, he also emphasized the paramount importance of establishing military hospitals dedicated to the treatment of mental diseases. Here Salmon stressed what would become one of his most significant contributions to military psychiatry: the need for a clear plan for the efficient evacuation of psychiatric casualties. To this end, he recommended that the U.S.

[41] The Surgeon General of the Army published Salmon's report as an appendix in the official history of neuropsychiatry during WWI. See Thomas Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army", in "Appendix," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 497-523. In the same volume, Frankwood Williams, a leading American military psychiatrist, recognized the Salmon report as providing information "of great value in the preparation of plans for dealing with the problem of mental and nervous disease in the United States Army, abroad and at home." Frankwood E. Williams, "Introduction," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 7. The hundred-year retrospective on American psychiatry produced by the American Psychiatric Association in 1944 called Salmon's report to Gorgas "a classic in the annals of military neuropsychiatry." Strecker, "Military Psychiatry: World War I," 386.

[42] Williams, "Introduction," in *The Medical Department of the United States of America in the World War* vol. 10, 7.

Army follow the example of their allies and construct clearing stations and hospitals both abroad and in the United States staffed by trained psychiatrists and nurses, ready to receive casualties from the outset.[43] "The importance of providing, in advance of their urgent need, adequate facilities for the treatment and management of nervous and mental disorders can hardly be overstated," Salmon wrote.[44] To meet this goal he suggested a special base hospital located near large groupings of soldiers with as many as five hundred beds for neuropsychiatric cases. These hospitals would treat those patients who mental health professionals anticipated would recover within six months, and could be expected to return to active duty after their treatment and convalescence. These hospitals would also house patients waiting to be evacuated to the United States for more extensive treatment and when possible, maintain a "special convalescent camp" to aid in recovery.[45]

Salmon seemed to anticipate resistance to construction of hospitals devoted solely to neuropsychiatric cases. Citing his three years of experience with French and British soldiers he implored the Surgeon General to realize that "few more hopeful cases exist in the medical services of the countries at war than those suffering from the war neuroses grouped under the term 'shell shock' *when treated in special hospitals by physicians and nurses familiar with the nature of functional nervous diseases and their management*." This was in contrast, he argued, to psychiatric casualties who found themselves at general military hospitals where they were "exposed to misdirected harshness or to equally misdirected sympathy" by misinformed or untrained military doctors. It was Salmon's experience that such patients languished in inactivity

[43] Williams, "Introduction," in *The Medical Department of the United States of America in the World War* vol. 10, 7.

[44] Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army" in *The Medical Department of the United States Army in the World War* vol. 10, 513.

[45] Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army" in *The Medical Department of the United States Army in the World War* vol. 10, 513-515.

resulting in self-pity, weakened will, and finally, an "attitude of permanent invalidism." These patients could not be returned to health let alone their military units. Thus, he concluded, "military efficiency" but also "common humanity" should motivate the U.S. Army to build specialized psychiatric hospitals.[46]

In addition to base hospitals overseas, Salmon also recommended an additional waypoint in the evacuation chain, again based on what he witnessed in France and Great Britain. These points would be smaller, thirty-bed wards also staffed by trained mental health workers. Most importantly, they would be located near to the frontlines. "The French and the British experience," Salmon wrote, "shows the great desirability of instituting treatment of 'shell shock' cases as early as possible." Though he admitted, "we do not know much about the onset of these cases," he explained that psychiatrists and neurologists who happened to encounter neuroses casualties in clearing stations had made an interesting – and ultimately, a very important – discovery about the effective treatment of psychiatric casualties. Salmon reported that early data seemed to suggest that soldiers presenting symptoms of war neuroses or shell shock who were treated within hours of their diagnosis proved more likely to recover.

Thomas Salmon was not the only American psychiatrist to embark on a research trip during the spring of 1917 in an effort to better understand the Allied experience with shell shock. His fellow travelers to Mexico, Pearce Bailey and Stewart Paton, left for Canada in May 1917 with goals similar to those outlined by Salmon in his European expedition. Pearce Bailey was born in New York two months after the end of the Civil War. He attended Princeton University and received his degree in medicine from Columbia University in 1889. Like many psychiatrists

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Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army" in *The Medical Department of the United States Army in the World War* vol. 10, 514-515. Emphasis in the original document.

and neurologists in his generation, Bailey furthered his medical studies in Europe before returning to the United States to practice neurology. Seeing a need for better mental health education in America, he served as one of the founding members of the Neurological Institute of New York. By the time the war broke out, Bailey was a prominent American neurologist and active in the mental hygiene movement.[47]

Bailey's research interests made him well-suited to a leadership position in the burgeoning military psychiatry field. In 1898, he published *Accident and Injury: Their Relations to Diseases of the Nervous System.* The volume's popularity led to an expanded edition in 1906 that incorporated additional research and a deeper exploration of trauma under the new title *Diseases of the Nervous System Resulting from Accident and Injury*. In the latter volume, Bailey framed his research as a study of diseases of the nervous system and the role of trauma in either causing or exacerbating nervous illness. As a neurologist, he approached the question from the perspective of pathology. However, he also accepted that psychic factors such as fright could affect the nervous system as well. He recommended labelling the condition "traumatic neurasthenia" and "traumatic hysteria." Such designations acknowledged the role of trauma in the genesis of the patient's symptoms while, in Bailey's opinion, recognizing that the neurologist needed to address the root of the patient's suffering as he would any other neurasthenic. Frederick Mott would make a similar observation regarding shell shock and neurasthenia in his Lettsomian Lectures a decade later.[48]

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[47] "Pearce Bailey, Neurologist, Dies," *New York Times*, February 12, 1922.; Byron Stookey, "The Neurological Institute and Early Neurosurgery in New York," *Journal of Neurosurgery* 17 (September 1960): 801-802.

[48] Pearce Bailey, *Diseases of the Nervous System Resulting from Accident and Injury* (New York: D. Appleton and Company, 1906), 361-363. For Bailey's history of nervous disorders, see pages 347-361. Transatlantic learning went both ways. David Forsyth cited Bailey's book in his article on war neuroses, calling Bailey's description of traumatic neuroses reflective of the "modern view." Forsyth, "Functional Nerve Disease and the Shock of Battle," 1399.

It was with this knowledge and interest in traumatic disorders that Bailey undertook his visit to Canada as chairman of the NCMH's new War Work Committee – then referred to as the Committee on Furnishing Hospital Units for Nervous and Mental Disorders to the United States Government. During his visit to Canadian military hospitals he met with military doctors to discuss their experience with psychiatric casualties. By January 31, 1917 approximately 300,000 Canadian soldiers had seen service in WWI, including 175,000 sent to the front. Their military reported 180,496 casualties, including killed and wounded, as well as men removed from service due to illness. Of these, nervous and mental casualties comprised a little over two-percent, or 4,316 men.[49]

Bailey's ideas about the role of trauma in the development of nervous illness are present in his May 12, 1917 report to the Surgeon General on his observations in Canada. The sixteen page letter, with multiple enclosures, highlighted important themes which Bailey felt American military psychiatrists would have to address in the present war. In particular, he discussed the nature of shell shock and best practices for classifying psychiatric casualties. He concluded with recommendations for the U.S. military based on the Canadian experience.

Regarding shell shock, Bailey was dissatisfied with the diagnostic nomenclature and its application by Canadian military psychiatrists. "There seems now to be a strong temptation to designate as 'shell shock' every medical case with nervous symptoms where the patient has been in the neighborhood of exploding shells," he reported. Bailey derided the tendency of the neuropsychiatrists to classify sufferers by the alleged cause of their disorder instead of their symptoms. He conceded that while "a true concussion effect upon the nervous system, with organic changes, doubtlessly exists," the Canadian Surgeon General assured Bailey that such

[49] Report to W.C. Gorgas from Pearce Bailey, May 12, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL.

instances were rare. This led Bailey to conclude that most of the cases that psychiatrists identified as shell shock presented "no feature with which neurologists were not fully familiar under the terms of hysteria and neurasthenia." Such thinking was in line with Bailey's earlier research and writing that favored categorizations of traumatic neurasthenia or traumatic hysteria over what he considered the weakness of traumatic neurosis as a diagnostic label.[50]

The report does not disclose Bailey's views on the role of fear or the psychological trauma of war in the etiology of shell shock, despite his pronouncement on the topic is his earlier publication. Indeed, in *Diseases of the Nervous System* he not only emphasized the role of fright, he specifically mentioned the bombardment during the Siege of Strasbourg in 1870. "The terror to the inhabitants of the town was indescribable," he wrote, and noted a rise in "cerebral disturbances" and epilepsy as a possible result amongst the townspeople. Such explicit discussions about the causes of shell shock are absent from his 1917 report to the Surgeon General.[51]

Bailey did, however, suggest to his American audience that there was strong evidence that some Canadian soldiers returned with diagnoses of shell shock when they likely suffered from a different form of psychiatric distress. "This new term," he wrote, referring to shell shock, "is made to cover various mental diseases, notably dementia praecox, which existed before enlistment, and would have developed in due course without reference to military service." Bailey noted that this tendency to misdiagnosis was especially troublesome when military

[50] Report to W.C. Gorgas from Pearce Bailey, May 12, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL. Forsyth argued that classifying traumatic neurosis by symptoms was also problematic, writing "at first glance the series admits no better classification than by the gravity of the symptoms; but the symptoms themselves are hardly ever the same twice over." Forsyth, "Functional Nerve Disease and the Shock of Battle," 1400.

[51] Bailey, *Diseases of the Nervous System Resulting from Accident and Injury,* 368-369.

officials failed to properly screen and identify individuals with mental disease prior to induction into the service.[52]

Both Bailey's report and his earlier writing demonstrate his belief that predisposition played an important role in a person's development of nervous disease. In *Diseases of the Nervous System* he agreed that, while nervous illness was rarely passed directly from parent to child, heredity could lead to an individual with "a nervous system whose powers of resistance are diminished" and susceptible to environmental triggers. He cited alcoholics, epileptics, and patients with tuberculosis as potential progenitors of these at-risk offspring. In his book, he also recommended that the diagnosing physician take into account the potential hysteric or neurasthenic's age, sex, race, and nationality. These, he argued, were "considerations of paramount importance" for determining the existing health of the patient, even more valuable than his or her previous medical history – though Bailey did consider the latter to be an important factor in a person's susceptibility to neuroses.[53]

The Canadian experience offered Bailey further evidence to support his belief in a connection between predisposition and nervous illness. He recounted a report received by the House of Commons in Ottawa that, of five overseas battalions, approximately eighteen-percent of the men had to be immediately returned to Canada due to pre-existing "disabilities." This was in line with an observation by the Quebec Discharge Depot that at least fifteen-percent of the returned men they encountered presented with conditions that predated their enlistment. Bailey used this evidence to recommend the Surgeon General utilize trained psychiatrists and neurologists to screen American recruits. He echoed the common refrain of many of his

[52] Report to W.C. Gorgas from Pearce Bailey, May 12, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL.

[53] Bailey, *Diseases of the Nervous System Resulting from Accident and Injury*, 6-7.

colleagues, that "the frequency with which these disorders occur and the certainty with which they disable, make the enlistment of men so affected a direct blow at the efficiency of an army and a source of unnecessary expense and hardship." It should be noted that in this particular report, Bailey did not explicitly say that soldiers suffering from shell shock did so because they were constitutionally predisposed and that their weakened nerves made them feel the ravages of war more acutely than their comrades. This was the argument put forth by Frederick Mott. However, Bailey's earlier research stating that individuals with "diminished" nervous systems were more susceptible to traumatic injury – including traumatic neurasthenia and traumatic hysteria – combined with his clear statement to the Surgeon General that shell shock was nothing but poorly labeled examples of the same, make it likely that Bailey considered war-related neurosis strongly influenced by predisposition.[54]

The report concluded with Bailey's recommendations to the Surgeon General. In addition to careful screening of recruits by trained administrators, he called on the American military to pay particular heed to what he considered the "chief defect" of Canadian military psychiatry: a failure of adequate classification of mental illness in soldiers. For Bailey, this lack of systematic agreement on the parameters of shell shock and other mental illnesses prevented not only effective screening of recruits, but the efficient treatment and rehabilitation of psychiatric casualties. Invalided Canadian soldiers were spread across hospitals and convalescent homes throughout Europe, England, and Canada. There were also complications inherent to transporting psychiatric casualties on the long boat ride across the Atlantic, something with which the French and the British did not have to contend. Bailey drew special attention to this problem, noting that the Americans would likely face the same challenges. In

[54] Report to W.C. Gorgas from Pearce Bailey, May 12, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL.

fact, he warned that that the U.S. would face additional difficulty due to the fact that the American Expeditionary Force could not utilize base hospitals in England with the same ease as Canada, a member of the British Commonwealth.[55]

For Bailey, as well as Salmon and others at the NCMH and War Work Committee, it was evident that the United States needed to take swift and decisive action to prepare for the likely mobilization of American troops overseas. Though doctors in the United States would continue to watch and learn from their colleagues in Europe, the time for action and mobilization had arrived. American mental health professionals had formulated thoughts and opinions based on observation. Now, it was time to operationalize those ideas.

Conclusion

The size and scope of World War I was a shock to participants on all sides. None expected it to be so brutal and none expected it to last for so long. As for the mental health community, both in the United States and abroad, none had anticipated the number of psychiatric casualties their governments, militaries, and professional ethics would call upon them to treat. The Europeans were the first to realize the scope of the psychiatric challenge laid before them. But the Americans were keen observers and prescient members of government and the medical community anticipated the eventual entrance of the U.S. into the war.

Mirroring the transatlantic interchange of ideas that had sustained a pre-professionalized American psychiatry during the nineteenth-century, U.S. mental health professionals followed the development of the European crisis through a variety of means, including editorials, journal

[55] Report to W.C. Gorgas from Pearce Bailey, May 12, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL.

articles, and informal observations. Interestingly, nostalgia – the popular explanation for soldierly malaise in the last two large U.S. wars – did not find its way into the American discourse. Men like Kirby, Viets, and Bailey all predicated their understanding of shell shock or war neuroses upon their own understandings of traumatic neurosis that had arisen in only the last twenty years. Again, the professional understanding of the etiology of mental illness – in this case, the role of nerves in the shaping of the human psyche – shaped the mental health community's response to the psychological trauma of war.

Its observations of the Europeans proved to the mental health community in the United States that the American military would need an organized military psychiatric effort in order to be successful in the coming fighting. Psychiatrists led by the NCMH began the systematic study of Allied successes and failures in order to shape the U.S. response. Through these studies, American psychiatrists began to understand the scope of the psychiatric challenges that U.S. troops would soon face and began to formulate plans to create a responsive military psychiatric corps.

The official visits of Bailey and Salmon, and the informal observations Americans gleaned from medical journals, led to three conclusions that would shape the U.S. response to the psychological trauma of war in World War I. First, while the etiology of shell shock was unclear, the condition and the casualties were very real and posed a threat to the strength of the fighting force of the U.S. military overseas. Second, the larger American military apparatus needed to recognize the significant number of psychiatric casualties overseas and provide for a corps of professional military psychiatrists to treat U.S. soldiers at home and abroad. Third, while the professionals disagreed about the direct cause of war neuroses, they did agree on one fact: men with a predisposition towards mental illness were at a greater risk than supposed

healthy men. To this end, the U.S. military and the psychiatrists acting on its behalf needed to institute a rigorous program to screen potential recruits.

Working from these conclusions, in 1917, the psychiatric community, under the leadership of the NCMH, began to construct the first organized system of American military psychiatry. Not only would this corps provide trained individuals to treat psychiatric casualties, it would create a pool of qualified individuals to examine military recruits and identify those men likely to be at risk for shell shock. The NCMH and the mental health community had bold plans for the first American military psychiatrists and their deployment to Europe, but as any military officer knows: no plan survives contact with the enemy. For American psychiatrists, the first enemies they had to conquer were their own unpreparedness and then, the U.S. military itself.

CHAPTER FIVE: MOBILIZING AMERICAN SOLDIERS AND PSYCHIATRISTS FOR WAR

The First World War proved to be an important moment for the mental health profession in the United States. Military psychiatrist Edward Strecker – himself a veteran of WWI – wrote in 1944 about the effect of the war on the profession in the American Psychiatric Association's hundred year retrospective on American psychiatry. "The psychiatry of the fratricidal conflict of 1861 was too feeble to furnish resourceful support," he conceded, and "the somewhat dubiously motivated Spanish War was scarcely more than a slogan" and a "'bully-beef' scandal." Strecker argued that it was not until WWI when "the terrorizing and lethal properties of machines of war for the first time approached the saturation level of human nervous resistance," that American psychiatrists met the challenge of treating the soldiers who suffered as a result.[1]

Neuropsychiatrists in the United States had closely observed the professional debates surrounding psychological trauma and war that developed in Europe in the opening years of WWI. They initially responded to this developing professional discourse through informal observation and debate, but once U.S. military involvement seemed inevitable, conversation necessarily turned to action. The advocacy of the National Mental Hygiene Committee, the research conducted by men like Thomas Salmon, and the experiences of the French and British militaries, convinced the War Department that the United States military required trained mental

[1] Edward, A. Strecker, "Military Psychiatry: World War I 1917-1918," in *One Hundred Years of American Psychiatry,* ed. J. K. Hall et al. (New York: Columbia University Press, 1944), 385.

health professionals to accompany American soldiers to France. Mental health practitioners in the United States would need to operationalize their theories. Whereas the fighting of 1914 and 1915 had served to mobilize ideas and discussion among American neuropsychiatrists, they now had to mobilize something more concrete – namely their profession and its members – in order to establish processes for meeting the challenges of mental illness and psychiatric breakdown during war.

This chapter describes the process of professional wartime mobilization and highlights the reliance of psychiatrists and military leaders on existing civilian organizations and expertise to create the foundation of American military psychiatry. While this effort succeeded in positioning hundreds of neuropsychiatrists at the disposal of the United States government, it also brought to light numerous challenges that still confronted the psychiatric profession. This chapter explores neuropsychiatrists' attempts to coordinate with military and medical officials to screen recruits for mental illness as an exemplification of the continued interaction between mental health professionals and the lay public. The resulting tension that developed between military psychiatrists and military leaders about the validity of mental illness suggests that, while professionalization had raised awareness of mental health in the United States and created a foundation for military mobilization, practitioners still needed to work closely with non-professionals to assert their legitimacy. In this way, the mobilization of American psychiatrists for WWI represents the success of professionalization at the end of the nineteenth century while also highlighting the continued interaction between psychiatrists and the public to craft a shared understanding of mental illness and specifically, the psychological trauma of war.

Creating the New American Military Psychiatry

American mental health professionals demonstrated limited interest in the new military psychiatry prior to the outbreak of war in Western Europe. However, one article that appeared in *The Military Surgeon* did try to call the attention the potential problem that awaited the more modern armies of the twentieth century. In February 1910, Captain R.L. Richards of the U.S. Army Medical Corps published "Mental and Nervous Diseases in the Russo-Japanese War" in order to provide medical colleagues with a glimpse into "the first time in the history of the world mental diseases were separately cared for by specialists from the firing line to the home country."[2]

Drawing on the Russian experience as told in French and German medical publications, Richards emphasized casualty evacuation as a key challenge faced by Russian psychiatrists. Mentally ill soldiers had to travel by train over 5,000 miles from the frontlines west to Moscow where there were more hospitals and doctors better able to assist them. As a result of the extreme distance, a rudimentary evacuation chain developed in which casualties stopped at a variety of public and private hospitals over the course of the month-long journey. Sometimes patients stayed on at a certain hospital because of delays or because their condition worsened and travel became difficult. Thus, the sickest patients often remained closer to the front, but the goal remained to get them to Moscow or another suitable hospital closer to their hometown. When possible, each hospital was staffed with trained mental health professionals and Richards noted that while the treatment the patients received was not exactly cutting edge, it was serviceable.

[2] R.L Richards, "Mental and Nervous Diseases in the Russo-Japanese War," *The Military Surgeon* 26 (February 1910): 177.

The policies and procedures surrounding the evacuation of psychiatric casualties would become one of the defining features of military psychiatry during the First World War.[3]

Of the cause of the psychic suffering of the soldiers in question, Richards noted the particular trials of war. "The circumstances of war," he wrote, "stamped psychoses with a depressive character such as is not noticed in times of peace." These circumstances included not only the "psychic trauma of battle," but also deprivations in the form of sleeplessness, hunger, thirst, and exertion. Richards continued, "war sets a special stamp upon mental diseases in the same way as do different social classes, or different races, or great catastrophes in nature. War is only a predisposing and exciting cause in an external way." In some ways this view reflected the opinions about psychological collapse held by surgeons during the Civil War, particularly the belief that men who broke down during a war did so because of a predisposition to mental illness or because of non-traumatic circumstances associated with warfighting, such as hunger or the strain of marching. Richards, however, also anticipated the theories of military psychiatrists confronting war neuroses just five years later in Europe; not only regarding predisposition, but their evolving belief that the trauma of combat could itself contribute to the rise of mental illness in an individual. He suggested that "soldiers develop a peculiar and different form of psychosis" than civilians and even though "battle as psychic trauma is not alone sufficient to cause a psychoses" such trauma could and did play a role.[4]

Ultimately, Captain Richard's concluded, "the tremendous endurance, bodily and mental, required for the days of fighting over increasingly large areas and the mysterious and widely destructive effects of modern artillery fire will test men as they have never been tested before."

[3] Richards, "Mental and Nervous Diseases in the Russo-Japanese War," 180.

[4] Richards, "Mental and Nervous Diseases in the Russo-Japanese War," 186.

Furthermore, he warned, "we can surely count then on a larger percentage of mental diseases, requiring our attention in a future war." If the mental health community in America and the Army Medical Corps was to learn anything from the Russo-Japanese war it was that psychiatric casualties were not only likely, but inevitable in the face of the destructive power of modern war.[5]

Despite Richards's efforts to spur professional interest in military psychiatry in the United States, his article was met with silence and inaction. One American neuropsychiatrist later reflected on the piece in his introduction to the official history of neuropsychiatry during WWI. Frankwood Williams, who served in leadership positions in the Division of Neurology and Psychiatry during the war, cited the article as one of the earliest discussions of specialized military psychiatry. However, he dismissed the possibility that it could have offered guidance to American psychiatrists trying to build a mechanism for organized military psychiatry in the United States. The Russians dealt primarily with insane soldiers, he argued, and encountered few cases of the functional neuroses that plagued soldiers and psychiatrists during WWI. He admitted that it was possible that "the neuroses may not have been distinguished from the psychoses in previous wars," however, he was confident that the experience of WWI was unique. "Though none of the symptomatic expressions of war neurosis were considered new," he wrote, "the great frequency of their occurrence in the World War was a decided novelty to war-time medical experience."[6]

In an important way, Williams was correct. The scope of WWI, including the high number of psychiatric casualties, played a significant role in the decision to form a specialized

[5] Richards, "Mental and Nervous Diseases in the Russo-Japanese War," 178-179.

[6] Frankwood E. Williams, "Introduction," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 3.

military psychiatry apparatus in the United States where one had not existed previously. But such casualties had existed in earlier wars as well. Size and scale are not what make wars traumatic for soldiers. It is the horror, the brutality, and the deprivation that can upset the mental balance of the individual, which is not specific to any particular war. The fighting of the Civil War and the Spanish-American War was no less devastating for its participants – even if those participants were fewer in number. As Williams also acknowledged, the symptoms of war neuroses had "been noted by the military surgeons in previous wars." However, the presence of psychological trauma in soldiers during those conflicts had not been enough to spur an organized professional response from American physicians. The medical response to World War I, and particularly that of psychiatrists, represented a significant shift in the practice of military medicine.[7]

By the 1910s, the American mental health community had passed two key thresholds that made an organized military psychiatry effort possible: the recognition that trauma can affect mental well-being and the professionalization of their field. The former prompted the creation of a transatlantic discourse that allowed for neuropsychiatrists in the United States to critically examine the reports coming from Europe in a way that they had not considered similar observations by military doctors during the Civil War and the Spanish American War. Men like David Forsyth in Great Britain and Pearce Bailey in the U.S. situated their understandings of shell shock in the discussions begun by Erichson, Charcot, and Oppenheim, while others like Frederick Mott drew upon studies of neurology that had flourished at the end of the nineteenth-century. The result was a foundation of professional knowledge that supported the observations of military psychiatrists during World War I.

[7] Williams, "Introduction," in *The Medical Department of the United States of America in the World War* vol. 10, 3.

The professionalization of mental health care and research in the United States was equally important to the formation of the new American military psychiatry. Starting with the March 1917 meeting between Surgeon General Gorgas and representatives of the NCMH, the U.S. military undertook a close partnership with the civilian mental health community. Prior to WWI, there was no organized American military psychiatric effort in either the Medical Corps or the Office of the Surgeon General. As such, the government relied heavily on the expertise of established civilian organizations, particularly the NCMH, to staff and organize the new division. This extensive network of interested, organized, and capable neurologists and psychiatrists had not existed prior to WWI. Without it, the U.S. response to psychiatric casualties would have been less coordinated and less effective.[8]

The earlier visit by Thomas Salmon, Pearce Bailey, and Stuart Patton to U.S. positions along the southern border – combined with observations of the Allied experience in Europe – highlighted the challenge the NCMH confronted. The organization needed to operationalize the ideas discussed by mental professionals in the preceding months. This included planning and building hospitals, mobilizing trained men and women to staff them, and establishing processes to screen recruits as well as treat and evacuate soldiers needing psychiatric treatment.

On April 6, 1917, when the United States ended its neutrality and officially entered the war, the Surgeon General authorized the NCMH to begin officially planning the U.S. military response to psychiatric casualties. Leadership at NCMH created the Committee on Furnishing Hospitals Units for Nervous and Mental Disorders for the United States Government shortly

[8] Pearce Bailey, "Division of neurology and psychiatry," in *The Medical Department of the United States of America in the World War* vol. 1 (Washington: U.S. Government Printing Office, 1923), 384. When the Surgeon General's office was reorganized in the latter part of 1918 the Division of neurology and psychiatry was eliminated and its functions made a section of medicine under the Division of Internal Medicine. Bailey, "Division of neurology and psychiatry," in *The Medical Department of the United States of America in the World War* vol. 1, 385.

thereafter. As its cumbersome name suggested, the goal of the committee was to undertake the complex process of identifying hospitals in the United States for government use to house mentally ill soldiers. As further evidence of the unpreparedness of American military psychiatry prior to WWI, there was only one hospital facility designated for the long-term treatment of mentally ill members of the armed forces and that was St. Elizabeths in Washington, D.C.. There were a handful of haphazard wards spread across the country, including a few beds in the basement of Walter Reed General Hospital and fifty beds in the same building that held prisoners at the Letterman General Hospital in San Francisco. In many instances mentally ill soldiers were simply placed in the general patient population of the military hospital. If they were dangerous, however, hospital administrators moved them in with prisoners, as officials did at Letterman. There were even instances in which particularly risky psychiatric patients were placed in portable steel cages. Not surprisingly, systematic treatment of these men was rare and, as Salmon, Bailey, and Patton discovered along the Mexican-American border, what treatment they received was often ineffective.[9]

While this early response to the housing of mentally ill soldiers may seem inadequate to the observer one-hundred years later – and certainly proved to be insufficient when scrutinized by contemporaries preparing for large-scale mobilization – the military medical establishment of the early 1900s considered it an appropriate amount of resources to devote to this particular patient population. In the immediate years prior to WWI, reports to the Surgeon General indicated that only approximately 200 military patients required extended psychiatric treatment per year. Furthermore, with a dearth of mental health specialists on staff, there were few professionals to advocate for better or more efficient treatment of the mentally ill at military

[9] Pearce Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 39.

bases across the country. It was only with the influx of men and the active participation of the mental health community that the military began to take steps to better recognize and treat mental illness within the ranks.[10]

Unfortunately, the first efforts of the military to overcome this deficit only served to reinforce the need for assistance from civilian professionals. They also exemplified the gulf that still existed between the understanding of mental illness stressed by psychiatrists and that held by the general public. Recognizing a need for more dedicated spaces to service the mentally ill in the military, the Army directed the establishment of neuropsychiatric wards at areas with large collections of soldiers in the United States, including camps, cantonments, and especially base hospitals. The War Department referred to these early wards as "Isolation-insane" and plans for their construction included heavily barred windows and doors, and an interior divided into small, screened cells "stoutly maintained." As Pearce Bailey described them, "'Isolation-insane' was all the term implies in misunderstanding and professional discouragement and indifference." The field of psychiatry had been largely successful in convincing its practitioners that cold and impersonal asylums were a relic of a pre-professionalized and unscientific era; however, laymen still turned to the old model as the representation of modern mental health care. As one psychiatrist observed of patients housed in the basement of Walter Reed, "treatment was impossible and the care in all respects, except possibly food, was about the equal of the county asylum of the old type."[11]

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[10] Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 39.

[11] Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 39-40.; Frankwood E. Williams, "Observation and Treatment," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 92.

The NCMH immediately stepped in and drafted plans for a different kind of military psychiatric ward. Their first step was to dispense with the term "Isolation-insane" because of its negative connotations. They recommended, instead, the more neutral term "psychiatric ward" or "psychiatric unit." It was their opinion that this nomenclature better represented the goals of hospitalization – "understanding and professional hope and activity." Psychiatric wards would eliminate cells and instead feature an open plan similar to other areas of the hospital. Bars and mesh were to be replaced or greatly reduced in favor of fresh air and light. Finally, NCMH plans shifted the focus of patient care from "isolation" to one of treatment. Each psychiatric ward would contain the latest in scientific material, including tools to administer psychological tests, immersion baths for hydrotherapy, a hand centrifuge and other laboratory equipment, and a variety of pharmaceuticals to address a patient's complaints.[12]

The implementation of the NCMH's plan for modern psychiatric wards met with mixed success. The War Department approved their designs and equipment requests. However, in some locations the early "Isolation-insane" plans had already been implemented, with bars and mesh firmly in place. The result was often a contest of wills between the base or hospital's commanding officer and its assigned psychiatrist. It fell to the latter to persuade military leadership that "hospitals and not jails were being built." As Pearce Bailey wrote after the war, "For a lieutenant or captain new to military service to convince a commanding officer of the 'isolation-insane' school was no small task." Military leaders, unfamiliar with recent shifts in medical thinking about the origins and treatments of mental illness, retained their earlier beliefs

[12] Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 40-41.; Letter to the Surgeon General, U.S. Army, "Semi Annual Report, Division of neurology and psychiatry," January 2, 1918, Thomas Salmon Papers, Box 2, Folder 4, Courtesy of the Oskar Diethelm Library, DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell Medical College. Hereafter ODL.

conditioned by years of popular discussions about psychiatric illness and the stigma surrounding asylums. Some psychiatrists succeeded in pleading their case and the bars were removed. In other instances, psychiatrist and commander reached a sort of compromise, and the bars remained, but only on the windows and doors of the parts of the ward for the most dangerous patients. Bailey conceded that "the physical standards of the wards varied from camp to camp," but he noted with pride that "although some of the wards appeared more like jails than hospitals on the outside, they were hospitals in fact on the inside."[13]

In the midst of establishing psychiatric wards, the Committee on Furnishing Hospitals Units for Nervous and Mental Disorders for the United States Government expanded its mandate to include the recruitment of qualified personnel to serve at military psychiatric hospitals and to deploy overseas. With this larger role, the committee renamed itself the War Work Committee (WWC) to better reflect the growing range of its responsibilities. While Bailey and Salmon traveled to Canada and Europe, members of the WWC reached out to professional organizations in the United States for assistance in gathering volunteers. They did not limit their search to only the NCMH and requested cooperation from their sister organizations, the American Medico-Psychological Association and the American Neurological Association. The American Medico-Psychological Association passed resolutions affirming its support of military psychiatry at its annual meeting during the last week of May 1917 and pledged the assistance of its members to the government's efforts. The editors of the *American Journal of Insanity*, the official organ of the Association, echoed this support, writing "the need of trained psychiatrists in the recruiting service, in the examination of men drafted into the ranks, as well as in base hospitals or at the

[13] Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 41.

front is a crying one and it is hoped that from our membership a large number can be secured." The editors told interested neuropsychiatrists to contact the NCMH directly.[14]

Despite this widespread assistance across the mental health community, the WWC still faced challenges assembling a trained pool of neurologists and psychiatrists for the Surgeon General. Again, concern among psychiatrists that the military did not understand nor respect their particular field of medicine created obstacles to an effective mobilization. In a report to Gorgas in early January 1918, Bailey described a misapprehension circulating amongst mental health professionals that caused some men to withhold their service. "These physicians were men for the most part without experience in surgery or sanitation, and felt at first that they could render the country the most efficient service by remaining in their civil positions." They worried that once they joined the Medical Corps they would be put to work in administrative roles or be assigned general medical duties. In some instances, this concern was not misplaced and the new Division of Neurology and Psychiatry spent some of its first weeks arranging for transfers for a number of psychiatrists in other divisions who found themselves in just such a situation. On occasion, the Division of Neurology and Psychiatry requested that neuropsychiatrists who showed aptitude in logistics or administration remain in those roles. Aside from these cases, however, the War Work Committee was able to work with the Surgeon General to centralize the location of psychiatrists and neurologists within the Medical Corps. This allowed them to assure civilian mental health practitioners that if they joined the military their specialized knowledge would be put to use. The creation of the Division of Neurology and Psychiatry in the summer of 1917 was met with fifty commissioned officers. By the end of the year this number rose to 235.

[14] Pearce Bailey, Frankwood E. Williams, and Paul O. Komora, "Organization," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 9. "Notes and Comment," *The American Journal of Insanity* 74 (1917): 8-9, 108-111.

When the armistice was signed on November 11, 1918 there were 693 neuropsychiatric officers in service, with 430 located in the United States and another 263 serving with American forces overseas.[15]

The mobilization of neuropsychiatrists for service at home and abroad was further hindered, however, by an obstacle already familiar to the mental health community: a lack of serious training in psychiatry and neurology at medical schools. Despite the growing public interest in mental illness and professional efforts to increase scientific exploration of the brain's functions, most medical students were only exposed to the field of psychiatry in a few lectures while at medical school. Even those who specialized in psychiatry did not encounter a rigorously developed curriculum. Like their predecessors, many of the psychiatrists of the early twentieth century still learned their trade through the everyday experiences of working at state-funded mental hospitals. Their duties, however, were often administrative and those patients with whom they did interact were in the relative comfort of an institutional setting, not the unpredictable environment of a battlefield or field hospital. Similarly, neurologists received little clinical instruction while in school and many saw their patients in out-patient offices and private practices away from hospitals entirely.[16]

In recognition of the limited ability of universities and colleges at the time, the Surgeon General requested that seven institutions located across the country offer specialized courses to augment mental health education for medical officers. Some of these institutions, such as the State Psychopathic Hospital in Ann Arbor, Michigan, were associated with medical schools – in

[15] Letter to the Surgeon General, U.S. Army, "Semi Annual Report, Division of neurology and psychiatry," January 2, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL. Bailey, "Division of neurology and psychiatry," in *The Medical Department of the United States of America in the World War* vol. 1, 385-387.

[16] Frankwood E. Williams and Paul O. Komora, "Personnel," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 30.

this case the University of Michigan. But others, such as the Mendocino State Hospital in Talmage, California and St. Elizabeths Hospital in Washington, D.C. functioned as independent entities. Pearce Bailey's newly built Neurological Institute in New York City was both a research center and hospital. The directors of all seven hospitals were either given officer commissions or put under contract and awarded the title of military director. Though they collaborated with medical instructors outside of their institutions when possible, the hospital directors remained in charge of crafting the training and instruction of the officers.[17]

Reflecting the existing bifurcation of the field, the instruction at these institutions for new and existing mental health professionals was a purposeful blend of neurology and psychiatry. Neuropsychiatric officers received lectures and coursework for about six weeks on topics ranging from neurology and serology to behavioral disorders and war neuroses. At the University of Michigan, students undertook a weekly two-hour lecture on "neurological disorders of the ear," read research on shell shock, war neuroses, and other "mental disorders of the present war" published by their European counterparts, attended clinical demonstrations on syphilis, epilepsy, and psychopathic personalities, heard lectures on "embryological development of the central nervous system" and the histology of the nerve and spinal cells, among many other intensive course offerings. Taken together, these short training sessions were designed not only to augment but also standardize the knowledge of psychiatrists and neurologists in an era when rigorous training was only starting to come into being. As one prominent psychiatrist wrote after the war, "The courses, as a whole, set an example of how neuropsychiatry should be taught and

[17] Williams and Komora, "Personnel," in *The Medical Department of the United States of America in the World War* vol. 10, 30-31.

how well it can be taught in this country." By December 31, 1917, one hundred and thirty-five medical officers had completed their training through these institutions.[18]

The War Department officially stood up the Army's Division of Neurology and Psychiatry in July 1917. Pearce Bailey reported for duty on July 10, 1917 and took the role of chief in the new division. On December 24, 1917, the Medical Department appointed a director of psychiatry for the American Expeditionary Force. The guiding principles of the Division of Neurology and Psychiatry echoed many of the conclusions reached by Salmon and his colleagues during their trip to the Mexican border and affirmed by his visit to Europe. In his post-war reflections on military psychiatry during WWI, Salmon identified three tenets that shaped the American response. First, psychiatrists were to treat soldiers quickly and effectively, using the best scientific practices available, while working to conserve the fighting strength of U.S. forces. Second, the neuropsychiatrists should utilize a "rational conception" of both the physiological and the psychological origins of mental illness, including those that occurred during wartime. Finally, Salmon and other psychiatrists strongly advocated that trained mental health professionals be the primary caregivers for psychiatric or neurologic casualties, as well as take leadership of any mental health response undertaken by the services so much as the "exigencies of actual service permit."[19]

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[18] Pearce Bailey, "Division of neurology and psychiatry," in *The Medical Department of the United States of America in the World War* vol. 1, 388.; A detailed chart describing the six-week training in neuropsychiatry offered at the University of Michigan can be found in Williams and Komora, "Personnel," *The Medical Department of the United States of America in the World War* vol. 10, 32-35.; Letter to the Surgeon General, U.S. Army, "Semi Annual Report, Division of neurology and psychiatry," January 2, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

[19] *Report of the Surgeon General, U.S. Army to the Secretary of War* vol. 2 (Washington: U.S.Government Printing Office, 1919), 1079.; Thomas W. Salmon, "Introduction," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 271.; Bailey, Williams, and Komora, "Organization," in *The Medical Department of the United States of America in the World War* vol. 10,

To adhere to these principles, the division assumed leadership in the following areas: examinations of military recruits to identify and remove those with neuropsychiatric conditions, preparation and maintenance of facilities for the care and treatment of military psychiatric patients both in the United States and overseas, and the safe and efficient transfer of psychiatric casualties from the frontlines to their final disposition home. Though a seemingly short list, these three ventures required a massive undertaking on the part of the division. The official history of neuropsychiatry during the war recalled no less than sixteen immediate challenges that required the attention of the Surgeon General and the division's leadership. These problems included numerous logistical concerns, such as mobilizing trained female psychiatric nurses and male orderlies, constructing hospitals with uniform equipment across two continents, and developing standard intake forms to routinize the new military neuropsychiatric bureaucracy. There were also more complex decisions that required ideological agreement from a medical community that had only recently begun to reflect professional unity. For example, there needed to be consensus on what constituted a psychiatric condition that excluded an individual from military service and there needed to be agreement about treatments for those deemed unfit. With professional psychiatric education in its infancy, the division needed to set standards by which its psychiatrists and neurologists were trained. Finally, neuropsychiatrists had to learn to work with their military medical colleagues, and the "military medical machinery" had to learn how to best incorporate and utilize this new form of military medicine.[20]

8-10.; Salmon, "General Overview of Neuropsychiatric Activities," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 273.

[20] Bailey, Williams, and Komora, "Organization," in *The Medical Department of the United States of America in the World War* vol. 10, 10-11.; Pearce Bailey, "Division of neurology and psychiatry," in *The Medical Department of the United States of America in the World War* vol. 1 (Washington: U.S. Government Printing Office, 1923), 385-387.

Given the relatively short amount of time in which the War Work Committee, the Office of the Surgeon General, and leading psychiatrists and neurologists had to construct the first organized American military psychiatry apparatus, the mental health profession succeeded remarkably well in establishing a framework for the treatment of American soldiers overseas. In large part this was due to the professionalization that had occurred in the field over the last two decades. This allowed the Surgeon General to rely on established networks of mental health practitioners to recruit, train, and deploy as a part of the new Division of Neurology and Psychiatry.

The mobilization of military psychiatrists also demonstrated the limits of professionalization in psychiatry. In the preceding decades, the field had made great strides towards organizing and implementing new, scientific ideas about the recognition and treatment of mental illness within its own ranks. Psychiatrists struggled, however, to expand this new understanding to individuals outside of their practices, including not just military leaders but other medical professionals. Whether it was building new, modern psychiatric wards or ensuring that the Medical Corps did not assign psychiatrists to general medical duties, the NCMH and later the Division of Neurology and Psychiatry undertook the painstaking task of demonstrating the worth of their profession to outsiders. For the mental health community and the new military psychiatrists, however, nowhere was their expertise more crucial or more valuable to the American war effort than in the screening of military recruits.

Psychiatric Screening

At the onset of America's entry into the war in April 1917, the regular army consisted of just under 130,000 men, including officers and enlisted soldiers. Around 80,000 members of the National Guard were under federal service along the Mexican Border with a comparable number serving in their home states. In order to fill the ranks, the Congress approved military conscription and by the end of 1918, the federal army had swelled to 3.9 million men, almost three-quarters of whom were draftees. For the first time in American military history, conscripts comprised the majority of citizen-soldiers in the United States armed forces. Given the problems of draft dodging and the conscription riots that plagued the Federal government during the Civil War, military officials and lawmakers held their collective breathes when Congress announced the implementation of the draft. However, their fears were largely unfounded and by July 1917 draft boards registered the names of approximately 10 million men in the prime fighting age of twenty-one to thirty years-old. Historian Peter Kindsvatter argues that young men in the United States viewed the war as an opportunity for adventure and approached the idea of military service with the hope of proving their manhood. Despite newspaper reports that described the difficult fighting overseas, men from across the country embraced military service. By the closing months of the war the number of soldiers registered for the draft rose to almost 24 million.[21]

[21] Jennifer D. Keene, *Doughboys, the Great War, and the Remaking of America* (Baltimore: Johns Hopkins University Press, 2001), 9-11. Keene also attributes the success of the draft to patriotic sentiment as well as a belief among young men that they had a civic duty to serve their country in a time of crisis. Keene, *Doughboys, the Great War, and the Remaking of America*, 3.; Peter Kindsvatter, *American Soldiers: Ground Combat in the World Wars, Korea, and Vietnam* (Lawrence, Kansas: University Press of Kansas, 2003), 2-3.

The steady flow of medical articles from Europe about Allied soldiers suffering from shell shock left little doubt among American psychiatrists that U.S. troops would shortly be at risk as well. To the mental health community, however, shell shock was just one of the many psychiatric conditions that could remove a man from battle and weaken American forces. Men with epilepsy, schizophrenia, and alcoholism needed to be identified and excluded as well. As Pearce Bailey wrote after the war, a man judged mentally unfit for army life was usually not detected and discharged until after he had received training, been issued equipment, and "interfered with the training of their brighter or better-adjusted comrades." Such men were a drain on money and morale, sometimes before they even left the United States.[22]

Thomas Salmon drew a similar conclusion from his observations of the British Army. "The most important recommendation to be made," he wrote to the Surgeon General in 1917, "is that of rigidly excluding insane, feebleminded, psychopathic, and neuropathic individuals from the forces which are to be sent to France and exposed to the terrific stress of modern war." The medical screening of recruits in Great Britain had been haphazard at the start of the war and only became more confused as the fighting continued, the need for men increased, and the responsibility for examinations shifted back and forth between civilian examiners and the military. British examiners paid little attention to mental ability during the screening process and it was not until late in the war that even the most basic assessment of mental capacity was integrated into the examination.[23]

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[22] Pearce Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 57.

[23] Thomas W. Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 513.; Mathew Thomson, "Status, Manpower and Mental Fitness: Mental Deficiency in the First World War," in *War, Medicine, and Modernity*, ed. Roger Cooter, Mark Harrison and Steve

The consequences of the lack of effective screening were evident to British military physicians, particularly as the number of psychiatric casualties mounted. William Osler penned a letter in 1917 to the American Medical Association – subsequently published in the *Journal of the American Medical Association* – entitled "A Note of Warning to Examiners of Recruits" in which he implored American physicians to prevent the enlistment of neurasthenics into the military. While he admitted that such men were difficult to identify, he warned that "they break like dry twigs and become a heavy burden in the hospitals and convalescent homes" and recommended "in any case when in doubt give the country the benefit."[24]

Of particular concern to examiners were those soldiers whose mental illness or predisposition to mental illness would not be readily apparent, even to an examiner with medical experience. These individuals could baffle even a trained professional because their symptoms varied from simple irritability to depression, suspicion to an "inability to control the passions" and worse, the symptoms did not always conveniently present themselves at the time of examination. But make no mistake, remarked Bailey in 1929, those who possessed such characteristics "are not the stuff of which soldiers are made… they are persons who cannot give the service required, and no system yet devised will make them adequate." He argued, "If individuals of this category are not recognized they fail the Army…By having attacks of mental disease; by the development of neuroses; by reappearance or increase of epileptic attacks" and by

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Sturdy (Gloucestershire, Great Britain: Sutton Publishing, 1998), 150-155. See also: "The Previously Insane Recruit," *New York Medical Journal* 104 (October 1916): 857.

[24] William Osler, "War Wastage: A Note of Warning to Examiners of Recruits," *Journal of the American Medical Association* 69 (1917): 290.

a "temperamental inability to adjust to the restrictions of military discipline or to profit by punishment."[25]

Informed by the experiences of their colleagues overseas and their own beliefs about risks associated with mental illness, in July 1917 the War Work Committee submitted a memorandum to the Surgeon General with recommendations for the examination of recruits as well as suggestions for which diseases and symptoms should preclude an individual from military service. Their hope was to prevent the induction of men who already had mental conditions. Additionally, they sought to screen out as many individuals as possible whose predisposition to mental illness psychiatrists believed would make them more susceptible to developing a war neurosis such as shell shock once exposed to the rigor of combat. "Perhaps the most frequent and important reaction of the psychopathic personality to the trying exactions of war, or even to life in the Army, is the neurosis," wrote Bailey. To mental health professionals, screening soldiers for symptoms of psychiatric illness served a dual purpose. Like a general health screening it identified those recruits most capable of carrying out the immediate duties of a soldier and those who could not. Just as a man with one hand could not fire a rifle, an epileptic or a man suffering from auditory delusions could not be expected to serve as a soldier. But mental health screening hoped to go a step further and provide a measure of prophylaxis as well by anticipating which men would become casualties, even though they appeared outwardly healthy at the time of screening and more than capable of soldiering at the time of examination.[26]

[25] Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10, 60.

[26] Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10, 59.

One month after receiving the memorandum from the NCMH, the Surgeon General issued Medical Department Circular No. 22 which contained the official screening procedures for mental illness. Based on the recommendations of the War Work Committee, the directive echoed the fears expressed by the mental health community that poor screening could result in a weak force immediately, but also in the future. It warned examiners to be wary of soldiers that might seem "strong, active, and apparently healthy," but in actuality, "can not be relied on by their commanders, break down under strain, become an encumbrance to the Army, and an expense to the Government." Most importantly, the circular tasked the psychiatrist or neurologist with identifying "slight variations from the ordinary normal standard." The Surgeon General did not define the "ordinary normal standard" for a recruit, but did offer a long list of behavior which the examiner should find troubling, including "irritability, seclusiveness, sulkiness… timidity, overboisterousness, suspicion…stupidity, personal uncleanliness, resentfulness to discipline… and any of the various characteristics which gain for him who displays them the name of 'boob,' 'crank,' 'goat,' 'queer stick,' and the like." The Surgeon General and the psychiatrists who advised him hoped that discharging men with these characteristics would drastically reduce the number of psychiatric casualties in the American Expeditionary Force.[27]

Circular No. 22 did not specify how practitioners should conduct their examinations. At first, neuropsychiatrists only examined individuals referred to them by commanding officers. This proved problematic because it relied upon the discretion of nonmedical personnel, resulting in psychiatrists only seeing patients with outwardly noticeable symptoms. Such a method

[27] Surgeon General's Office, "Medical Department Circular No. 22," August 1, 1917. Quoted in Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10, 66-69.

precluded examiners from identifying the population that caused them the most concern, the borderline cases whose neuroses might become triggered when exposed to combat. From a bureaucratic standpoint, the referral system was also inefficient, with psychiatrists located away from camps or recruitment centers, leading to long delays between the identification of a troubled soldier and his eventual appointment with a doctor. Military psychiatrists then adopted general surveys of recruits and soldiers already inducted into the service. These proved more efficient and brought examiners in to contact with more men. An experienced examiner with the help of a clerk for administrative tasks could see between one hundred and fifty and two hundred cases a day. This preliminary exam consisted of brief questions about the man's hereditary background, his education, and medical history. The psychiatrist also tried to find physical signs of mental illness such as tremors, tics, and poor coordination. These brief interviews were hardly thorough and were often conducted at the same time a soldier was being tested for other disqualifying medical conditions such as tuberculosis. As one examiner noted after the war, "this type of survey is unsatisfactory for it can never be complete." Often, soldiers who did not pass the exam were sent to the base hospital for more in-depth testing before the neuropsychiatrist made the recommendation for their discharge.[28]

[28] Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10, 62.; E. Stanley Abbot, "The Work of Psychiatrists in Military Camps," *American Journal of Insanity* 75 (April 1919): 460-461. It is important to note that the type of screening administered by neuropsychiatrists was not the same sort of testing conducted by psychologists. The psychological testing of recruits – which ultimately amounted to intelligence testing – differed in methodology and in purpose from neuropsychiatric examinations. Neuropsychiatrists sought to prevent medical casualties and preserve the fighting strength of the U.S. military. Psychologists envisioned testing as a way to categorize soldiers and thus, better utilize manpower. For more on psychological testing see Franz Samelson, "World War I Intelligence Testing and the Development of Psychology," *Journal of the History of Behavioral Sciences* 13 (1977): 274-282.; John Carson, "Army Alpha, Army Brass, and the Search for Army Intelligence," *Isis* 84 (June 1993): 278-309.; Robert M. Yerkes, "The Relation of Psychology to Military Activities," *Mental Hygiene* 1 (1917): 371-376.

Psychiatrists augmented their screening efforts by reaching out to general military officers and attempting to educate them on the importance of careful selection. They did this by highlighting the consequences of failing to identify the mentally deficient. A memorandum to commanders at Camp Sherman, Ohio sought to explain why it was imperative to find and discharge potentially ill soldiers. In addition to reiterating the symptoms delineated by the Surgeon General, the memorandum cautioned against sending soldiers who appeared healthy but were in fact afflicted because they were "more than useless as soldiers, for they cannot be relied upon by their commanders… and break down under strain." The document reflects the wider goal of screening, which was not to identify and treat men with mental illness, but to maintain the fighting force of the army by preventing psychiatric illness from pervading the ranks. The memorandum ridicules the "feeble minded" as a weakness upon "the military reputation of the finest body of fighting men in the world." Additionally, it warns against any sentimentality or a belief that mentally ill soldiers could still serve in the military outside of a combat role. The memorandum ends with a lengthy quote from a medical officer currently in France, drawing upon the doctor's professional legitimacy and war experience to lend weight to his warning.

> And just one recommendation. Keep the feeble minded at home. I know there is a difference of opinion as to whether or not there is any place for them in the Army, maybe there is but not in France…If they are not children, all we have been saying about childish minds in adult bodies is sentimental rot. It [sic] they are children, the hell of the trenches is no place for a child. If anyone thinks that the officers of labor battalions have time or inclination to make special allowances for the feeble minded members of such organizations, he has not seen those organizations at work in France.

The unnamed doctor's quotation ends with a blunt statement that spoke to the shared knowledge of the nature of the fighting in Europe. "If providing the fodder for the Boche's guns will help

win the war, send them over. It won't… what will win the war is an army of keen, alert, steel nerved, clear eyed American soldier boys."[29]

With the support of the Surgeon General and a cadre of psychiatrists eager to educate others about the benefits of psychiatric examination, American military psychiatrists believed themselves poised in 1917 to meet the challenge of identifying and eliminating the mentally ill – or those who could become psychiatric casualties – from service. But like most plans in war time, psychiatric screening procedures proved challenging to implement and carry out. The screening of recruits was unevenly executed across the country and limited only to enlisted men. Officers were not systematically examined for mental illness during their training or after they received their commissions. One psychiatrist later called this lapse in screening "an outstanding defect of the neuropsychiatric service" since many officers became psychiatric casualties.[30]

Even if officers had been carefully screened, however, there was no guarantee that they would have been removed from service. Neuropsychiatrists with varying levels of expertise had only a vague list of symptoms for guidance. The attempt by the Surgeon General to delineate a set of characteristics to identify the mentally deficient was an important step in codifying the importance of mental health to the successful construction of a fit and able fighting force. The broad instructions in Circular No. 22, however, relied largely on the subjective opinion of the neuropsychiatrist. For example, it fell to the examiner to determine what level of "irritableness" constituted a symptom of mental defect and not just a soldier's general frustration with military

[29] Undated memorandum to Commanders of Troops, Camp Sherman, Ohio, 730 Neuropsychiatry, General 730 (Epidemiology) Box 429, General Correspondence , 1917-1927, Records of the Office of the Surgeon General (Army), Record Group 112, National Archives at College Park, College Park, Maryland.; For more on attempts to educate officers and soldiers see M.S. Gregory, "Neuropsychiatry in Recruiting and Cantonment," *Archives of Neurology and Psychiatry* 1 (1919): 92-93.; Abbot, 459.

[30] Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10, 63.

life or perhaps even his annoyance at being interviewed by a psychiatrist in the first place. Such a distinction would be hard for an experienced mental health professional afforded the chance to examine the soldier over many hours, let alone a neuropsychiatrist forced to ask his questions while a soldier was also being poked and prodded by another doctor.

Screening required neuropsychiatrists to work closely with general medical officers and line officers who oversaw the army camps that served as rallying points for soldiers prior to deployment to Europe. In some instances, psychiatrists found common cause with their medical colleagues and brother officers. But often, the relationships were strained to the point that neuropsychiatrists felt unable to successfully meet the goals outlined by the Surgeon General.

The official history of neuropsychiatry during the war tried to be circumspect, acknowledging "the introduction of novel and special examinations of so many kinds created great administrative difficulties." The author, Pearce Bailey, reasoned that military officers were upset that psychiatric examinations "interfered with established military routine," and he surmised that "it probably was this fact, rather than any lack of open-mindedness as to their usefulness, that was the basis of such opposition as was made to them." To be sure, he admitted, there were division surgeons who complained that neuropsychiatric examiners prevented "the prompt getting in order of their camps." Equally difficult were the line officers who maintained the belief that "if the specialists did not stop eliminating the unfit, there would be no army left." But ultimately, he concluded, "on the whole the cooperation existing between the neuropsychiatrists and other medical offices, as well as with officers of the line, was harmonious and attended as always by a joint desire to detect and eliminate the mentally or nervously unfit from the service."[31]

[31] Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10, 58.

In the opinion of one military psychiatrist, Major M.S. Gregory, the line officers and base commanders that oversaw the build-up of troops were the best allies of the neuropsychiatrist, even more so than other medical officers who offered "very little assistance or cooperation." He argued that the goal of the examiner to select out individuals with characteristics that ran counter to standards of military discipline aligned with the goal of the commanding officer to rate and organize soldiers based on conduct of behavior and military efficiency. "The officer eagerly seeks counsel and aid, as he at once recognizes that both he and the examiner are dealing with similar problems," Gregory wrote after the war. Whereas medical officers needed to be convinced of the utility of psychiatric examination through "tact, persuasion or even strategy," it was his experience that the nature of the work of military psychiatry "naturally bring[s] the line officer very close to the neuropsychiatrist." [32]

Not all military psychiatrists had Gregory's positive experience with line officers. Major Frank Leslie, who served as a neuropsychiatrist at many stateside hospitals and camps during the war, wrote to a colleague in March 1919 of some of "unusual obstacles" he encountered. He recounted that the examination of an entire camp was held up for three months because an executive officer "was himself pyscho-neurotic" and feared discovery. In another instance, the division surgeon prevented Leslie from conducting examinations because the surgeon was suspicious of psychiatry. After some gentle inquiry, Leslie discovered that the doctor "had a

[32] Gregory, "Neuropsychiatry in Recruiting and Cantonment," 91-92. Gregory advised his colleagues that the best way to win over the medical officers was "painstaking demonstration" of the most severe and overt cases of mental illness available at the camp. He suggested cases of "dementia praecox or of manic-depressive psychosis, which has been unrecognized and unsuspected," because they "will go a great way in rousing the interest and even the enthusiasm of the medical officers." Gregory, "Neuropsychiatry in Recruiting and Cantonment," 91-92.

most unpleasant experience at a former post with one of our academic psychiatrists who inquired minutely into the sexual life of every officer he examined."[33]

Fear of the stigma of mental illness and widespread unfamiliarity among commanders and general medical officers with the current paradigms of psychiatric thought posed a significant challenge to neuropsychiatrists. Bailey reported that "the greater number of the officers in the Medical Reserve Corps had had practically no instruction in neuropsychiatry." In an era where even specialists were woefully undertrained, general medical practitioners received even less exposure to theories of mental health. Bailey lamented that the psychiatric education of non-neuropsychiatrists was limited to a few lectures at medical school, "together with a visit to a neighboring institution, where a few striking and bizarre cases of chronic mental disease had been demonstrated to them." The result was physicians with only a cursory understanding of the state of the fields of psychology and neurology and at best, only a passing familiarity with "sterile forms of legal commitment." Such preparation did little to prepare general medical officers for the intensive processes of battlefield psychiatry.[34]

With regards to the complex questions surrounding screening, this unfamiliarity, combined with a general lack of respect for the professional expertise of military psychiatrists, led many medical officers to question and overrule the decisions made by the examiners. Both Leslie and Gregory related frustration with authorities within the camp – line officers and medical officers – who overturned their recommendations that certain soldiers be discharged from the military. Leslie wrote of a regimental commander who repeatedly refused to sign the

[33] Frank Leslie to Frankwood Williams, March 12, 1919, 730 Neuropsychiatry, General 730 (Epidemiology) Box 429, General Correspondence , 1917-1927, Records of the Office of the Surgeon General (Army), Record Group 112, National Archives at College Park, College Park, Maryland.

[34] Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 43.

discharge order for a soldier Leslie diagnosed with a "constitutional Psychopathic State." The commander explained, "that while 'that man might have a feeble mind, his back looked strong and he could make a trooper of him.'" The soldier in question was subsequently sent to another camp and "lost track of," before he was finally successfully discharged after being reexamined by a different neuropsychiatrist. In the end, Leslie complained, "the soldier had been in the service a year, had been fed and clothed and paid and instructed, treated by probably 20 Medical Officers in field and hospitals, transported 2,500 miles at government expense and never earned a penny."[35]

Gregory also remarked at the number of enlisted men he spoke to who were assured by army doctors that military service "would correct their trouble," suggesting that the discipline of military would eliminate their symptoms. Gregory, of course, strongly disagreed, writing "the entrance of such individuals has been detrimental to themselves as well as to the Army." In this statement, Gregory echoed the sentiments of the anonymous doctor who urged line officers to reconsider sending mentally ill soldiers with the hope that such individuals could be made useful through war service when, in fact, their impact was negative. Even the official history, which suggested a degree of cooperation between psychiatrists and military leaders, could not help noting the deleterious effect of officers "taking things into their own hands," and overriding the discharge orders of psychiatric examiners based on the premise that if the soldiers "looked alright to them, they probably were alright."[36]

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[35] Frank Leslie to Frankwood Williams, March 12, 1919, 730 Neuropsychiatry, General 730 (Epidemiology) Box 429, General Correspondence , 1917-1927, Records of the Office of the Surgeon General (Army), Record Group 112, National Archives at College Park, College Park, Maryland.

[36] Gregory, "Neuropsychiatry in Recruiting and Cantonment," 90; Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 58. Ben Shephard briefly describes a similar tension between British military psychiatrists and their non-medical colleagues, especially early in the war. See Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth*

The problem reached its zenith when no less than the commander of the American Expeditionary Force registered his dissatisfaction with the number of psychiatric casualties. In July 1918, General John Pershing cabled back to Washington that the high incidence of mental illness in the replacement troops arriving in Europe had overextended army medical personnel and psychiatric hospitals established by the military. He reiterated the "urgent importance of intensive efforts in eliminating [the] mentally unfit" before they left the United States. Upon receiving the 1918 cable from General Pershing, Frankwood Williams, then a major in the Division of Neurology and Psychiatry, responded by forwarding a report to the Surgeon General that detailed the number of divisions that deployed with men whom psychiatric examiners had identified as mentally unfit. Based on reports forwarded by psychiatric examiners, Williams identified at least 3,035 men from thirty-one different divisions that were sent overseas against the recommendation of neuropsychiatrists. [37]

Williams's response to Pershing further highlighted the lack of standardization in the processes of examining and discharging the unfit. The number of soldiers who slipped through the cracks varied from division to division. The 39th Division, for example, allowed two hundred and forty-four men to remain in their ranks, as opposed to the 81st, which only let three

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Century (Cambridge: Harvard University Press, 2000), 23-26. His argument that this tension was indicative of a larger disinterest in mental health on the part of the Royal Army Medical Corps mirrors the experience of American neuropsychiatrists. Charles Myers wrote that while he was in France he "never met with a regular Officer who had had any specialist's training and experience in mental or nervous disease and disorders." He suspected this was the reason his duties expanded during his war service to include supervising wards of psychiatric casualties, providing evidence for Court Martials, and taking charge of examining neurological cases, among many other things. These duties were assigned to him even though he "vainly pointed out that no expert could be found who would claim special knowledge in all these kinds of work." Nor did Myers claim to be the exception, writing, "for my part, I had had no special 'Asylum' experience, nor had I a specialist's knowledge of neurological diseases." He ultimately resolved that "an Army Medical Officer has to obey commands," but he blamed the lack of attention from the RAMC on mental health care for his burden. Charles Myers, *Shell Shock in France* (Cambridge: Cambridge University Press, 1940), 15-17.

[37] Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 58-59.

travel to France. A total of twelve divisions retained one hundred or more men whom examiners considered unfit. As Williams pointed out in his report, these were not necessarily men who received vague diagnoses, but soldiers who examiners identified as suffering from epilepsy, dementia praecox, or neurologic symptoms resulting from syphilis. In his opinion, they were "totally unfit for military service" and undoubtedly, a burden on doctors and military commanders from the moment they set foot in Europe. Furthermore, Williams wrote to the Surgeon General, even when all agreed that a soldier should be separated from the military, the amount of time that lapsed between the decision and the man's separation from the army ranged from five days to three weeks depending on where the soldier was examined. This seriously undermined the effectiveness of screening and, he argued, contributed to the problems identified by General Pershing.[38]

Given the difficulties encountered by so many American psychiatrists in convincing their military colleagues of the benefits of screening and neuropsychiatrists' own difficulties with implementing the steps necessary to make the process effective, it is surprising to note that immediately after the war, the psychiatric profession considered military screening to have been reasonably successful. As will be discussed in the next chapter, American troops were still plagued by the same war neuroses that affected their European counterparts, and military psychiatrists like Thomas Salmon and Pearce Bailey worked hard to overcome the challenges of putting all of their efforts towards mobilization into practice. But in reflecting on the mental health community's efforts to identify and remove men before they could become psychiatric casualties, American military psychiatrists claimed a limited victory. The official history of the division remarked that neuropsychiatric examiners had screened approximately 3.5 million men

[38] Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 58-59.

during the American mobilization. Of those men, they identified mental illness in 69,394 potential recruits, or about one in every twenty men they examined. Furthermore, Bailey reported after the war that, of the nearly two million Americans deployed overseas, prior to February 1, 1919 only 4,039 men had to be returned home from the American Expeditionary Force for nervous or mental disabilities. "A small number," wrote Bailey, "especially when deduction is made of the 3,181 soldiers who were sent overseas in the face of psychiatric recommendations to the effect that they were not fit for military service of any kind." He concluded, "The insane, suicide, and delinquency rates in the American Expeditionary Forces were extraordinarily low for an expeditionary campaign." Moreover, he argued, psychiatric screening had performed an important public service by identifying individuals unfit for military service and instead directing them towards civilian war work in the United States.[39]

When considering Bailey's protestations about the success of screening it is important to recall his own understanding – and that of many of his colleagues – of the origins of traumatic neurosis. For a significant number of neuropsychiatrists, war neurosis and psychiatric casualties

[39] Bailey, "Detection and Elimination of Individuals with Nervous or Mental Disease," in *The Medical Department of the United States of America in the World War* vol. 10, 84.; Pearce Bailey and Roy Haber, "Analysis of Special Neuropsychiatric Reports," in *The Medical Department of the United States of America in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929),157-159. It should be noted that this number of 4,039 men evacuated to the United States for psychiatric reasons nearly doubled when the immediate postwar months are taken into account. Between January 1, 1918 and July 1, 1919 there were 8,772 men evacuated to the United States. Bailey maintained that psychiatric screening had still been successful, claiming that, "it seems probable that 8,640 cases were retained which were at one time recommended for discharge by the neuropsychiatrists." If there were 8,772 men evacuated from France, he wanted it known that such a number bore "close correspondence" with the number psychiatrists identified but were still deployed. Bailey, "Analysis of Special Neuropsychiatric Reports," in *The Medical Department of the United States of America in the World War* vol. 10, 175-176. As was the case with the British during WWI, accurate statistics for psychiatric casualties in the American army in the United States and the American Expeditionary Forces in Europe are difficult to ascertain. The same challenges that made it difficult for British statisticians – unclear diagnostic labels, a lack of routinization in recording psychiatric casualties, and the stigma that prevented some men from ever being diagnosed – make it difficult for historians to evaluate the true number of American soldiers suffering from severe psychological distress in WWI. All statistics should be viewed as approximations.

stemmed from a predisposition to mental illness in the individual. Pre-enlistment exams, therefore, were prophylactic in nature. The Surgeon General supported this assessment, writing in his report to the War Department in 1918 that "the chief functions of a neuropsychiatric department are therapeutic and preventative; of these the therapeutic is the least important from a purely military point of view… the real value to an army of neuropsychiatrists is the prevention of the occurrence of nervous and mental disease among troops." Thus, when Bailey and others considered the success of screening they did so not just by examining the number of psychiatric casualties that actually resulted from the war, but the number they imagined could have resulted had there been no attempts at screening at all. The process of psychiatric examination was a reflection of the profession's beliefs about the causes of psychological breakdown and it formed their views of success as well. These theories were grounded in the larger professional paradigms surrounding the etiology of mental illness, particularly the role of predisposition. By identifying and excluding almost 70,000 men from the military, the Division of Neurology and Psychiatry felt had performed an important service to the war effort on behalf of the mental health profession. As one military psychiatrist observed in the *American Journal of Insanity,* "Whatever may have been its shortcomings, psychiatry, in the examination of soldiers "made good."[40]

[40] *Report of the Surgeon General, U.S. Army to the Secretary of War* (Washington, DC: Government Printing Office, 1918), 369, 370.; George E. McPherson, "Neuro-Psychiatry in Army Camps," *The American Journal of Insanity* 76 (1919): 35.

Conclusion

Just as early discussions of shell shock in the U.S. and abroad built on an existing professional discourse related to traumatic neuroses, the response of American military medicine to the mental health challenges of WWI relied upon established frameworks built in the preceding decades in order to assemble the first organized military psychiatry apparatus in the United States. This coordination between civilian institutions and military leaders on the eve of WWI drew attention to the successes of the professionalization of the field at the turn of the new century. It led to the timely identification, recruitment, training, and deployment of mental health professionals through existing civilian networks. It also situated psychiatry within the larger pantheon of military medicine, providing yet another tool to help maintain the fighting force of the United States overseas.

Mobilization also laid bare the many challenges that still plagued the mental health profession in the early decades of the twentieth century. Some of these problems were systemic, such as a lack of coordinated training and educational standards across the field. These were remedied by again turning to established professional models. Other complications, however, highlighted more significant hurdles for the American psychiatrists to overcome. Public interest in neurasthenia and psychiatric illness had raised national awareness about mental health and helped reshape popular views of mental disease. The efforts of psychiatry to move the profession from the asylum to the laboratory galvanized its membership and increased its standing within the broader practice of medicine. Despite these advances, however, military psychiatrists still struggled for legitimacy among military leaders and their military medical colleagues, who remained in the grip of an older cultural perception of mental illness. As Pearce

Bailey wrote after the war, "the greatest obstacle to neuropsychiatry in both civil and military practice has been the barrier that tends to separate nervous and mental diseases from all other diseases." He argued that "the greatest good" for both neuropsychiatry and its patients could only occur when "a determined effort [was] made to break through this barrier" and "place the mental patient on par with patients incapacitated by reason of other diseases."[41]

Military psychiatrists tried to establish their legitimacy through relentless education and dedication to their patients. They worked with military leaders to build the hospitals they believed would be the most effective and cajoled base commanders to allow for rigorous screening. Unfortunately, whereas a surgical wound or a disease like influenza was apparent to the layman, neuropsychiatrists often found themselves negotiating with non-professionals about the severity of symptoms that were not readily obvious. To the frustration of both psychiatrist and commander, mentally unfit individuals still deployed despite all of these efforts. So while mobilization provided a significant opportunity for the mental health field to once again emphasize the crucial nature of its work, it also reiterated the importance of continuing to foster a close and productive relationship with the public and highlighted the consequences of failing to do so. The American mental health community would need to rely on their partnership with military leaders once they deployed overseas and put the new military psychiatry to the test on the field of battle.

[41] Pearce Bailey, "Provisions for Care of Mental and Nervous Cases," in *The Medical Department of the United States of America in the World War* vol. 10, 42-43.

CHAPTER SIX: CONFRONTING THE CHALLENGE OF SHELL SHOCK – AMERICAN FORWARD PSYCHIATRY IN WORLD WAR I

From the start of the war in Europe in 1914 through the deployment of American soldiers in mid-1917, the mental health profession in the United States observed their allies, theorized about the nature of war neurosis, and began the important work of establishing the first ever American military psychiatry apparatus. They built hospitals, screened recruits, and mobilized psychiatrists for war. Despite all of their preparation, however, there was one last threshold for the mental health community to cross: to deploy their ideas on the battlefield and test them against the challenges of war. For all of their debate and study on the topic, men like Thomas Salmon, Pearce Bailey, and the rest of the Division of Neurology and Psychiatry ultimately had one goal in mind: to preserve the fighting force of the United States by decreasing the incidence of mental illness in American soldiers overseas. Their ability to do so – and thereby, the success of military psychiatry – could only be judged once the first soldiers and the first psychiatrists landed in Europe.

The operationalization of American ideas about mental illness and psychological breakdown in battle culminated in the creation of the process called forward psychiatry. This method incorporated targeted therapy with the efficient evacuation of psychiatric casualties through a series of escalating echelons of care, with mental health experts placed at different levels to guide the treatment of the soldier in question. Forward psychiatry was premised on two important principles. The first coincided with the primary objective of military psychiatry, and

that was to return men to the line of battle as quickly as possible. Fortuitously for psychiatrists, their understanding of shell shock allowed the second principle to complement their desire to expeditiously return men to the front. Based on their study of shell shock in England and France, American mental health experts came to regard the condition as they did any other neurosis. This meant treatment centered on preventing the neurotic thoughts from settling in the mind of the patient and creating what psychiatrists feared might be a chronic condition. In a war-setting, this meant providing therapy to the soldier as quickly as possible in the hopes of keeping his mind focused on the fighting and not his individual suffering.

The success of forward psychiatry required the American mental health community to continue to foster the relationships it had developed during its period of mobilization. Military psychiatrists needed to maintain a close and cooperative partnership with U.S. military officials, particularly when the challenges of war required them to adjust their plans in order to improve care. Additionally, American mental health experts at home and stationed in Europe had to continue to observe and learn from their more experienced Allied partners. Forward psychiatry mirrored some processes already established by the British and the French, but even more so, it reflected the success of American psychiatrists in overcoming the mistakes of their European colleagues.[1]

[1] This chapter does not purport to judge the adequacy of military psychiatry during WWI against what mental health professionals understand about psychological trauma in the twenty-first century. It does, however, explore what contemporary American military psychiatrists considered to be successful treatment. Additionally, discussions of American forward psychiatry during WWI are not new. Ben Shephard, for example, has an adequate summary in *A War of Nerves* (2001). This chapter offers a more substantial examination of American efforts than that provided by Shephard. Furthermore, it adds to our understanding of American military psychiatry in WWI by highlighting both the influence of the European experience on American decisions and the interaction between U.S military psychiatrists and other military officials during the war.

The Concept of Forward Psychiatry

The first soldiers of the American Expeditionary Force (AEF) began to arrive in France in the summer of 1917. While Pearce Bailey worked to recruit and train psychiatrists for the Army Medical Corps, and the War Work Committee of the National Committee on Mental Hygiene (NCMH) coordinated with the Office of the Surgeon General to build psychiatric wards, a battalion of men from the 16th Regiment of the regular army participated in a parade through Paris on July 4, 1917. The parade was more symbolic than strategic. America's aid to its French allies marked the recognition of the alliance formed between the two nations during the American Revolutionary War over a century ago. More significantly however, these soldiers signaled the entrance of a potentially powerful new actor into a war that, after more than two and a half years, had grown into a protracted and bloody stalemate between the opposing sides. By October 1917, the 1st Division held a small sector of the Western Front in France and later in November, suffered the first American casualties of the war. By January 1918, approximately 175,000 American soldiers had arrived in Europe. The deployment of American soldiers peaked in July 1918, with more than 30,000 soldiers arriving in France almost daily. By the time of the armistice in November 1918, the AEF comprised almost 4.8 million soldiers, sailors, and marines.[2]

The arrival of the Americans in mid-1918 was fortuitous because it coincided with a series of successful attacks engineered by German commander Erich Ludendorff. The AEF participated in sustained, active operations during the last five and a half months of the war.

[2] Robert Zieger, *America's Great War: World War I and the American Experience* (Lanham, MD: Rowman and Littlefield Publishers, Inc., 2000), 91, 98.; Edward M. Coffman, *The War to End All Wars: The American Military Experience in World War I* (Louisville: The University of Kentucky Press, 1968, reprint 1998), 357.

U.S. forces contributed to Allied efforts at Chateau-Thierry and in Belleau Wood, joined French soldiers in the Second Battle of the Marne in July, undertook the first major U.S.-led action at St. Mihiel in September, and participated in the Meuse-Argonne campaign, the final Allied offensive of the war. Despite the relatively short amount of time that U.S. troops fought in WWI, around 60,000 Americans died in battle and approximately the same number succumbed to diseases, including influenza.[3]

During these battles, American soldiers and marines encountered the same horrific conditions that had bedeviled British, French, and German troops since the opening weeks of the conflict, including gas attacks, artillery bombardments, terrifying attacks across "No Man's Land" and life in mud-filled trenches. The arduous nature of the war was compounded by the rushed mobilization of American soldiers and their rapid deployment overseas to help stem the Ludendorff Offensives in the spring and summer of 1918. Americans on the frontline faced inadequate training, inexperienced officers, and supply shortages. The myth of heroism and adventure that had inspired so many young men to rally around the flag did not last long when confronted by the reality of war.[4]

Rapid mobilization and difficult conditions also challenged Thomas Salmon and the new Division of Neurology and Psychiatry (DNP) from their arrival in Europe in 1917 until the demobilization and return of American forces throughout 1919. The DNP had to place psychiatrists, establish hospitals, and begin treating casualties all in the midst of an evolving military situation. Salmon arrived in France in late December 1917 and assumed the role of senior consultant in neuropsychiatry to the AEF. He led the American psychiatric effort in

[3] Zieger, *America's Great War,* 95, 97-102,108.

[4] Zieger, *America's Great War,* 92-97.; Coffman, *The War to End All Wars*, 212-261.; David M. Kennedy, *Over Here: The First World War and American Society* (New York: Oxford University Press, 1980), 191-205.

Europe in coordination with Pearce Bailey, who was now the Chief of the Division of Neurology and Psychiatry. Bailey stayed in Washington, D.C. in the Office of the Surgeon General, but he remained in close contact with Salmon in the ensuing months. In the fall of 1918, he made the trip to American lines in Europe to consult with Salmon face-to-face and observe American military psychiatry in action.[5]

American military psychiatrists turned to familiar avenues to help them overcome the challenges of establishing a foothold in Europe. Bailey, Salmon, and the rest of the DNP relied heavily upon the work done by the NCMH and the War Work Committee prior to the division's mobilization in the United States. This continued throughout the DNP's deployment overseas. In addition to overseeing the construction of psychiatric hospitals within the United States, the NCMH worked closely with Salmon to provide support to psychiatrists in Europe. The committee's principal assistance came in the form of financial contributions. Rushed mobilization and the newness of military psychiatry meant that it lacked consistent support from the American military. The DNP frequently turned to the NCMH for money in order to purchase supplies for military psychiatrists in Europe. In a letter to the NCMH, Salmon complained that attempts to work within the bureaucracy of the Medical Department failed to yield results in a timely manner. In response to this need, members of the National Committee for Mental Hygiene provided Salmon with $5,700 in 1918 and pledged another $5,000 in 1919. Salmon couched his requests to the NCMH by pointing out that military psychiatrists were caring for

[5] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2000), 130-131.; Thomas Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 294-297.

"just the class of patients that the National Committee exists to serve." Nevertheless, Salmon and the rest of the mental health community remained frustrated by military inefficiency.[6]

In addition to relying on their civilian network back home, American military psychiatrists also continued to learn from the expertise of their allies, often adapting as the war dragged on and American casualties mounted. They paid particular attention to the British experience evacuating psychiatric casualties from the frontline. This manner of treating mental health patients would be new to American military medicine. Indeed, a codified process of organized evacuation for any medical casualty during wartime was still relatively novel. The French first experimented with ambulances during the Napoleonic wars of the early nineteenth-century, with the British following suit with little success during the Crimean war in the 1850s. Even in the rare instances that such ambulances could be organized, well-staffed hospitals with clean conditions were difficult to come by in Western militaries. Military doctors often treated men where they fell before moving on to the next wounded soldier.[7]

The American system of evacuation using ambulances and hospitals had more success during the Civil War, though as historian Margaret Humphreys describes, this was not without "a steep learning-curve." The idea of hospitals – military or otherwise – was only just gaining

[6] "In Reference to an Appropriation of $5,000 from our War Work Fund for the Year 1919," Thomas Salmon Papers, Box 2, Folder 4, Courtesy of the Oskar Diethelm Library, DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell Medical College. Hereafter ODL. In turn, the NCMH relied on the Rockefeller Foundation for financial support. In December 1917, the foundation appropriated $25,000 for the committee's "special work in mental hygiene in connection with the American Army and Navy during 1918." Letter to Clifford Beers from Edwin Enbree, December 6, 1917, Thomas Salmon Papers, Box 2, Folder 3, ODL. Psychiatrists were not the only group to turn to civilian organizations for assistance in their war efforts. The Committee on Medical Preparedness -- comprised of the American Medical Association and the American College of Surgeons – supported efforts to train, supply, and mobilize doctors and surgeons for the American military. For a discussion of their efforts see Mary C. Gillet, *The Army Medical Department 1917-1941* (Washington: U.S. Government Printing Office, 2009), 4-11.

[7] Richard A. Gabriel, *Between Flesh and Steel: A History of Military Medicine from the Middle Ages to the War in Afghanistan* (Dulles, VA: Potomac Books, 2013), 143-161.

popularity within the United States when that war broke out. The exigencies of war, particularly the desire of the military to keep their soldiers close and not return wounded men to their families, led to the purposeful requisition or construction of army hospitals relatively close to the fighting. The Union army utilized litter-bearers and ambulances to greater effect as well, though the deployment of ambulances could be haphazard and the construction of the ambulances themselves could make them unusable on some terrain. Despite these challenges, however, the United States military realized that an organized system of patient care, particularly evacuation, would be necessary to the efficient conduct of a war. This was especially obvious after the difficulties military doctors encountered during the Spanish-American War. Chains of evacuation, spread across oceans in this instance, were confused and chaotic, rendering treatment slow and sometimes ineffective. An Army Medical Department manual released in 1911, only six years before the United States deployed soldiers to Europe, laid out a plan for medical care designed to support an army division of twenty-thousand men. It called for a chain of evacuation beginning with a clearing station close to the frontline and ending with a well-staffed hospital further in the rear. Trained ambulance companies would ferry the wounded using everything from hand-carried litters to automobiles or even trains.[8]

Thomas Salmon and other American mental health professionals had studied the British process for evacuating psychiatric cases during their observations of the Allied experience with

[8] Margaret Humphreys, *Marrow of Tragedy: The Health Crisis of the American Civil War* (Baltimore: The Johns Hopkins University Press, 2013), 21-26. It is interesting to note that, just as the National Committee on Mental Hygiene provided invaluable support to the organization and operation of the Division of Neurology and Psychiatry in WWI, Humphreys attributes much of the success of Union Army medicine to the assistance of a non-military organization, in this case the United States Sanitary Commission. Like the NCMH, the USSC provided training to doctors and assisted with the organization of hospitals. See Humphreys, *Marrow of Tragedy*, 103-130. Mary C. Gillet, *The Army Medical Department 1818-1865* (Washington: U.S. Government Printing Office, 1987), 151-176.; Mary C. Gillet, *The Army Medical Department 1865-1917* (Washington: U.S. Government Printing Office, 1995) 332-333. For an extended discussion of the Army Medical Department's efforts to systematize military medicine at the turn of the twentieth century see Gillet, *The Army Medical Department 1865-1917*, 313-346.

shell shock casualties. The Americans were not impressed by the early British efforts, but they were not alone in this; British psychiatrists were displeased as well. Confronted by a growing number of mental health complaints in the winter of 1914, military leaders in London ordered that all such soldiers should be evacuated back to England for further treatment. This became the British practice, regardless of the soldier's psychiatric complaint, for the first two years of the fighting. Charles Myers, who oversaw the British response to war neurosis in Europe, quickly realized that this was unworkable. He argued that, not only was the military evacuating men whom he believed could remain in their units after minimal treatment, but from a therapeutic perspective, Myers worried that serious cases of shell shock received little specialized treatment either in Europe or upon arrival England. This, he warned, could worsen what he considered a temporary condition. He began to agitate for specialized hospitals to treat shell shock near the frontlines and by 1916 the British had established special care centers for the treatment of war neuroses nearer to the frontlines.[9]

Salmon absorbed these lessons during his overseas trip in the summer of 1917 and used them to inform his thinking on American military psychiatry, as well as his views on the nature of shell shock. Like Myers, Salmon believed the difficulties of the British early in the war stemmed from their failure to understand the make-up of war neuroses. He was determined to prevent a similar catastrophe within the United States military. He described his concern, as well as his optimism, in an October 20, 1917 letter to Brigadier General Alfred E. Bradley, the Chief Surgeon of the AEF whom Salmon had met while he toured England. "I am convinced," he wrote to Bradley, "that, through profiting by the English and Canadian experience, we can avoid errors which have led to much confusion in dealing with [psychological] disorders, especially

[9] Charles S. Myers, *Shell Shock in France* (Cambridge: Cambridge University Press, 1940), 88-92.; Shephard, *A War of Nerves*, 27, 54.

war neuroses." Instituting rigorous screening procedures for military recruits was a crucial part of Salmon's solution, as he outlined in his 2017 report to the Surgeon General. But he knew that despite the best efforts of psychiatrists in the United States, the scourge of mental illness – particularly shell shock – would not be eliminated through screening alone and war neurosis would undoubtedly plague American soldiers. Forward psychiatry practiced by trained professionals, he argued, would meet this need.[10]

Forward psychiatry meant creating a chain of evacuation for psychiatric casualties that prioritized treatment as close to the frontlines as possible. This concept proved to be both an efficient means of moving men and conducive to military psychiatrists' theories about the treatment of war neurosis. Salmon, Myers, and other military psychiatrists based their belief that forward psychiatry would be effective treatment for war neurosis upon their developing understanding of the nature of the condition. Salmon, for example, argued that war neurosis was "curable in the great majority of instances" because it was "essentially a problem of psychological medicine." In this he meant that the illness – particularly minor cases – could be addressed with suggestion, distraction, and structured discipline. Specifically, the psychiatrists needed to help the patient realize that the condition was merely temporary and something that the soldier could easily overcome.[11]

Experience led military psychiatrists from France and Britain to conclude that such therapy was best done as near to the frontlines as possible. In their opinion, every mile removed

[10] Thomas Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army", in "Appendix," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 513, 515.; Thomas Salmon to General Alfred Bradley, October 20, 1917, General 710 (Shell Shock), Box 396, General Correspondence, 1917-1927, Records of the Office of the Surgeon General (Army), Record Group 112, National Archives at College Park, College Park, Maryland. Hereafter RG 112, NARA II.

[11] Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army," in *The Medical Department of the United States Army in the World War* vol. 10, 509.

from the fighting made it easier for the neurosis to implant itself in the mind of the patient. Charles Myers observed, "When [shell shock patients] were in a Base hospital almost within sight of England, their chances of rapid recovery were very much diminished, since consciously or unconsciously they were influenced by the expectation of being sent home." Therefore, he argued, men with symptoms of war neurosis should receive treatment nearer to the front. Salmon echoed this same observation in his report to the Surgeon General in 1917, writing, "recovery within the sound of artillery or at least somewhere in France is more prompt and durable than that which takes place in England." Salmon and Myers were not alone in their views on the importance of proximity to successful treatment. Other military psychiatrists strongly supported the argument that forward psychiatry led to greater success. Pearce Bailey wrote to Salmon shortly before the latter arrived in France in December 1917, "the idea should be thoroughly disseminated [among American military personnel] that shell shock does not constitute a disability serious enough to merit a man being sent back to a base hospital and never is a cause for discharge from the Army."[12]

Salmon heard similar pronouncements from neuropsychiatrists while he toured England earlier in the year. He compiled these anecdotal testimonies about the effectiveness of treating shell shock casualties close to the frontline and included them when he made his case to the Surgeon General about the need for organized military psychiatry in the United States. He also sent excerpts, along with his recommendations, in his letter to General Bradley in November 1917 in hopes of persuading the general about the utility of forward psychiatry. One U.S. Army

[12] Myers, *Shell Shock in France*, 88-89.; Salmon, "The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army," in *The Medical Department of the United States Army in the World War* vol. 10, 509.; Pearce Bailey to Thomas Salmon, December 10, 1917, General 710 (Shell Shock), Box 396, General Correspondence, 1917-1927, RG 112, NARA II.; See also Pearce Bailey, "War Neuroses, Shell Shock, and Nervousness in Soldiers," *Journal of the American Medical Association* 71 (1918): 2148-2153.

neurologist serving in a base hospital with the British expeditionary force reported to Salmon: "It is a mistake to send these cases to England… I hope our Army will have a psychiatrist in each Casualty Clearing Station to weed these cases out and send them to their proper places and not have them knock around from one general hospital to another, being pampered into hard set neuroses." From Frederick Mott, Salmon recorded, "I regard this matter of preventing the fixation of a functional paralysis as of supreme importance both in respect to the welfare of the individual and from the economic point of view of the State." C.B. Farrar, whom Pearce Bailey had met during his tour of Canada, offered a candid observation regarding necessity of treating men close to the frontline. He told Salmon, "It seems to be a fact that treatment is more satisfactorily carried out and cure is more speedily accompanied in hospitals close to the front and where the spirit of army discipline is most felt." This was in contrast to treating men away from the war theater. "It is conceded," Farrar continued, "that the worst possible place to treat a case of war neurosis is in his hometown. Out of danger, far from the front, perhaps among hero –worshipping friends the invalid is unavoidably conscious of himself more as an individual and less as a link in the battle line." In such instances, he concluded, "all the conditions are favorable for the fixation and reinforcement of the neuroses as an ideogenic process."[13]

The French and the British learned the lesson of forward psychiatry too late. Myers did what he could to establish focused treatment centers, but by the time the first spaces were erected in 1916, the British Expeditionary Force was too fixed in its existing processes to make radical changes to their care of psychiatric casualties. The treatment centers made a difference, but it

[13] Thomas Salmon to Edgar King, "Recommendations for the care and treatment of war neuroses ("shell shock") and insanity, in the American Expeditionary Force," November 6, 1917, General 710 (Shell Shock), Box 396, General Correspondence, 1917-1927, RG 112, NARA II.

was too little, too late to help many of the men suffering from psychological trauma. American military psychiatrists witnessed this struggle and answered with a form of therapy built around an organized chain of evacuation, staffed with carefully-placed, well-trained mental health experts. While the United States had learned from their allies that treating soldiers with war neurosis close to the frontline was seemingly the most effective form of therapy, American military psychiatrists led by Thomas Salmon were the first to operationalize this form of treatment over the entire chain of evacuation.

Forward Psychiatry in Practice

Any number of circumstances could start a man on the journey through the evacuation process of forward psychiatry. While American psychiatrists in 1917 largely agreed that war neurosis stemmed from psychological and not physical causes, they could not identify any particular set of circumstances in which shell shock would, or would not, result. What led the condition to develop in some men, they observed, would leave others unaffected. After the war, American neurologist and NCMH member E.E. Southard compiled a book of five hundred and eighty-nine case histories in order to try and understand the different manifestations of shell shock. He collected these cases from American neuropsychiatrists, but also French, British, and even Russian doctors. Skimming through the pages of the book, it is obvious to the historian, as it likely was to the practitioner, that there are no patterns or common traits among the men in question. Dozens of soldiers are grouped together as having experienced a physical event that led to their examination for a psychiatric illness. Examples of these precipitating events ranged from the mundane, such as shell explosions, bullet wounds, or burial after an artillery blast, to

the more unique, like a man kicked by a horse or the soldier rendered unconscious after being hit over the head by "marauding gypsies" while training in England. Southard's text also reports numerous instances of soldiers whose symptoms appeared with no clear link to a somatic complaint. He recorded men whose suffering began after the death of a comrade or near-miss by an unexploded shell. One soldier lapsed into a coma-like state when he mistakenly believed his brother had been killed, while another collapsed after witnessing a particularly violent battle. Doctors had to restrain the latter soldier when he continually escaped the hospital in a delirious state in an attempt to rescue the wounded from his unit.[14]

Regardless of the situation that brought on the symptoms of war neurosis, American soldiers all moved within the same hierarchy of treatment—excepting those serving in French units early in the American deployment. With only a limited American military medical apparatus in place – let alone specialized treatment centers – commanding officers evacuated psychiatric casualties or men displaying symptoms of exhaustion to French hospitals far in the rear. Overwhelmed with their own wounded, the French military passed off American casualties to U.S. doctors as soon as they were able. It was not until the end of 1917 that the DNP was able to gain a foothold in France and begin implementing forward psychiatry.[15]

Like any wounded man on the frontline, the first stop for a U.S. soldier suffering a psychiatric complaint was the advanced aid station – sometimes referred to as the battalion aid station. These spaces could either be semi-permanent structures dug deep into trench lines or a

[14] Elmer E. Southard, *Shell-Shock and Other Neuropsychiatric Problems: Presented in Five Hundred and Eighty-Nine Case Histories* (Boston: W.M. Leonard, 1919).

[15] Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 273-276.; Edwin G. Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 305.

makeshift series of tents and tables. Their construction often depended on the stability of the battle line, with medical officers having to make-do with any relatively secure area when troops were making rapid forward progress. Ideally, the advanced aid station would be no further than five-hundred yards from the front. Some battalions located their aid stations in close proximity to the communication tents so that the surgeon in charge could have ready access to the commanding officers. Other battalions did the exact opposite; situating the medical team as far away from the military leadership as practicable for fear a single well-placed shell could devastate two key components of the battalion.[16]

A soldier showing signs of mental illness encountered his first round of medical triage at the advanced aid station. With a skeleton staff usually limited to a single medical officer and a handful of enlisted men, the goal of this stop in the chain of evacuation was to administer more advanced aid beyond the splints or bandages applied by a stretcher bearer. At the same time, the medical personnel at this stage were not equipped for complex or extended medical treatment. Thus the level of triage at this stage was very simple: did this soldier require medical care beyond what could be provided in a few moments? Patients with minor injuries or illnesses received care and immediately returned to their companies, often after a warm meal. More serious cases saw their bleeding staunched, bandages changed, and morphine and a tetanus shot administered. Medical personnel also began to fill out the special identification tags that would follow the patient further up the line of evacuation.[17]

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[16] Charles Lynch, Joseph Ford, and Frank Weed, *The Medical Department of the United States Army in the World War* vol. 8 (Washington: U.S. Government Printing Office, 1929), 111-116. The volumes of *The Medical Department of the United States Army in the World War* were variously written by one or two authors (in this case three) or edited volumes of chapters written by a dozen or more authors. Volume eight is an example of the former, whereas volumes one and ten, for instance, are examples of the latter.

[17] Lynch, Ford, and Weed, *The Medical Department of the United States Army in the World War* vol. 8, 111-116.

At this level, a psychiatric casualty may have received a brief examination by a medical officer who likely possessed no specialized mental health training. It was up to the discretion of this officer to determine whether or not the soldier's symptoms warranted escalation to the next level of care. There are no exact statistics that indicate the frequency with which psychiatric casualties or suspected psychiatric casualties moved from the advanced aid station up the chain of evacuation. Soldiers at this stage did not receive an official diagnosis, making it difficult to determine the number of men with psychiatric complaints who filtered through these stations. Undoubtedly, soldiers with overt symptoms such as severe tremors or paralysis were sent along with little debate. If, however, a soldier's symptoms were more subtle, his further care depended on the medical officer's acceptance – and appreciation – of the nuances of psychiatric illness. It is likely that many an American soldier suffering a psychiatric complaint came up against an officer with either little respect for mental illness or a limited understanding of shell shock. Even if the Medical Department had maintained careful statistics at this level, it is probable that a tally of the casualties would never accurately reflect the actual number of sufferers that arrived at an advanced aid station in mental distress; nor would the percentage paint an adequate picture of the frequency with which psychiatric casualties at this stage returned to the line or subsequently moved on through the chain of evacuation.[18]

The battle casualty then traveled from the advanced aid station located only a few hundred yards from the fighting to a dressing station between 3,000 and 6,000 yards away from the front. Dressing stations were overseen by the division's ambulance company and were positioned close enough to the fighting to be within distance of enemy artillery. Whereas aid stations were hastily assembled and often impermanent, dressing stations tended to be more

[18] Lynch, Ford, and Weed, *The Medical Department of the United States Army in the World War* vol. 8, 111-116.

stationary and thus could be found in buildings, churches, or other abandoned structures further back from the line. The mode of transport from aid station to dressing station varied based on the location of the division, the terrain, and the exigencies of battle. Ambulance trains used for moving soldiers along the chain of evacuation were comprised of a collection of motorized vehicles, horse drawn carts, litters – sometimes carried by hand and sometimes wheeled when the terrain permitted – and in some locations, even Spanish mules and British motorcycles equipped with sidecars. If the dressing station was further away than a thousand yards, the ambulance company set up a series of relay stations where litter bearers could be exchanged, horses watered, and most importantly, patients checked and necessary aid re-administered.[19]

Dressing stations performed a mission similar to that of the advanced aid station, but on a larger-scale. Some dressing stations performed extensive triage on behalf of the division. In those instances, a psychiatrist would be at this location to begin the first formal examinations and treatments of the psychiatric casualties. There would also be an orthopedist, surgeon, and a gas officer to treat any gas casualties. Most divisions, however, utilized the dressing station to conduct a more thorough triage than the soldier received at the aid station before moving him once again to the next hospital where he could receive specialized care.[20]

Upon his arrival at the dressing station, the battle casualty would be examined by one of the handful of available staff. Medical officers at this level of care sorted casualties twice, each time into broad categories based on the severity of the man's wound or illness. The classification identified patients suffering from gas exposure, venereal disease, miscellaneous illnesses, skin conditions, or just general exhaustion and separated them from all other casualties

[19] Lynch, Ford, and Weed, *The Medical Department of the United States Army in the World War* vol. 8, 122.

[20] Lynch, Ford, and Weed, *The Medical Department of the United States Army in the World War* vol. 8, 122-134.

– for example, explicit surgical or orthopedic cases. Then the groups were organized again, this time by the severity of their condition ranging in gradations from "very slight" to "nontransportable." Men in the first category were returned to duty while the last were kept at the station until either their wounds or illness improved enough that they could be moved. Sometimes doctors made the unfortunate decision a man would not improve with further treatment and he was made comfortable until he passed away.[21]

Mental health cases proved as challenging to classify at this level of evacuation as they were at the aid station. Again, few medical officers at this echelon of care possessed psychiatric training and they had to rely more on instinct than on procedure in the proper dispensation of a psychiatric casualty. One doctor recalled after the war, "Men claiming mental or nervous disability were especially difficult to classify, for some of them were malingerers, others were slightly affected but magnified their symptoms, and a few were bona fide cases of disability." With more time for examinations at their disposal, medical officers at dressing stations usually felt confident identifying some of the more overt symptoms of mental illness, such as tics, tremors, and stupors. Even without physical signs, often times the suffering of these men was readily obvious. The official history of neuropsychiatry during the war painted a vivid description of the psychiatric casualties that arrived at dressing stations with clear signs of nervous exhaustion. These were "men who were worn out, upon seeing their comrades killed or injured, and possibly being knocked over themselves by an exploding shell." As a result, these

[21] Lynch, Ford, and Weed, *The Medical Department of the United States Army in the World War* vol. 8, 122-134.

men "lost their nerve, cried, shook all over and felt afraid, crouched and put up their arms as if to protect themselves each time they heard a shell coming or exploding."[22]

If the medical staff at the dressing station determined that a casualty warranted further care, they made the soldier as secure and comfortable as possible and loaded him into an ambulance or available form of transportation for the journey to a division field hospital. The Medical Corps made no special provision for the movement of psychiatric casualties at this stage, so these men traveled along with their wounded comrades. The only unique accommodation came in the form of labelling. Each casualty carried a medical tag identifying the care rendered at each stop and any other immediately important information about his condition. The Surgeon General, on the recommendation of mental health practitioners, ordered medical personnel to write "N.Y.D. (nervous)" on the tags of all men suspected of suffering from a nervous disorder, including war neuroses. This identified the casualty as "Not Yet Diagnosed," but initial observations pointed to a mental complaint. Medical officers at dressing stations knew that some signs of mental illness were subtle and they worried that these symptoms could either be hidden to avoid treatment or feigned by a determined malingerer. As one military psychiatrist recalled, it was not uncommon for soldiers to "wander into dressing stations and cheerfully announce that they were 'shell shocked.'" The truth of that statement had to be judged by either a medical officer or, during especially busy times, an enlisted man attached to the ambulance company or sanitary train. Just as with their colleagues at the aid station, medical officers at

[22] Lynch, Ford, and Weed, *The Medical Department of the United States Army in the World War* vol. 8, 124.; Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 311.

dressing stations had to rely on their best judgement when determining the severity of a soldier's psychiatric complaint.[23]

The use of N.Y.D. (nervous) as a naming practice is yet another example of a lesson the Americans learned from their British allies. By late 1915, British soldiers and medical professionals recognized the presence of shell shock on the battlefield, even if they did not wholly understand the nature of the condition or its cause. Military leaders in London instructed British doctors and psychiatrists to label shell shock casualties either "Shell-Shock W" or "Shell-Shock S." The two terms reflected the ongoing debate among psychiatrists about the etiology of the condition. "Shell-Shock W" patients were those men whose symptoms could be definitively linked to enemy action, particularly a shell blast or other explosion. The "W" in the diagnosis signified that the patient was wounded in combat and entitled to the benefits accorded any wounded man, including a pension. Doctors used "Shell-Shock S," however, to denote men whose psychiatric condition could not be readily connected to a physical blow. The "S" in this label marked the shell shock sufferer as sick and not wounded, meaning that the man did not receive the special consideration provided to this latter subset of soldiers. "Shell-Shock S" patients were not entitled to a pension, nor did they receive the less tangible – but still very real – respect the military and the public bestowed on wounded men.[24]

Despite these efforts by the British military to efficiently organize shell shock casualties, the two designations quickly proved to be unworkable in the field. Doctors applied the labels inconsistently, if they used them at all. As historian Ben Shephard notes, "Depending on the circumstances, a shell-shocked soldier might earn a wound stripe and a pension… be shot for

[23] Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 311.

[24] Shephard, *A War of Nerves,* 28-29.

cowardice, or simply be told to pull himself together by his medical officer and sent back to duty." More than one British psychiatric casualty simply received the diagnosis "GOK" or "God Only Knows." Historians can interpret this diagnostic label as tongue-in-cheek or perhaps representative of the chaotic nature of frontline medicine where doctors had little time for nuanced examinations or careful diagnosis. It is just as likely, however, that the "GOK" label represented a genuine bafflement among British military physicians when they were confronted by psychiatric casualties. Like their American colleagues, British doctors had little formal training in mental health care and were unprepared for the high number of psychological cases that required their attention. It is very possible that an English military physician did not know how to appropriately diagnosis a shell shock patient and thus, left the determination to a higher power – the doctor at the next hospital.[25]

The British also discovered another unintended consequence of using the shell shock label. Soldiers learned that a case of shell shock meant removal from the frontlines and a possible pension. Undeterred by the stigma attached to the condition and reasoning that the danger of war outweighed the risk of a charge of malingering, British troops began to visit aid stations claiming they suffered from shell shock. Charles Myers received numerous complaints from medical officers who dealt with such men. These soldiers were "dirty sneaks," the doctors complained and Myers was inclined to agree, writing that he also saw "too many men at Base Hospitals and Clearing Stations boasting that they were 'suffering from shellshock, Sir.'" Myers feared that military physicians would start to turn away all psychological casualties, denying much needed to treatment to actual psychiatric patients. He also worried that the military's reliance on the phrase "shell shock" perpetuated a misunderstanding of the condition among

[25] Shephard, *A War of Nerves*, 29.

soldiers and military leaders. As the British Army prepared for the Battle of the Somme in the summer of 1916, the mental health community coalesced around the understanding that shell shock was likely caused by psychological and not physical factors. The continued use of "shell shock," with its implicit connection to shell blasts, created a narrower definition of the illness than Myers and other psychiatrists preferred. In 1917, after repeated entreaties by Myers, the British Army directed that all suspected cases of war neurosis be labeled "NYDN – Not Yet Diagnosed Nervous" at the frontline and then sent for further treatment at a specialized center for psychiatric disorders. By September 1918, the phrase "shell shock" was officially eliminated from the British Army's lexicon. [26]

Having witnessed the difficulties experienced by the British, the Americans adopted the parallel diagnostic label "N.Y.D. (nervous")" soon after their arrival in France. From the perspective of military medical leaders, this served two important purposes. The first reflected their observations of the British, as well as their own experiences with a soldier population familiar with – but not adequately educated about – shell shock. Despite the efforts of military psychiatrists, particularly Thomas Salmon, to limit the use of the phrase "shell shock," it remained popular among the military and in the public back home. Military psychiatrists noted after the war that it "manifestly impossible" to eliminate the term in "ordinary speech." By choosing not to apply the label of shell shock or war neuroses and instead offering the purposefully vague "Not Yet Diagnosed, (nervous)," military psychiatrists felt they could

[26] Charles Myers quoted in Shephard, *A War of Nerves*, 29. See also Shephard, *A War of Nerves*, 54-55.; Myers, *Shell Shock in France*, 98-101.

dissuade attention-seekers or malingerers who believed a shell shock diagnosis meant an easy way out of combat.[27]

The second and more important purpose related to men whom doctors believed might actually be suffering from war neurosis. As the official history noted, "By using the term 'N.Y.D. (nervous), [potential shell shock patients] had nothing definite to cling to and no definite suggestion had been given to assist them in formulating in their own minds their disorder into something which was generally recognized as incapacitating and as warranting treatment in a hospital." If that man was a malingerer, medical personnel feared that providing an official diagnosis like shell shock would supply the man with a false justification for his claims, "thus honorably releasing them from combat duty." For true sufferers, however, a nebulous diagnosis allowed military psychiatrists along the chain of evacuation to influence the soldier's perception of his illness. This, recall, was a key tenet of forward psychiatry. Indeed, this non-diagnosis represented one of the first actions designed by military psychiatrists to treat war neuroses. "The patients," the official history recorded, were "open to the explanations of the medical officers and to the suggestion that they were only tired and a little nervous, and that with a short rest they would be fit for duty again." By not naming the condition – whether the man suffered from it or not – military psychiatrists believed they could prevent war neuroses from settling like a pall over a man's conscious and preventing him from responding to their treatment techniques.[28]

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[27] John H.W. Rhein and Roscoe W. Hall, "Army Neurological Hospitals," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 333-334.; Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 311.; Shephard, *A War of Nerves,* 128-129. For a longer discussion of the public interest in shell shock, see Chapter Seven.

[28] Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 311.; Shephard, *A War of Nerves,* 128-129.

Medical officers sent those psychiatric casualties whom they deemed serious from clearing stations to field hospitals further back from the frontline. These hospitals existed anywhere from six to eight miles from the fighting, though this varied from division to division depending on the location of appropriate buildings. Divisions placed their field hospitals in established structures in towns, barracks, or the chateaux of wealthy French citizens, though during times of heavy action, military leaders might order the construction of large tents near a roadway or thoroughfare to fulfill this function. Whether tent or building, the term "field hospital" rarely referred to a single structure, but instead, described a collection of spaces that functioned more as a medical campus. Different medical specialties established a base of operations in their respective building, including surgeons, internists, orthopedists, and psychiatrists.[29]

Here at the division level, a psychiatric casualty received his first specialized aid from a mental health professional. The idea of a division psychiatrist was among Salmon's greatest contributions to military psychiatry. It was also a direct result of his observations of the difficulties encountered by British military doctors who, early in the war, had chosen to send their psychiatric casualties back to England. The principles of forward psychiatry depended on a shell shocked soldier receiving specialized treatment from a mental health expert as near to the frontlines as possible. For Salmon and the DNP, this meant placing trained military psychiatrists at the division level, capable of treating men with a structured program of therapy and returning them back to their units.[30]

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[29] Lynch, Ford, and Weed, *The Medical Department of the United States Army in the World War* vol. 8, 125-128, 142-143.

[30] Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 277.; Shephard, *War of Nerves,* 128-129.; Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 303.

At first, the United States War Department and the Army Medical Corps only approved attaching neuropsychiatric consultants to tactical divisions. Unfortunately, as consultants, these men had no standing within the chain of command of the medical organization and found themselves subordinated to other doctors. In some instances, these doctors tasked the consultants with general medical duties, the very outcome many psychiatrists had feared when first recruited for overseas duty by the NCMH.[31]

To remedy this situation, the DNP advocated reclassifying psychiatric consultants as medical officers at the division level. The War Department approved, and on January 15, 1918 the General Bradley, the Chief Surgeon of the AEF released Circular No. 5. Directed to medical officers and division leaders, the document codified the role of the division psychiatrist within the military medical hierarchy and outlined his specific duties. Salmon and other leaders of the Division for Neurology and Psychiatry relied on the weight of the office of the theater's highest-ranking medical officer to stem the misuse of division psychiatrists. Though the document did reiterate that the division psychiatrist "must be prepared at all times to render such services as [the Chief Surgeon of the Division] may require," the purposeful delineation of specific duties was designed to educate general medical officer on the proper use of mental health practitioners.[32]

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[31] Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 277.

[32] Office of the Chief Surgeon, "Circular No. 5: Duties of Medical Officers Detailed as Psychiatrists in Army Divisions in the Field," January 15, 1998, Thomas Salmon Papers, Box 2, Folder 4, ODL. Circular No. 5 did not eliminate all abuses of divisional psychiatrists and the Chief Surgeon had to send out periodic reminders that mental health professionals were to be utilized in the capacity as the War Department intended. See "Chief Surgeon to All Division Surgeons," September 8, 1918, quoted in Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 307-308.; "Circular Letter No. 207, Neuro-Psychiatric Personnel," May 12, 1919, 211. Neuro-psychiatrists, General 211 (Internes), Box 87, General Correspondence, 1917-1927, RG 112, NARA II.

In order to convince general medical officers and military leaders of the utility of the division psychiatrist, the circular highlighted the danger of psychiatric casualties and the division psychiatrist's role in ameliorating that threat. First and foremost, the responsibility of the division psychiatry was to preserve the fighting force. "It is essential," wrote the Chief Surgeon, "for such officers to bear in mind the prime military necessity of preserving or restoring for military duty as many as possible of the officers and enlisted men who may be brought to their attention." This was especially true regarding cases of war neuroses.

Bradley also argued that division psychiatrists – and military psychiatrists generally – presented a "unique opportunity" for the military to limit the "ineffectiveness" that could be wrought by shell shock on the American military organization. According to the Chief Surgeon, division psychiatrists would return shell shocked men to the front as quickly as was practicable or, in the same manner, speedily evacuate "all persons likely to continue [to be] ineffective or to endanger the morale of the organization of which they are a part." Furthermore, the division psychiatrist would protect the health of the division by identifying men with "constitutional mental defects" and bringing them to the attention of company commanders because, as the Chief Surgeon noted, it was "certain that they will break down under stress." Circular No. 5 directed division psychiatrists to meet these goals by conducting examinations of officers and enlisted men, advise on the disposition of psychiatric cases, and provide guidance and education regarding mental health issues to other medical staff.[33]

With such a broad mandate, the division psychiatrist found himself existing in a therapeutic space reminiscent of the asylum superintendents of the previous century. Though his administrative duties were fewer – high-ranking consultants like Thomas Salmon handled the

[33] Office of the Chief Surgeon, "Circular No. 5: Duties of Medical Officers Detailed as Psychiatrists in Army Divisions in the Field," January 15, 1998, Thomas Salmon Papers, Box 2, Folder 4, ODL.

military bureaucracy on behalf of the DNP and rarely saw patients – he alone organized treatment regimens for his patients, directed enlisted men in the care of psychiatric cases, and generally served as the sole advocate for mental health care within a division. As the official history reported, "in some divisions, the authority, as to the management of neuropsychiatric cases, was absolute." Edward Strecker served in this position during WWI and later described the division psychiatrist as the "doctor to a city of canvas and wood housing some 30,000 men. He was not only mental-health doctor to the soldiers; he was their friend and counselor. He lived with them, ate and slept with them, played with them, and upon occasion quarreled with them." Put simply, Strecker wrote, "the divisional psychiatrist was the vertebral column of the psychiatric service."[34]

The DNP's primary reason for situating a mental health specialist so close to the frontline was so that trained professionals could begin administering immediate, targeted therapy with the goal of quickly returning men to their units. This, after all, was the entire purpose of forward psychiatry. Psychiatric casualties at a field hospital and under the care of a division psychiatrist remained at this echelon of care an average of three to ten days. During that time, the psychiatrist administered treatment in an environment carefully engineered to convey military discipline and an expectation of swift recovery. After the war, a collection of military psychiatrists referred to this "atmosphere" as "the general feeling and understanding which existed among all those who came into medical contact with the war neuroses, and which sought to provide an urge or incentive for the soldier to return to his duty on the firing line." In order to create this "atmosphere," most division psychiatrists required that patients as well as enlisted

[34] Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 303, 309; Edward Strecker, "Military Psychiatry: World War I," in *One Hundred Years of American Psychiatry,* ed. J. K. Hall et al. (New York: Columbia University Press, 1944), 388, 390.

medical personnel follow a strict set of guidelines. At one field hospital, the psychiatrist in charge posted six rules that all enlisted men were to follow upon the arrival of a new casualty. The rules ranged from the very specific to the general, with rule number one requiring each patient to receive a hot beverage on arrival, to number six, which reminded staff to maintain a "hopeful attitude" when interacting with new or existing patients. This last directive signaled a core tenet of the therapeutic principles at work not only at the division level, but underlying the whole tenor of forward psychiatry.[35]

American military psychiatrists inculcated two refrains into the minds of soldiers in an effort to "cure" their shell shock. These techniques of suggestion were designed to reorient the patient's perception of their illness, which psychiatrists believed would limit, if not eliminate, the condition. The official history described a process "separated roughly into positive and negative elements, the first being concerned with the advantages of returning to the front, and the second with the disadvantages of evacuation to the rear." A division psychiatrist or psychiatric aid continually reiterated the honor of fighting and "emphasized the glory and traditions of the division… and the very important part which each soldier played in contributing his share." At the same time, the psychiatrist took care to speak of further evacuation from line in the direst terms. "Evacuation to the rear was painted in gloomy colors," wrote the authors of the official history. Shell shocked soldiers were led to believe that removal for war neurosis would, at best, mean a missed opportunity at "future honor and rewards," but at the worse, it could be construed

[35] Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 313-314.

as failure. "It was in a sense a desertion," psychiatrists told them, "since it left comrades to 'carry on' alone."[36]

The official history of neuropsychiatry during the war is vague about the specific successes of this method of treatment at the division level and statistics are scant. The authors of the chapter on division psychiatry wrote after the war, "of 400 war neuroses, embracing all types and occurring in different operations at the front, approximately 65 per cent were returned to front line duty after an average treatment period of four days." They observed that this percentage could fluctuate to a large extent depending on the position of a hospital and the presence of active operations. For example, during the Battle of the Ourcq in July 1918, the official history reports that the "recovery rate" dropped to forty-percent, but during the second half of the Meuse-Argonne campaign in November, it rose to seventy-five percent. The authors argued that division psychiatrists along the Ourcq only had thirty-six hours to treat their patients, resulting in many soldiers being evacuated that "would have recovered if it had been possible to retain them 48 hours longer." If a division psychiatrist had enough time to provide adequate treatment, they believed, a soldier was more likely to return to the fighting than be evacuated.[37]

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[36] Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 314. Division psychiatrists were creative – one might even argue they were shameless – in their efforts to guide the emotions of their patients. They read medal citations of brave comrades, spread rumors about major offensives that a soldier would miss because he was in the hospital, hinted that a unit might move back for a "well-earned rest" in the immediate future, and in at least one instance, encouraged soldiers to interact with German prisoners of war in hopes of stirring "patriotic fervor." Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 314.

[37] Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 317. The authors do not explain the meaning of "400 war neuroses." In general, the inclusion of psychiatric casualty statistics in this volume at any point in the chain of evacuation below the level of the neurological hospital is severely lacking. However, the authors' assertion that, on average, sixty-five percent of the psychiatric casualties that reached the division level were returned to their unit seems reasonable. As the first mental health specialist the patient would have encountered, division psychiatrists dealt with soldiers with a wide range of symptoms, ranging from mild to severe. The authors acknowledged that "the

By the time a psychiatric casualty received treatment at a field hospital, he had been away from the fighting for an average of a week to ten days. For some soldiers, this was where the chain of evacuation ended and division psychiatrists returned them to their units. Other casualties, however, proved more difficult. Even then, medical professionals remained optimistic that such men could still be returned to their units. In 1917 and early 1918, only one option remained for these patients: base hospitals far back along the chain of evacuation. However, as U.S. troops took part in more of the fighting in the summer of 1918 and the psychiatric casualties increased, the DNP realized they needed to adjust their current process of evacuation. Up until this point, the American army's practice of forward psychiatry very much resembled the plan initially laid out by Thomas Salmon in early 1917. But, in consultation with division psychiatrists, the Division of Neurology and Psychiatry decided to create another echelon of care between the field hospital and the base hospital. By the end of the war, they established three new zones of evacuation, which they called Army neurological hospitals.[38]

In creating these sites, Americans once again took their cues from their European allies. The DNP situated the neurological hospitals just a short distance behind the field hospitals and still within a few miles of the frontline. Their construction mirrored the war neurosis centers built by the British in 1916 and the neurological centers created by the French around the same time. American psychiatrists believed these hospitals could serve both the needs of patients and the military, by providing the former with longer treatment than a busy division psychiatric

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experience of these officers with the treatment and final outcome of the cases was limited chiefly to the milder forms of the neuroses." Given the division psychiatrist's mandate to preserve the strength of the army, it is likely that he took a wide view of what symptoms were considered "mild," leading to a majority of men being returned to the front as soon as the doctor felt it reasonable to do so. Zabriskie, et al., "Division, Corps, and Army Neuropsychiatric Consultants," *The Medical Department of the United States Army in the World War* vol. 10, 317 313.

[38] Rhein and Hall, "Army Neurological Hospitals," in *The Medical Department of the United States Army in the World War* vol. 10, 325.

officer could offer at a field hospital, while still keeping them close enough to the fighting that they could easily be returned to the front. According to the official history, "the primary function of the hospital was to return as many cases as possible to duty with their divisions, in as short a time as possible."[39]

A soldier sent to one of the three neurological hospitals typically remained there for anywhere between ten days to a month. His treatment plan was a continuation of the therapies started at the division-level, focusing on "persuasion, suggestion, and a simple, practical psychological reeducation." Whereas division field hospitals only maintained a single psychiatrist, neurological hospitals boasted sometimes up to a half dozen. Like their colleagues, these mental health experts worked to "cure" a patient by explaining the nuances of shell shock and instilling in them a desire to get well. Many soldiers crafted their understanding of the condition based on rumor and supposition, believing, for example, that neurosis meant an end to their wartime service. "This attitude was one of the main problems to combat in the neuropsychiatric hospitals," one set of psychiatrists wrote after the war, because it contradicted the goal of psychiatrists to return men to their units.[40]

To overcome this mindset, experts at neurological hospitals implemented a strict regimen of physical activity and therapeutic conversation. They required able-bodied soldiers to participate in marches and calisthenics, and later implemented work details in which patients helped to maintain the hospital. While the latter had practical purposes in a space with few enlisted men able to perform menial tasks, the work details also helped doctors to foster an

[39] Rhein and Hall, "Army Neurological Hospitals," in *The Medical Department of the United States Army in the World War* vol. 10, 325, 332-333.

[40] Rhein and Hall, "Army Neurological Hospitals," in *The Medical Department of the United States Army in the World War* vol. 10, 329, 334.

environment of military discipline. In doing so, psychiatrists believed they could prevent patients from dwelling on their conditions and allow them retain a mindset conducive to returning to combat.[41]

Neurological hospitals reported the same high level of success as their divisional counterparts. In this instance, the authors of the official history of these centers described what they considered to be a positive outcome. A patient was "cured" if "they acknowledged that they felt well, in which they expressed themselves as willing and anxious to return to their organizations, and in which to all appearance they seemed to be able to do so." Army Neurological Hospital No. 1, located near Verdun and St. Mihiel, considered sixty-percent of its approximately one thousand patients between September and November 1918 to have met these standards. Hospital No. 2, located just south of its sister hospital in Toul, reportedly returned forty-four percent of its patients to combat in September 2018. This number rose to almost one-hundred percent during the month of October.[42]

For the soldiers who did not return to their units, there was still one remaining option. If the psychiatrist at the neurological hospital believed that the neuropsychiatric casualty still had a remote chance of recovery, but would require longer or more focused treatment than he could provide, he would recommend that the soldier be moved to the next echelon of care. The final stop in the chain of evacuation for American psychiatric casualties in Europe consisted of specialized base hospitals designated for the treatment of mental illness. For men identified as suffering from war neuroses, the destination was the specially built Base Hospital No. 117

[41] Rhein and Hall, "Army Neurological Hospitals," in *The Medical Department of the United States Army in the World War* vol. 10, 329-331.

[42] Rhein and Hall, "Army Neurological Hospitals," in *The Medical Department of the United States Army in the World War* vol. 10, 329, 343-344.

located in the small village of La Fauche, in the northeast of France between Chaumont and Neufchateu.[43]

For Thomas Salmon, a base hospital dedicated solely to the treatment of war neuroses was a key component of forward psychiatry in the same vein as the division psychiatrist. Just as these experts provided specialized treatment to psychiatric casualties, the staff at a base hospital, he argued, would do the same for the most difficult cases. He discussed this in a February 10, 1918 letter to the General Bradley. He reminded the Chief Surgeon that the British only managed to cure less than twenty-percent of shell shock cases when the casualties were evacuated back to specialized hospitals back in England, often five months after the initial diagnosis. He reported that the number of men returned to duty increased to over sixty-percent once the British constructed neuropsychiatric hospitals on the Continent and arranged for the quick transfer of any men showing signs of war neurosis. "These facts make it imperative for us to provide facilities for the treatment of this class of cases at the earliest possible date," Salmon wrote. Only then, he believed, could American military psychiatrists provide any sort of "check"

[43] Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 277. Base Hospital No. 117 was for the exclusive treatment of war neurosis. The Medical Corps established other hospitals to serve as clearing houses for soldiers suffering from other forms of mental illness. The first of these was Base Hospital No. 8 in Savenay, which in February 1918 offered the earliest dedicated space for neuropsychiatric casualties, regardless of type. As the war continued and the need for more of these hospitals became apparent, the Medical Corps authorized the construction of additional locations. Most significant of these was Base Hospital No. 116, built in July 20, 1918 and purposefully located near Base Hospital No. 117. At Base Hospital No. 116, medical personnel received soldiers suffering from a variety of illness, ranging from war neurosis (these were usually sent on to Base Hospital No. 117 when the symptoms became less acute) to epilepsy, morphine addiction, and "defective mental development." The most frequent diagnoses were "psychoses" such as dementia praecox or "manic-depressive insanity." Military psychiatrists did not necessarily believe these conditions to be caused by the war, though they sometimes recognized war as the exciting factor that triggered a soldier's predisposition to one of these conditions. The goal of hospitals such as Base Hospital No. 8 and Base Hospital No. 116 was not to treat these men and return them to duty, but instead address their immediate symptoms and arrange for their safe return to the United States. A good summary of the activity of these hospitals can be found in Michael Thornton and Sanger Brown, "The Care and Disposition of Cases of Mental Disease," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 369-405.

on shell shock and "establish a sound method of management. The consequences, he warned, could be dire. "Failure to do so is certain to open a serious source of wastage for the army." Salmon called for the immediate reclassification of Camp Hospital No. 4 in La Fauche for the sole use of war neurosis casualties and suggested it be designated as Base Hospital no. 117. [44]

Salmon's selection of this particular location was purposeful, not only from a strategic perspective – the existing Camp Hospital No. 4 was located close to the frontline and able to receive casualties quickly, as well as near a larger hospital further down the line which could handle any non-psychiatric medical issues that arose – but from a treatment perspective. The proximity to the frontline, he believed, would aid his staff in perpetuating the belief among war neurosis sufferers that recovery was possible. He argued that it was "absolutely essential" that patients believed that their condition was "temporary and curable" and ready access to front would signal that "they are not going into a long invalidism or necessarily en route to the United States." Salmon's letter also indicated that Camp Hospital No. 4 was ideal because its large, grassy fields could provide room for expansion – a prescient observation on his part – but also space for military drills and exercises, all in support of reminding the soldier that he was preparing to return to the fighting, not to the United States. Finally, he pointed out a number of smaller, unused buildings which could be transformed into workshops for occupational therapy and a small swimming pool at a nearby chateau offered the prospective opportunity for physical therapy. In this way, the physical space of Base Hospital No. 117, from its location to its

[44] Letter to the Chief Surgeon, GHQ, AEF, from Major Thomas Salmon, Director, Division of Psychiatry, "Use of Camp Hospital No. 4 for Treatment of War Neuroses," February 10, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

organization would be harnessed to provide a therapeutic environment for shell shock casualties.[45]

While Salmon worked to convince his leadership, the NCMH scoured the United States for the best mental health professionals to staff the new hospital in France. The Committee contacted state hospitals and private institutions and solicited men with experience not only in mental health but with neuroses specifically. The search quickly expanded to include trained psychiatric nurses and male orderlies familiar with working with mental patients. The NCMH immediately sent individuals selected for Base Hospital No. 117 for more intensive training at psychiatric wards in military hospitals within the United States. Here they had a chance to familiarize themselves with military processes and learn from colleagues with some existing knowledge of the war neurosis they would encounter overseas. The stateside training was brief, however, because the unit mobilized in March 1918 after the Chief Surgeon agreed to Salmon's request to establish Base Hospital No. 117 in France. The men and women of Base Hospital No. 117 set sail from Ellis Island, New York in May 1918. They arrived in England shortly thereafter with the promise of three additional months for extra training.[46]

This training was not to be, however, because the temporary staff at Base Hospital No. 117 was overwhelmed and by May, had begun to turn away patients. With the increased participation of U.S. forces in the military actions of the summer of 1918, Salmon and other

[45] Letter to the Chief Surgeon, GHQ, AEF, from Major Thomas Salmon, Director, Division of Psychiatry, "Use of Camp Hospital No. 4 for Treatment of War Neuroses," February 10, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

[46] Frederick Parsons, "Hospital for War Neuroses (Base Hospital No. 117)," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 355, 359.; Thomas Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 277.; Eleanor Hope Johnson, "Reminiscences of World War I: Base Hospital No. 117," *American Journal of Orthopsychiatry* 15 (1945): 607-608. Frederick Parsons was the commanding officer of the unit stationed at Base Hospital No. 117.

military leaders expected the flow of patients to the hospital to continue to grow in the coming weeks. The unit left England within days of its arrival and undertook the cross-channel trip to France in the middle of the night. The staff arrived in La Fauche on June 16, 1918 after a brief stopover at another hospital to assist with a large amount of psychiatric patients designated for redeployment to the United States. Within a few weeks the men and women of Base Hospital No. 117 established the management of their hospital and began to administer the high level of care that became its hallmark until it officially closed its doors in early January 1919. After the war, Thomas Salmon applauded the hospital, writing that "Base Hospital No. 117 rapidly became the center for scientific work and training in neuropsychiatry in the American Expeditionary Forces. Its ability to receive patients… was limited only by its capacity."[47]

Capacity was indeed an issue for the hospital and in September 1918 the Medical Corps agreed to double the number of beds to 1,000. Still, men with war neuroses poured into Base Hospital No. 117. Salmon reported after the war that between No. 117's opening in March 1918 to its eventual closure less than a year later in January 1919, the hospital admitted 3,268 patients. While he worked to rapidly expand the existing hospital, Salmon recommended the Medical Corps consider a second specialized war neuroses hospital in the style of No. 117. In a September 1918 letter to the Chief Surgeon, Salmon argued that in order to adequately manage war neuroses among American soldiers, the AEF needed, at the very minimum, to make one bed available for every one-thousand soldiers in the theater. He worried that even an expanded Base Hospital No. 117 was not equipped to handle the number of soldiers military leaders predicted would be necessary for the spring fighting of 1919. He recommended the immediate

[47] Parsons, "Hospital for War Neuroses (Base Hospital No. 117)," in *The Medical Department of the United States Army in the World War* vol. 10, 355,; Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 277-278.; Johnson, "Reminiscences of World War I: Base Hospital No. 117," 607-608.

construction of second war neurosis hospital located just north of Epinal, France and within sixty miles of the front. He warned the Chief that the army would need to consider a third hospital in the south of France during the summer of 1919. The expansion of Base Hospital 117 was completed just before the armistice, but the cessation of fighting negated the need to construct additional hospitals.[48]

Soldiers evacuated to Base Hospital No. 117 represented the most difficult cases of war neuroses. Eleanor Hope Johnson served as a psychiatric nurse at the hospital where she had extended interaction with the patients. After the war she described the men under her care as "the most discouraging and discouraged patients." In the weeks before the permanent staff arrived, No. 117 received patients directly from the frontline who had had no initial triage or early treatment for shell shock. As the war continued and the line of evacuation expanded to include division psychiatrists, only the most complicated cases came to La Fauche. These patients often possessed chronic symptoms that a division psychiatrist could not ameliorate in the rushed environment of a field hospital or clearing station. At Base Hospital No. 117 they could receive longer, more focused treatment.[49]

Military psychiatrists and other mental health professionals at Base Hospital No. 117 held to five therapeutic principles for the care American soldiers presenting severe cases of shell shock. The first was the most important and it shaped the other four. The purpose of the hospital was to further the overall purpose of military psychiatry: to maintain the fighting strength of the American Expeditionary Force. The official history of neuropsychiatry during the

[48] Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 278-279.

[49] Johnson, "Reminiscences of World War I: Base Hospital No. 117," 608.; Sidney Schwab and Norman Fenton, "War Neuroses as a Medico-Military Problem," in *The Medical Department of the United States Army in the World War* vol. 10 (Washington: U.S. Government Printing Office, 1929), 398.

war states, "the war neuroses were regarded as temporary conditions into which a soldier might fall and thus become a subject for medical treatment," and operating under that belief, "the hospital was planned and equipped for the purpose of returning him to duty and, given his support, in most cases, this was accomplished." Of the approximately 3,200 men treated at Base Hospital No. 117, fifty-percent of these men returned to combat duty and an additional forty-one-percent were reassigned to other military duties within the AEF away from the fighting. [50]

The remaining four principles outlined rules designed to meet the all-important goal of force maintenance set by the first. Like the work of division psychiatrists and doctors at neurological hospitals, these edicts also reflected the intersection of forward psychiatry and mental health professionals' perceptions about how best to treat war neurosis. For example, the second principle that guided military psychiatry at Base Hospital No. 117 held that patients should remain at the hospital for the least amount of time possible. Indeed, the average time a man stayed at No. 117 was about three weeks, including instances when nearby military action prevented the prompt transportation of troops from the hospital. The third principle also espoused speed and stated that all treatment options designed to elicit a cure needed to be rigorously administered as quickly as possible, and certainly no later than forty-eight hours of the patient's arrival in La Fuche.[51]

The fifth principle emphasized the importance of work and military discipline. Just like their colleagues at the division-level and at neurological hospitals, military psychiatrists at Base Hospital No. 117 believed that extended treatment of shell shock served to solidify the condition

[50] Schwab and Fenton, "War Neuroses as a Medico-Military Problem," in *The Medical Department of the United States Army in the World War* vol. 10, 398-399.; Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 278.

[51] Schwab and Fenton, "War Neuroses as a Medico-Military Problem," in *The Medical Department of the United States Army in the World War* vol. 10, 399.

in the mind of the patient. By keeping the soldier focused on his eventual return to combat, practitioners expected the man's recovery to be faster and, hopefully, longer lasting. One way to accomplish this was through occupational therapy. No. 17 used work "as a curative agency" in the same way that neurological hospitals used military discipline and patriotic sermons. For weeks, patients at the hospital helped to build a road from the collection of buildings to the main highway nearby. While menial labor, an account of the history of the hospital painted the work in a more therapeutic light. Much of the road construction required breaking up rocks. The author points out that the act of gripping and swinging a hammer required dexterity that some shell shock patients lacked. Similarly, to actually hit the rock called for hand-eye coordination, a steady hand, and a reasonable amount of strength. For psychiatrists at Base Hospital No. 117, the goal of occupational therapy was not to rebuild physical strength, however. Instead, these tasks were designed to demonstrate a truth about shell shock to the patients. "The psychological phase of this kind of work was found in the proof to the patient that a defect in muscular power must be only an evanescent one, if a muscle group that is not acting right is capable of carrying out effectively so complicated a type of movement as handling a hammer," notes the hospital's history. The repetitive nature of the work was designed to show shell shocked soldiers that they were still the masters of their own bodies, and therefore, their own minds.[52]

By enacting these five principles, military psychiatrists at Base Hospital No. 117 boasted a nearly one-hundred-percent success rate of keeping men within military service in Europe. About half of the men they treated returned to their units, while the other half were reassigned to

[52] Parsons, "Hospital for War Neuroses (Base Hospital No. 117)," in *The Medical Department of the United States Army in the World War* vol. 10, 363-364.

support battalions away from the front. Though they no longer fought, these men were still expected to contribute.[53]

For those few patients who simply did not respond to treatment at Base Hospital No. 117, the chain of evacuation ended at a French port and a return ship to the United States. The disposition of these men once they arrived on the East Coast was less established than the mechanisms of treatment afforded them in France. Some men went to the psychiatric wards at military hospitals, including St. Elizabeths, which had housed Civil War soldiers only a generation earlier. The military shifted other returning casualties to civilian hospitals. Regardless of where the men ended up, though, there was no clear plan on what to do with these veterans once they were an ocean away from the fighting. Before the DNP and the NCMH could reach a decision, however, the sudden ending of the war, demobilization, and the return of so many men from overseas meant that a plan for shell shocked veterans had to wait. The continued treatment of these veterans was now a postwar issue, one which the mental health profession found itself grappling with well beyond the cessation of combat.[54]

Conclusion

The application of forward psychiatry by the Division of Neurology and Psychiatry during WWI represented the culmination of two important aspects of the mental health

[53] Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 278.

[54] Salmon, "General View of Neuropsychiatric Activities," in *The Medical Department of the United States Army in the World War* vol. 10, 284. For discussions of shell shocked veterans see John M. Kinder, *Paying with Their Bodies*: *American War and the Problem of the Disabled Veteran* (Chicago: The University of Chicago Press, 2015) 103-104.; Annessa Stanger, "Healing the Soldier, Restoring the Nation: Representations of Shell Shock in the USA During and After the First World War," *Journal of Contemporary History* 49 (2014): 255-274.

community's preparation for American intervention into WWI. First, it signified the fruition of the close partnership between military leaders and mental health professionals that began when Stewart Patton, Pearce Bailey, and Thomas Salmon first met with Surgeon General Gorgas in 1917. The construction of the DNP and the division's execution of forward psychiatry relied upon close cooperation between mental health professionals, the Office of the Surgeon General, and other medical officers. For the first time in the history of American military medicine, psychiatrists and military officials had a plan in place for the organized treatment of the psychiatric casualties of war.

Second, forward psychiatry was the tangible product of the trans-Atlantic learning that took place between the United States and Europe starting with the first casualties in 1914 and continuing through the end of the war. By watching and learning from the successes and failures of the French and British, American psychiatrists constructed an understanding of the nature of shell shock that prioritized immediate treatment to ensure a quick recovery. Using their observations of the Allied experience with war neurosis, Thomas Salmon and other American military psychiatrists implemented a system of evacuation that emphasized rapid, specialized treatment as close to the front as possible.

From the perspective of the mental health community, forward psychiatry was a success in that the vast majority of men who moved through the chain of evacuation ultimately remained of use to the United States military. Of the two million Americans who saw service overseas, only about 4,000 soldiers were sent home to the United States for psychiatric reasons before the end of the war. Psychiatrists returned all other mental health casualties to the front or reassigned them to support battalions. This success, however, was predicated on the idea that fitness for military service meant a soldier had conquered their psychological suffering. The veracity of

this reality would be tested in the following decades as psychiatrists and psychologists in the interwar years encountered veterans of the First World War.[55]

This problem, however, lay in the future. For the year and a half that American forces were in Europe, the DNP focused on the patients in front of them. But to their increasing frustration, a persistent concern continually called their attention back to the United States. As during the Spanish-American War, the American public closely followed the developments in Europe, including the prevalence of shell shock. Whereas mental health experts had refrained from engaging with the public during the previous two wars, the scope of the press coverage on war neurosis in combination with the presence of a psychiatric profession finally organized enough to present a unified message, set the stage during WWI for the first interaction between the public and the profession on the issue of the psychological trauma of war. Unfortunately, instead of forming a partnership in which the mental health community educated the public, military psychiatrists were reluctant to engage. This led, once again, to a public constructing its own understanding of mental illness in wartime, even if it was at odds with that of the medical professionals.

[55] Strecker, "Military Psychiatry: World War I," 405.; A good discussion of the challenges faced by WWI veterans can be found in Stanger, "Healing the Soldier Restoring the Nation," 255-274. For a psychiatrist's perspective, see William C. Menninger, *Psychiatry in a Troubled World: Yesterday's War and Today's Challenge* (New York: MacMillan Company, 1948).

CHAPTER SEVEN: PSYCHIATRISTS, AMERICAN NEWSPAPERS, AND THE STRUGGLE TO SHAPE PUBLIC OPINION ABOUT WAR NEUROSIS

A burgeoning national news media in the United States brought the far away fighting of World War I into the homes of an increasingly large number of Americans. Just as concern about nostalgia during the Spanish American War had created a robust public discourse on the mental suffering of soldiers, sensational reporting about men left "shocked" by the artillery barrages in France and Belgium reignited public interest in the traumatic effects of war. While the public in the early 1900s had tentatively linked nostalgia to the unique circumstances of soldiering in the Philippines, early popular opinion on shell shock coalesced around an equally novel explanation: the powerful new weapons that characterized the current war were undoubtedly creating a new kind of casualty as well.

For the first few months of the war, the mental health profession's understanding of shell shock mirrored that of the public. However, as psychiatrists' views evolved to support a psychological etiology for shell shock, the popular discussion of the condition became muddled. Some articles promulgated the new theories of military psychiatrists, but other newspapers continued to describe shell shock in connection to physical injury.

The First World War coincided with a growing desire among some psychiatrists to utilize newspapers to shape popular ideas about mental health. The mobilization of the profession for war, coupled with public concern over psychiatric casualties, provided an important opening for American psychiatrists to foster the connection between themselves and the rest of the country. However, the profession failed to capitalize on this opportunity. While mental health

professionals in the United States and military psychiatrists overseas lamented the public confusion, they lacked an organized response to remedy it. Some, such as Thomas Salmon, attempted to work with journalists to educate the public. Others, such as Pearce Bailey, tried to force the public discourse to change by invoking censorship.

This professional frustration occurred against the back drop of an important realization by military psychiatrists in the later years of the war. Their entire premise of treatment for war neuroses was based on the belief that the patient had to possess a very carefully crafted understanding of his illness: that it was impermanent, curable, and no cause for removal from the fighting. A national media that perpetuated an idea that artillery caused irreparable damage to a soldier's mind did so in direct contradiction to the goals of military psychiatry. To the regret of American psychiatrists, they had no clear idea of how to correct this misunderstanding.

"Wounded Without Wounds"

For a public protected by the diplomatic power of neutrality and the geographic buffer of the Atlantic Ocean, the media served as the primary window into the war that seemed, perhaps, unreal to many in the United States. "Here in beautiful California," wrote a reporter for the *Los Angeles Times,* "Peace, resplendent in her stilly triumph, reigns over rose gardens and golden orchards," while in Europe "millions of men are straining every nerve…and preparing themselves for the operating table or the soldier's grave." But the media served an important purpose beyond simply reporting. It also helped to shape public perceptions about the nature of

the war. "Safely distant from the war zone, [Americans] had unique opportunities for reflection," observed historian David Kennedy.[1]

A popular press with an increasingly national audience proved influential on this reflection, so much so that President Woodrow Wilson would eventually utilize the power of the media to enlist public support for American intervention in 1917. Kennedy wrote of Wilson, "the manipulation of mass opinion for political purposes was becoming a highly refined art – and Woodrow Wilson was its consummate practitioner." In his history of mass communications, Paul Starr identified the WWI era as a turning point in the way states utilized tools of communication. This transition took many forms, from militaries utilizing the latest in radio and cable technology to shape the battlefield, to governments such as Wilson's harnessing the mass press for the purposes of propaganda. While this revolution in communications took place in many industrialized nations during this period, Starr noted that the case of the United States was distinctive. He argued that, compared to their European counterparts, the communication networks and media in the United States reached beyond metropolitan centers and were widely accessible in rural areas. Citizens beyond urban centers were as connected to the flow of information as their city-dwelling counterparts. This is evident in the wide distribution of syndicated articles that appeared in major newspapers such as *The New York Times* as well as smaller local papers. At the start of the century, some of the largest newspapers had circulations of over half a million readers and by 1910, the average household received more than one daily newspaper. As the war unfolded and news of psychiatric casualties began to trickle into media accounts, those articles reached a broad audience across the country.[2]

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[1] David M. Kennedy, *Over Here: The First World War and American Society* (New York: Oxford University Press, 1980), 45.; "Gains and Losses of War," *The Los Angeles Times*, March 23, 1915.

[2] Kennedy, *Over Here*, 47-48. For a thorough discussion of Wilson's and others' use of the press to stir pro-war sentiment, see Kennedy, *Over Here*, 45-92. Paul Starr, *The Creation of the Media: Political Origins of Modern Communications* (New York: Basic Books, 2004), 222-228, 252.

When the war began thousands of miles away, American readers eagerly followed the latest developments with the help of daily newspapers and magazines. Articles about skirmishes and larger battles appeared alongside carefully drawn maps detailing the movements of soldiers on the developing Western Front. From the outset, the reporting favored the cause of the Allies and focused on the heroic deeds of French and British soldiers. But few journalists shied away from exposing the darker side of the war, whether that was the impact of the fighting on civilian populations or the men themselves. This often resulted in a tension between the author's attempts to convey the stoic heroism of soldiers amidst the growing reality of the terrible fighting in Europe. "No war has tried men's souls more than the great struggle in Europe," reported an article in *The Sun* out of Baltimore. "The excitement and glory have gone out of the battle, and war has become a soul-harrowing duty to endure an almost constant hell of shrapnel and machine-gun fire in insanitary conditions." Despite such depravity, the author remained confident that "the terrible ordeal does not shake the soul of the soldier," and readers should be assured that "the 'red badge of courage' is as conspicuous as ever."[3]

The dichotomy of the heroic and the tragic is present in an article by British war correspondent Philip Gibbs published in *The New York Times*. Writing from France, Gibbs described the French retreat through the Meuse Valley in the closing days of August 1914. "For France," he wrote, "the story of that retirement is as glorious as anything in her history." He described "one of the most heroic episodes of the war," when five thousand French soldiers engaged twenty thousand German infantry outside of Marville, "inflicting tremendous punishment and suffering very few losses." For Gibbs, these displays of heroism were tempered

[3] Starr stated that a study of *The New York Times* coverage during the war discovered that only 4% of articles published on the front page originated from Germany, while 70% arrived from Allied news sources, particularly London-based journalists. He argued that this disparity probably helped sway U.S. popular support for the Allied cause. Starr, *The Creation of the Media,* 223-224.; "What it is to be Under Fire," *The Sun*, December 26, 1914.

by the destructive power of the battle on its participants. He tried to convey this to his audience, cautioning "the armchair reader" against underestimating the "psychological effect" of the chaos of the retreat. He wrote of the "weary, filthy, and exhausted" French citizens fleeing the Germans, passing young soldiers marching in the other direction in an effort to protect the retreat. A particularly poignant moment for the journalist came from watching these soldiers. These "boys," as Gibbs called them, tried to put on brave faces and raucous displays of bravado, but the reporter observed that "here and there a white-faced boy tried to hide his tears" as he was forced to make his way past the death carts carrying the bodies of his countryman back from the front. The entire experience left Gibbs with a feeling of confusion, which he attempted to impart on his reader. "It all seems to me now like a jigsaw puzzle of suffering and fear and courage and death" he wrote, "a litter of odd, disconnected scraps of human agony and of some big grim scheme which, if one could only get the clue, would give a meaning."[4]

Media portrayals of the fighting also focused heavily on the technological advances that came to define the First World War. A survey of American newspapers suggests a particular fascination among writers and readers with artillery shells, from the smallest detail of their construction to their deployment overseas. In a September 1914 article titled "Hopes Pinned to Artillery," the *Los Angeles Times* argued "the greatest importance is ascribed by military men to the part which field artillery will play in the present struggle." The piece continued with an extended discussion of the new guns employed by the French and Germans and the best strategies for their use, from the length of the recoil and the range of shrapnel to the effectiveness of indirect fire. A few days earlier, a nearly identical article appeared across the country in *The Farmer and Mechanic* out of Raleigh, North Carolina. It also described the technological marvel of the new European guns, comparing the "monster pieces" to the artillery used in the American

[4] Philip Gibbs, "Vivid Narrative of Great Retreat," *The New York Times,* August 31, 1914.

Civil War and the Napoleonic wars. The author concluded by recommending that the United States heed the "lessons" of the current war and suggested that military leaders evaluate the state of the country's artillery now or "court national disaster."[5]

Many newspapers ran articles aimed at educating their audiences about the mechanics of artillery weaponry. *The Ogden Standard* in Ogden, Utah provided its readers with a military glossary so they could "understand the full force of the terms" they encountered in the paper's war coverage. In addition to defining "shrapnel" and "cordite," the glossary described the difference between a field gun and a howitzer and listed each kind of artillery employed by the belligerents down to their weight and caliber. In Virginia the Sunday edition of the *Richmond Times-Dispatch* explained how shrapnel worked by referring to hand-drawn cutaway images of artillery shells that allowed the reader to see a depiction of the innards of the weapons in question.[6] *The Chicago Daily Tribune* devoted one of its "Popular Science" columns to explaining "The Mechanics of War Shells," also with carefully sketched diagrams, while *The Washington Herald* educated the readers near Washington, D.C. thru its running column "Newest Scientific Discoveries and Remarkable Facts." A full page article in a January 1915 issue of the *Herald* depicted black and white photographs of guns and gun crews accompanied

[5] "Hopes Pinned to Artillery," *Los Angeles Times*, September 27, 114.; "Artillery Chief Factor in War of European Nations," *The Farmer and Mechanic*, September 22, 1914. This was a syndicated article that appeared in multiple newspapers across the country. The syntax of the piece bears a striking resemblance to the *Los Angeles Times* article mentioned above, though they are not identical. It is likely the latter drew heavily upon the syndicated article. An additional perspective on the weakness of American artillery can be found in Frederick Palmer, "America Without Big Guns to Offer Slightest Defense," *Evening Star*, December 26, 1916.

[6] "What Shrapnel Shell Is And What Other War Terms Mean," *The Ogden Standard*, June 9, 1915.; "Shrapnel Most Deadly of Modern Explosives," *Richmond Times-Dispatch*, April 4, 1915. An article in *The St. Mary Banner* of Franklin, Louisiana also used cutaway images of shells to describe the history of shrapnel. "How Shrapnel is Made and Used," *The St. Mary Banner*, September 4, 1915.; See also: "Bursting Gun's Wide Ruin," *The New York Times*, November 3, 1914.; "New French Shell Kills by Concussion," *The New York Times*, April 6, 1915.; "Writer Sees 'Machine-Made' War in Europe; Sees Kaiser's Big Guns Fired at Close Range," *Chicago Daily Tribune*, October 15, 1914.; "Describes French Artillery Gun 75," *The Grand Forks Daily Herald*, March 29, 1915.; "Forts at Longwy Held Out Five Days Against Heavy Bombardment," *Courier-Journal*, September 7, 1914.

by sensational headlines that announced "Terrible War Engine Hurls 1650lb. Shell Nine Miles!" and a hundred pound German cannon that was a "Marvel of [the] Age." The newspaper even invited eager readers to envision the size of artillery by drawing two large circles across the entirety of the page, the smaller circle nestled in the larger in an image that recalled a simple bulls-eye. These circles, the writers of "Newest Scientific Discoveries explained, represented the "exact sizes of the mouths of the world's greatest guns." The fact that the smaller circle represented the size of an American shell and the larger exemplified a German round was likely another subtle reminder of the general lack of American preparedness.[7]

Just as journalists tried to balance depictions of soldierly heroism with recognition of the attendant suffering inherent to the war, reports about artillery often reflected the awesome technological advancement in military firepower and the destructive capability of the "great soulless monsters." "Newest Scientific Discoveries," for example, ran another column on artillery following their January edition, but this time with the headline "The Human Mowing Machines of War," reminding readers of the true purpose that motivated all of the advancements to artillery technology. *The New York Times* reported that the accidental detonation of a pile of unexploded artillery shells in Belgium killed over two hundred soldiers, some as far as six miles away.[8]

Discussions of military medicine provided a further window into the destructive power of artillery on the human body. *The Washington Post* published an article in October 1914 on the medical challenges posed by shelling. The author included a discussion of time fuses and shrapnel size, but also quoted a doctor's description of the effects of shelling on the human body.

[7] "Popular Science: The Mechanics of War," *Chicago Daily Tribune*, April 11, 1915.; "Newest Scientific Discoveries & Remarkable Facts: 16 ½ Gun Crumbles Great, Modern Forts with Single Shot!," *The Washington Herald*, January 10, 1915.

[8] "Newest Scientific Discoveries & Remarkable Facts: The Human Mowing Machines of War," *The Washington Herald*, February 28, 1915.; "Bursting Gun's Wide Ruin," *The New York Times*, November 3, 1914.

Shrapnel, explained the doctor, "tears away the flesh and tissue so that there is little left to mend." Another article devoted to battlefield medicine included a cartoon image of a soldier standing helpless as a shell detonated in the air, showering shrapnel from his head to his feet. The caption of the cartoon described how an exploding shell unleashed "262 bullets, sometimes making a couple of dozen wounds on one soldier and smashing every bone in his body."[9]

One poignant discussion of the horrors of shelling appeared in the form of excerpts taken from a soldier's letter to his mother, published by the *Bismarck Daily Tribune* just after the July Fourth holiday weekend. The article captured not only the physical violence of an artillery bombardment, but the psychological toll as well. The young man had joined the Canadian Expeditionary Force from his small hometown on the border of North Dakota and Minnesota. He wrote the letter from an English hospital after being injured by a German shell. "Our trench was simply cut to pieces," he told his mother. "Comrades were cut to pieces all around me and great splashes of blood were over everything. Every time a shell burst I shut my eyes, not that I was afraid mother, but I knew what the result would be … waiting for the shell to burst that would claim me." When that shell finally came, shrapnel struck him in the chest and the concussion of the blast knocked him unconscious. He awoke to discover, "I was literally painted red with my own blood." Such descriptions served as harsh reminders of the human toll exacted by this new, seemingly marvelous technology.[10]

Early descriptions of the physical and the psychological toll of shelling also appeared in magazine articles. The long-form structure of magazine articles, which combined a narrative format with investigative reporting, proved another important way of depicting the war for the

[9] "Heavy Guns Heroes of Battle that Gave Combles to Allies," *Evening Public Ledger,* September 29, 1916.; "Worse Than Dumdums: Shrapnel Makes Wounds that are Very Difficult to Treat," *The Washington Post*, October 18, 1914.; "Astonishing Miracles of Surgery on the Battlefield by the World's Foremost Doctors," *Richmond Times-Dispatch*, March 28, 1915.

[10] "North Dakota Boy Wounded," *Bismarck Daily Tribune*, July 6, 1915.

public. [11] American nurse Ellen N. La Motte wrote for *The Atlantic Monthly* about her experiences with artillery fire in the city of Dunkirk. La Motte arrived in the French town during the summer of 1915. The seaport at Dunkirk had long been a target for German artillerymen and La Motte described her initial excitement at witnessing the effects of "the most formidable and powerful cannon that the enemy possesses… each shell a ton of devastating steel." She was surprised to discover that "under the shadow of this constant menace, life in the little town seemed to go on unchanged." La Motte's perspective changed once she experienced the shelling herself. "As yet I did not know enough to be afraid," she reflected. What she had originally interpreted as normalcy was in fact a veneer worn by townspeople who had learned to live their lives between bombardments. She painted a picture for her readers of the physical destruction, of "the havoc wrought by those awful guns" that left "jagged holes in many roofs," tore up the cobblestone roads and collapsed houses. "For the first time I saw war in the concrete," she wrote. "A feeling of cold terror passed over me." But the worst aspect of the shelling, La Motte discovered, was the anticipation of the next shell falling. Like the soldier from North Dakota writing to his mother, she attempted to capture this dread for her audience. "Our nerves were merely being racked by this long pause, this long and irregular interval between shells!" She and her compatriots attempted to go about their business, but "underneath… is a terrible tension as each shell falls, and the tension in the intervals of waiting is still more awful." La Motte closed

[11] The magazine industry realized a boom in readership similar to that of newspapers at the end of the nineteenth century. Fueled by a combination of cheap postage and even cheaper paper, the number of magazines with a circulation of 100,000 or more quadrupled between 1885 and 1900. In 1905, there were 159 magazines that reached an audience of over 100,000 readers. The popular *Ladies Home Journal* reached a circulation of one million in 1903. Influenced by the muckraking trend of the Progressive era, magazines during WWI were less focused on leisure and entertainment and increasingly devoted to investigative reporting. Magazines, like their newsprint counterparts, were important mediators between the public and organizations of power, whether that was the government, the military, or professional organizations like the mental health community. Their articles would also serve as important influencers of public opinion in the twentieth century. Starr, *The Creation of the Media*, 260-262.

the article by revealing that she was writing the piece during a bombardment, "to kill time" as the shells approached. "No human power can protect us or intervene," she concluded.[12]

As the war progressed and the news media fed the American public's interest in artillery shells, articles began to appear that described bizarre wounds or strange circumstances associated with deadly bombardments. Many of these articles focused on deaths or wounds related to the concussion caused by the explosion. Journalists appeared to suggest that what made these deaths so unique was the seeming lack of an obvious physical injury. *The Washington Post* reported that "the shock" alone of exploding French shells easily killed whole trenches of German soldiers. A similar description appeared in a *New York Times* article about a French shell that could kill not just by "wounds inflicted" but by a massive concussion that paralyzed the heart. The piece quoted a British chemist who described seeing a regiment of Germans killed by such a bombardment still standing "bolt upright" in their trench with their guns held at the ready. Noting the man's credentials lent his observations an aura of expertise. Articles such as these suggested something distinctive about the modern artillery that characterized WWI. Not only was it a technical wonder, but the popular accounts appeared to suggest that it caused a sort of suffering unique to the victims of the war.[13]

Not all of the media reporting focused on physical wounds to the body, however. Given the public's fascination with the technology of artillery and the numerous articles that delineated in careful detail the horrific bodily damage wrought by shells, it is unsurprising how quickly the media embraced the notion that shells could also affect the mind. As early as December 1914, *The New York Times* published accounts of soldiers who seemed to exhibit debilitating

[12] Ellen N. La Motte, "Under Shell-Fire at Dunkirk," *The Atlantic Monthly*, November 1915, 692-700. See also Mary Roberts Rinehart, "For King and Country," *The Saturday Evening Post*, June 12, 1915, 11-13, 38-42.; A Captain of the Royal Irish Dragoons, "The Baptism of Fire," *Collier's*, February 27, 1915, 7-8, 28.

[13] "French Guns Make Field a Cemetery For Force of 500 Germans Surprised," *The Washington Post*, October 3, 1914.; "New French Shell Kills by Concussion," *The New York Times*, April 6, 1915.

psychological reactions to shelling. These pieces appeared before Charles Myers published his initial research on shell shock in the *Lancet* in February 1915 and they did not mention the condition by name. They did, however, utilize terminology like "nervous" and "shock" which would have been familiar to a public conversant in popular discussions of neurasthenia. An early article, published on December 2, referred to soldiers who were "wounded without wounds… Men [who] have been so dazed by the shock as to be incapable of remaining at the front." A follow-up article published on December 4 described men showing signs of "nervous shock." The latter delved more deeply into the symptoms of the soldiers, including men struck deaf, dumb, and blind. It singled out one man in particular who's "mind is a complete blank" as a result of shell fire. The author assured readers that doctors believed the young man would make a full recovery, but noted that for now, the soldier "is as helpless as a newborn infant." Despite the invocation of familiar diagnostic terminology, these articles suggest a certain novelty to the suffering of the men in question, as though the "wounds without wounds" portended something unique to the nature of the fighting of the current war. In May 1915 the *Washington Post* published a long article entitled "New and Peculiar Military Cruelties which Arise to Characterize Every War." In it, the authors identified different technological advances they considered seminal to the history warfare, including elephants, Greek fire, and gunpowder. They argued that the artillery of the current war represented another such advancement because of the damage it inflicted on the mind as well as the body. "British and German fighting forces achieve history's horror climax," the piece trumpeted, "by employing as engines of terror and destruction in the present World War bombs laden with poisonous gases and monster shells which drive soldiers deaf, dumb, blind, and insane." For these authors, as well as other reporters, the new technology of the war had resulted in new kinds of suffering.[14]

[14] "Unwounded, But Badly Hurt" *New York Times*, December 2, 1914.; "Shell Fire Wrecks Reason," *New York*

Just as European mental health professionals in 1914 and 1915 struggled to classify the symptoms they witnessed, the media cast about for an appropriate nomenclature as well. At first, a variety of labels for soldiers' psychiatric suffering appeared in newspapers. In February 1915, the *Los Angeles Times* published a piece entitled "Troops Have Wild Dreams." The paper drew upon an article in *The Lancet* to depict a British army plagued by soldiers turning insane as a result of their time at the front. "The number of English soldiers and officers who have suffered nervous breakdown more or less approaching insanity as a result of the strain of war has shown such increase that some of the leading medical journals are pleading for special consideration and treatment for this class," wrote the paper. The article went on to describe the condition of the afflicted as "trench insanity" and while the author tried to express optimism that the condition was curable, the article still cast horrific images for its readers. In a particularly evocative depiction, the paper quoted a British surgeon who described soldiers who, as a response to shelling, "develop a tendency to sleep-walking and are found wandering about the premises with faces expressing the utmost terror and anxiety." To the doctor in question, this was evidence of "the powerful effect which modern warfare has on the mind." In April 1915, *The Sun* described a "strange diseases caused by battle." The article went on to reference the research of French military doctors into a condition called "hypnosis of battle." The doctors characterized the condition by numerous symptoms, including limited mobility and hallucinations. They also attributed battle hypnosis to the harsh conditions of the war, particularly the patient's "very trying experience in battle." The same article did mention shell

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Times, December 4, 1914.; "New and Peculiar Military Cruelties Which Arise to Characterize Every War," *The Washington Post*, May 30, 1915. See also "Air Pressure Kills When Shells Explode," *New York Times*, January 25, 1915. This incident also described in "Made Deaf and Blind by Roar of Cannon," *Los Angeles Times*, December 27, 1914.

shock, but limited its characterization of the diagnosis to a condition contracted by a soldier's exposure to shelling.[15]

Labels such as "battle hypnosis" and "trench insanity" never caught on in the American media, but the term "shell shock" certainly did. As during the Spanish American war, the popular discourse drew heavily upon the developing medical discourse to inform its understanding of the psychological trauma of war. As the diagnosis of "shell shock" gained traction in medical circles in England and France in 1916, newspapers across the United States leaned on observations from European medical experts in order to educate their readers and add legitimacy to the newspapers' claims about the severity and uniqueness of the condition.

The research of both Frederick Mott and Charles Myers appeared in numerous articles, helping to solidify the shell shock diagnosis within the public conversation. The Associated Press reported on Myers's research as early as March 1915. The short piece described the more exotic symptoms Myers depicted in his *Lancet* articles earlier in the year. It highlighted the soldiers' loss of smell and taste, and Myers's efforts to remedy the latter by exposing his patients to varied flavors like salt and acid. The article concluded with Myers's theorizing on the psychological component of the condition, quoting from the *Lancet* article, "the close relation of these cases to those of hysteria appears certain." *The Atlanta Constitution* discussed Myers again in 1916 when it highlighted the doctor's use of hypnosis to treat shell shock. Faced with soldiers who "seem beyond all hope," the paper reported with optimism that "science…has called upon hypnotism, the mystic correspondence of the mind," which resulted in "some astonishing cures." The article noted that Myers used hypnosis on two-thirds of his patients and that "20 per cent of

[15] "Troops have Wild Dreams," *Los Angeles Times*, February 28, 1915.; "Strange Disease Caused by Battle," *The Sun*, April 25, 1915.

the cases seem to be completely cured" and an additional 26 percent showed "distinct improvement."[16]

Frederick Mott's theories of shell shock also appeared in American newspapers. Mott's research provided journalists with scientific credibility in the same way as Myers's writing. Mott, however, could offer reporters something more and that was sensationalism. Newspaper articles about Mott's interest in the physical causes of shell shock emphasized some of his more graphic claims. Though Mott only gave cursory attention to the idea that shell bursts caused nitrogen bubbles to form in the blood, at least one syndicated reporter seized on the theory. In an article that appeared in both *The Washington Post* and the *Richmond Times-Dispatch* on March 19, 1916, the headline proclaimed that there were now "explosions that bring instant death by making blood bubble like champagne" and "swift-moving bomb fragments that literally boil the flesh they penetrate." The piece identified Mott as "a distinguished English nerve specialist" and described some of his theories regarding the imbalance of cerebrospinal fluid. It devoted an extended discussion, however, to his ideas about nitrogen in the blood. Fortunately for journalists, the seemingly complex physiological process described by Mott came with a ready-made real world example: a champagne bottle. "We all know that charged waters or wines have air and carbonic acid gas in solution inside the bottle. With the cork air tight, pressure keeps the bubbles in solution." A shell blast, the analogy continued, was the equivalent of popping the cork because the shock wave altered the pressure in the blood, creating the bubbles, and resulting in instant death. The *Richmond Times-Dispatch* went a step further to help its readers by

[16] "Shell Shock Ruins Taste," *The Topeka State Journal*, March 2, 1915.; "Here's a Wound that Caused Loss of Both Taste and Smell," *The Omaha Bee,* April 3, 1915.; "Hypnotism is Newest Cure for Shell Shock," *The Atlanta Constitution*, July 23, 1916. See also "New and Peculiar Military Cruelties Which Arise to Characterize Every War," *The Washington Post*, May 30, 1915.

including two sketches of a champagne bottle, one with the cork securely placed and the second showing the cork removed and bubbles racing towards the surface.[17]

The article did not question the veracity of Mott's research or his firm belief that shell shock had a physical antecedent. Similarly, none of the newspapers that covered Myers's early writing discussed his frustration that the etiology of shell shock remained difficult to define. More significantly, American journalists did not inform their readers about the ongoing professional debates in Europe about the cause and nature of war neurosis. Newspapers remained focused on shocking imagery and the mysterious symptoms that seemed to be connected to the particular horrors caused by the technology of the current war. The public discussion of shell shock on the eve of American mobilization lacked nuance. The general population was aware that a concerning number of soldiers were falling victim to this illness that European doctors called "shell shock." They had a vague sense that the condition was psychological in nature; however, the media's constant discussion of the physical wounds wrought by artillery shells left many convinced that shell shock must be the result of tangible damage to the human body. Newspaper reports ultimately left the cause of shell shock undefined and they contained little by way of discussions of treatment or whether or not the illness could be cured. This lack of detailed discussion by American media certainly reflected the nascent understanding possessed by medical professionals at the same time. Additionally, shell shock, like the war itself, was a distant problem to readers in the U.S. in 1915 and 1916. The illness was a curiosity much in the way that the new technologies and their uses were a cause for fascination. Shell shock, like the new weapons of war, was certainly troubling, but it was a

[17] "Bullets of High Velocity Fatal by Making Bubbles in Blood when Capsule of Air Explodes," *The Washington Post*, March 19, 1916.; "Science's Newest Discoveries About Shell Fire and Bullet Wounds," *Richmond Times-Dispatch*, March 19, 1916.

European problem. This changed when American entrance into the war became more likely in early 1917. Now, American readers had cause for greater concern.

American Psychiatrists and the Other War Against "Shell Shock"

The public and the mental health profession did not develop a shared understanding of the psychological trauma of war during either the Civil War or the Spanish American war. Psychiatrists were too disorganized to craft a unified response in 1865, and even when the mental health community began to embrace professionalization at the end of the nineteenth century, they did not insert themselves into the popular discourse on nostalgia among soldiers in the Philippines, despite high levels of public concern. In fact, they and the rest of the medical community denied the severity of the condition in the face of public outcry. However, the interaction between the public and the psychiatric profession did increase in other areas during this time. Medical interest in nervous disorders such as neurasthenia spurred public curiosity about the possibility that modern life was incompatible with the proper function of the human body. The work of psychiatrists and their professional discussions of mental disease increasingly appeared in the press. Similarly, with psychiatrists out of their asylums and instead working in hospitals and private practices, more and more patients made their way to the psychiatrist's office.[18]

Not only was the public more interested in the work of psychiatrists, but psychiatrists were taking a greater interest in the public. The national mental hygiene movement, from which the National Committee on Mental Hygiene was born, sought to cure social ills as well as the suffering of individuals. As historian Gerald Grob describes, the purpose of mental hygiene was

[18] See Chapters Two and Three.

to promote specific patterns of behavior from the family level to the national level. One mental hygienist wrote in 1918 that the goals of the organization aimed "not only at the prevention of acute mental disorder, but at the development of wholesome interests and habits of healthful mental activity in all normal children and adults – habits that ensure happiness and efficiency as well as sanity." To achieve this goal, the movement sought as wide an audience as possible. In the first issue of the organization's eponymous journal *Mental Hygiene*, the editors reiterated this broad reach. They encouraged practitioners to spread the tenets of the mental hygiene beyond mental health professionals and to reach out to teachers, magistrates, parents, and students. Their cause, the editors argued, was to inform "understanding [about] the complex fabric of organized society through knowledge of those factors which mould [sic] the mental lives of individual men and women."[19]

Despite their desire to reshape society, mental health professionals were slow to engage with the public through print media. In 1915, the historian and journalist Douglas Southall Freeman chided psychiatrists for their failure to recognize the power of newspapers. Freemen addressed the American Medico-Psychological Association – the forerunner of the American Psychiatric Association – at its annual meeting, held that year near his home in Richmond, Virginia where he was the editor of *The News Leader*. The *American Journal of Insanity* later published Freeman's remarks in full with the editors of the journal noting "the annual address… was in manner and matter one of the most interesting addresses delivered before the Association in a long time."[20]

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[19] Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 150-151.; William H. Burnham, "The Scope and Aim of Mental Hygiene," *The Boston Medical and Surgical Journal* 179 (December 1918): 753. *Mental Hygiene* quoted in Grob, *Mental Illness and American Society, 1875-1940,* 162.

[20] Douglas Southall Freeman, "Publicity and the Public Mind," *American Journal of Insanity* 72 (July 1915): 17.; "Notes and Comments," *American Journal of Insanity* 72 (July 1915): 213.

Despite having no medical background, Freeman had a firm understanding of the goals of psychiatrists and the mental hygiene movement. "As long as insanity remained solely a medical problem any discussion of its social aspects was by the mark," he began. But "now that insanity is viewed not less as a disease of society than as a disease of the individual" it was time, Freeman argued, for the mental health profession to consider what "congregate social forces" could influence what he referred to as "the mind of the reading public." He warned that "publicity" was one of the social forces that had deleterious effects on individual mental health, as well, perhaps, as the health of a society. "The greatest of the agents of publicity, the newspaper, has acquired dimensions that are almost too large to be impressive," he announced, and "the subconscious influence exerted by the press is so profound." In his view, mental health professionals had been slow to realize what journalists like himself had already discovered: news media had the ability to shape popular perception and stir public passion to a fevered pitch. "The reading of the people shapes the mind of the people," he concluded, and psychiatrists had a responsibility to explore that connection and, perhaps, even use it to their advantage to staunch the spread of mental disease.[21]

Freeman's address resonated with at least one prominent American psychiatrist. At the 1916 meeting of the American Medico-Psychological Association, Edward Brush used his Presidential Address as an opportunity to harken back to the speech made the preceding year. He used Freeman's discussion of the power of news media to frame a critique of the organization he had been chosen to lead. While he applauded the efforts of the mental health community at "moulding [sic] the opinion and practice of its members," he lamented that "it has too often, except in purely local matters, neglected to use the weight of its influence in matters relating to the entire body politic." He asked his members to consider, "how much are we doing to train

[21] Freeman, "Publicity and the Public Mind," 17-33.

and inform the public mind?" Whereas Freeman had advocated that mental health professionals enter the public discourse in order to observe and perhaps mediate the effects of mass communication on "the reading mind," Brush's goals were more pragmatic. He viewed newspapers as medium though which to enlist public support for the cause of mental health. "No better method could, in my opinion, be devised to awakening public interest in and public support and sympathy for the work of hospitals of our special kind," he stated, "than showing the public that the medical officers of these hospitals have not only an interest in the welfare of the patients… but also in that of the people of the community." Brush thought a closer relationship between the public and psychiatrists would make it easier for the profession to overcome the political and economic challenges that threatened to slow the progress of an overhaul of American society. An engaged and educated public, he argued, would assist psychiatrists in their endeavors instead of sitting passively to the side or worse, working against them.[22]

It was with this tentative acknowledgment of the power of public opinion that American mental health professionals launched military psychiatry and their efforts to treat shell shock. As Thomas Salmon, Pearce Bailey, and other psychiatrists explored the research of European medical professionals, the public continued to observe the experience of Allied armies overseas. Once America entered the war in 1917, popular interest shifted to the efforts of psychiatrists to safeguard the United States military from meeting a similar fate. A Baltimore journalist spoke with Thomas Salmon upon the latter's return from his European fact-finding mission. Salmon assured the journalist – and by extension, the reader – that the American mental health community, in concert with the U.S. military, was undertaking careful preparations in order to meet the challenge of shell shock. "The medical department of the army… is arranging to make

[22] Edward N. Brush, "Our Work as Psychiatrists and its Opportunities," *American Journal of Insanity* 73 (July 1916): 1-17.

special provision for those suffering from shell shock," he explained. This included the creation of special hospitals, the enlistment of psychiatrists into military service, and, Salmon emphasized, coordination with the public. In particular, he applauded publically organized recreation efforts for soldiers such as those undertaken by the Y.M.C.A. "Diversion is as important for mental hygiene as sanitation is for physical hygiene," he told the reporter.[23]

One effort undertaken by American military psychiatrists that caught popular attention was the attempt at mass screening military recruits for mental illness. This national awareness was not surprising, given the large scope of the undertaking. A close reading of contemporary news articles on the topic does not suggest that the mental health community made a concerted attempt to use newspapers as a platform through which to educate the public about the need for screening. Despite the lack of direct action on the part of military psychiatrists, the media still managed to convey the current medical understanding of shell shock that underpinned the need for the careful examination of recruits. Articles appeared throughout the summer and fall of 1917 that described psychiatric screening as a necessity to ensure the "right" men were sent overseas. *The New York Times* wrote about "a committee of scientific men" who would use mental testing "to grade the courage of the men who are to fight in France." The *Courier-Journal* in Louisville, Kentucky expanded on this, writing that psychiatrists examining men at the nearby Camp Zachary Taylor were doing so in order to create a fighting force "composed of men whose nerves have, by test, been found capable of withstanding the shock of heavy gunfire and concussion caused by bursting shells." The article further explained that the decision to implement such testing stemmed from American observations of shell shock in European soldiers and the growing supposition by medical professionals that predisposition towards mental illness made some men more susceptible to shell shock. By "taking advantage of the lessons

[23] "Tells of Shell Shock," *The Sun*, July 27, 1917.

learned by the warring nations," the author wrote, the United States "does not intend to send men to the front whose nerves are so highly strung that the first engagement would drive them insane." A piece in the *Chicago Daily Tribune* echoed the sentiment, quoting a medical officer as saying "men susceptible to disorganization of their nervous system are the more liable to shell shock." Interestingly, though military psychiatrists met opposition from military leaders about the need for screening, news articles did not appear to question the necessity of this effort. The public's recognition of the need for screening likely stemmed from the awareness of the dangers of shell shock that the media had cultivated over the past two years.[24]

While American readers in 1917 were fully aware of the scope of the shell shock problem, they continued to disagree about the cause of the condition. Americans by late 1917 and early 1918 had a more sophisticated appreciation of the illness than they possessed in the early months of the war. Newspaper articles no longer focused on grim, yet sensational, images of dead soldiers with invisible wounds. Instead, the news media cultivated a more nuanced understanding of shell shock which focused on screening, symptoms, and treatment. This greater shared knowledge, however, did not mean there was unanimity of opinion. Like the mental health community, the popular press could not agree on the cause of shell shock. But whereas psychiatrists had reached a tentative understanding by 1916 that the etiology of shell shock was psychological and not somatic, journalists continued to publish articles stating that war neurosis was caused by physical factors as late as 1918. For example, in November 1917, *The Atlanta Constitution* reiterated the claim that the blast of high explosive shells "take out a man's nervous system." In March 1918, *The New York Times* reported that the Dean of the

[24] "To Make Tests of Courage," *The New York Times*, July 28, 1917.; "Nerve Test Awaits Men," *Courier-Journal*, September 25, 1917.; "Rainbow Camp to Weed Out All Nervous Bucks," *Chicago Daily Tribune*, October 4, 1917.; See also "Teeth First at Meade," *The Sun,* November 9, 1917.; "Guards' Minds O.K.," *The Sun,* August 4, 1917.; "Drop Unfit Soldiers," *The New York Times*, February 7, 1918.

College of Physicians and Surgeons at Columbia University had given a presentation on military medicine in which he reiterated that shell shock resulted from exposure to the vibrations caused by shells, as well mental fatigue.[25]

To be sure, some media outlets described a psychological antecedent to shell shock. Often they did so by discrediting the notion of a physical cause. For example, the *Chicago Tribune*'s popular medical advice column "How to Keep Well," firmly reminded its readers that "it is now recognized that there is no organic basis for shell shock – no rupture of nerve fibers and no shaking to pieces of brain cells." In fact, the article continued, "it is merely a matter of giving down under strain" and regrettably, "under the strain of trench life… some develop that form of funk known as shell shock." The article's author, the columnist Dr. W.A. Evans, chastened his audience that "it would be a great mistake to class men who suffer from shell shock as cowards" because what they suffered was a malady of the mind, not of courage.[26]

The Louisville *Courier-Journal* also stressed the psychological nature of shell shock and, like the *Tribune* to the north, utilized the authority of a medical professional to legitimize their claim. In a November 1917 article entitled "Shell Shock Nothing But a State of Mind, Says Noted Authority," the newspaper recounted an article on shell shock written by neurologist Morton Prince and recently published in the *Journal of the American Medical Association*. Reminiscent of how newspapers during the Spanish American war relied on a doctor's credentials and experience to convince the reader of an article's authority, the *Courier* piece devotes four sentences to Prince's expertise. It notes that Prince is "one of the world's foremost medical psychologists" and that he had spent time in military hospitals "for the express purpose

[25] Carl Pierce, "Some Sidelights of the World War – Curing War Neurasthenia," *The Atlanta Constitution,* November 11, 1917.; "War Has Many Medical Problems," *The New York Times,* March 3, 1918.

[26] W.A. Evans, "How to Keep Well – Counteracting Shell Shock," *Chicago Daily Tribune,* March 4, 1918.

of studying shell shock." The article assures its readers that "Dr. Prince writes as an authority," and therefore, "what he has to say deserves careful consideration."[27]

What Prince had to say to his medical colleagues – which was then repackaged by the *Courier* for the consumption of the public – reflected the current consensus among American mental health professionals: shell shock was a psychological condition. In fact, Prince used the very word "consensus" in his *JAMA* article, noting that "it is now the consensus of opinion," that shell shock was a traumatic neurosis in the same vein as railroad spine. The journalists at the *Courier* repeated this verbatim to their readers while adding that this was "particularly significant," because it meant that "the popular view as to the cause of shell shock is entirely wrong." Prince's original article implored the mental health profession to increase its efforts at educating the public about the psychological etiology of the disorder. Specifically, he wanted to see neuropsychiatrists reach out to soldiers and military leaders so that these laymen would understand that shell shock was caused by fear and psychic, not physical, trauma. Prince argued that if military psychiatrists conveyed such a message, "it is to be expected that an anticipatory attitude of mind of healthful preparedness (instead of fear and mystery) would be formed, and also that fear… would be so minimized as not to produce the psychoneurosis." The *Courier* aptly summarized Prince's main thesis and concluded their article with the statement, "Education, not speculation, is needed."[28]

Morton Prince wrote his article out of frustration over media coverage of shell shock like that which appeared in the *Atlanta Constitution*. Prince's piece then served as a source for the *Courier-Journal,* which published excerpts in order to educate its readers – an action that

[27] "'Shell Shock' Nothing But a State of Mind, Says Noted Authority," *Courier-Journal*, November 12, 1917.

[28] Morton Prince, "The Prevention of So-Called 'Shell-Shock,'" *Journal of the American Medical Association* 69 (September 1917): 726-727.

conveniently served the purposes laid out by Prince in *JAMA*. As during the Spanish American war, the public was once again interested in the manifestations of the psychological trauma of war, even if, as before, they did not understand or agree upon the specific details of how or why the symptoms came into being. Also like the previous war, the news media in 1917 served as a platform upon which the public could grapple with these questions. During the war with the Philippines, however, popular perception of nostalgia developed without the input of mental health professionals. Though Americans could sometimes rely on the observations and experiences of general medical officers from the field, psychiatrists refrained from guiding popular understanding of this particular psychiatric condition. As the Morton Prince example indicates, however, World War I represented a change in this dynamic.[29]

Psychiatrists during WWI were emboldened by public interest in nervous disorders such as neurasthenia, which had helped to open an important early dialogue between psychiatrists and laymen. Additionally, the goal of the mental hygiene movement to promote public health by focusing on broad social concerns further drove psychiatrics to present their profession for public consumption. As Brush and Freeman discussed in their addresses before the American Medico-Psychological Association, such interactions could be beneficial to both public and profession. Thus, when the war began and public concern about shell shock grew, American mental health experts were poised to enter the public discourse on psychological trauma in a way they had been unprepared to do during the Civil War and the Spanish American war.

Psychiatrists' decision to enter the popular discussion about shell shock was motivated, however, by more than just a desire to further spread the gospel of psychiatry. Their understanding of shell shock and its connection to other neuroses supported the belief that continued use of the phrase "shell shock" could have a negative effect on the treatment of

[29] See Chapter 2

sufferers. Once military psychiatrists reached a tentative agreement in 1916 that shell shock was the culmination of psychological and not physical suffering, they altered their language to discussions of "war neurosis" instead of "shell shock." The change reflected their understanding of the condition as a form of neurosis similar to traumatic neurasthenia, not an illness with a somatic connection. It also underscored their adoption of treatment techniques that focused on healing the mind more so than physical injury to the brain. Beginning as early as 1916, military psychiatrists like Charles Myers had actively discouraged military leaders from using the phrase "shell shock" because they believed it painted an inaccurate image of the condition and they worried that it would alter soldiers' perception of the affliction. They held similar concerns about the public perception of war neurosis and worked just as hard to shape popular understanding as they had military understanding.[30]

Just as American military psychiatrists met difficulty educating soldiers and military leaders about the nuance of war neurosis, they also struggled to alter public perception of shell shock. Morton Prince gave voice to the professional frustration in his *JAMA* article and he was far from alone. Thomas Salmon was also concerned, particularly later in the war when public attention turned to soldiers returning from France. On October 31, 1918, he wrote a stern letter to the Office of the Chief Surgeon, AEF protesting a recent news article that described an effort by the senior surgical consultant to erect new hospitals to treat American soldiers "whose minds had been unbalanced by the terrific shocks of German shells exploding near them." Salmon reported that his office had received multiple copies of the article from concerned readers and he strongly protested its content. He implored the Chief Surgeon to issue a statement to correct its many errors, writing of the clipping, "nothing can be better calculated to render more difficult the task of treating soldiers who are returning to the United States with functional nervous

[30] See Chapters Four, Five, and Six.

disease." Furthermore, he continued, "such publicity gives a wholly misleading idea as to the prevalence of functional nervous diseases and as to the relation to shell fire to these disorders." This "pernicious publicity," Salmon argued, must be countered swiftly from the highest medical authority.[31]

An excellent example of Thomas Salmon's views on the role of the press and the importance of public education can be found in a correspondence he conducted with Captain Arthur Samuels in mid-1918. Samuels was the editor of *Carry On*, a monthly publication edited by the Office of the Surgeon General and distributed by the Red Cross that began circulation in the summer of 1918. The magazine focused on issues of rehabilitation and the return of wounded soldiers. In July 1918, Samuels wrote to Salmon and asked if he would be willing to contribute an article on shell shock. He wrote, "the question of handling shell shock cases seems to be of more general interest to the pubic than any other form of disability." He attributed some of this interest to "morbid curiosity," but stated that his publication thought "the real truth out to be told." *Carry On* wanted to raise awareness that "not all of our disabled soldiers will suffer from loss of limb but that mental diseases, tuberculosis, etc. will furnish the greater percentage of reconstruction subjects."[32]

Coincidentally, just as Samuels was writing to Salmon, the latter was putting pen to paper after having read excerpts from *Carry On* while in Europe. Salmon wrote a lengthy letter to Samuels despite his busy schedule during preparations for the major American offensives of late summer. Salmon's reason for devoting so much time was evident in the opening paragraph. "I think there is no work of such a high usefulness as yours," he wrote. He concluded with a

[31] Letter to Colonel McCaw from Thomas Salmon, October 31, 1918, Thomas Salmon Papers, Box 2, Folder 4, Courtesy of the Oskar Diethelm Library, DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell Medical College. Hereafter ODL

[32] "Note and Comments – Recent Periodicals on Reconstruction," *Mental Hygiene* 2 (1918): 651.; Letter to Thomas Salmon from Arthur Samuels, July 25, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

similar reference, noting "I have no time for letters as a rule but I wanted to write a note just to say how glad I am that you are doing much good work." Despite – or, perhaps, because of – Salmon's enthusiasm about educating the public on issues of rehabilitation, his response was long-winded, but did not touch on issues related to mental health. Instead, he focused on broader ideas about assuring the populace that wounded men were still capable of contributing to society.[33]

Predictably, Samuels received Salmon's letter with surprise and delight over their shared interest in rehabilitation. While thankful for Salmon's initial thoughts, his response tried to steer the psychiatrist towards a discussion of his work in Europe – the treatment of shell shock. "The enormous amount of publicity that the newspapers are giving [rehabilitation] is, I think, going to forestall undue emotion," he wrote. "The psychological side can never be overstated or repeated too often. We are realizing that there is more to reconstruction than the orthopedic aspect." When he did not receive a response from Salmon to this follow-up letter, Samuels sent him another note in early September. He reiterated his gratefulness for the first letter, calling it "a source of very great inspiration" and noted that he had shared it with many colleagues at *Carry On*. But, he also pushed Salmon for the doctor's thoughts on shell shock. "The country seems to be more interested in the shell shock cases than any other kind of disability,' he wrote. "I want to run an article telling exactly how the term shell shock came into use and a general description of the facts of war neuroses." He emphasized that the piece he envisioned would be written in "a popular style" and subtly hinted that the author could only be Salmon. "There is no one who can do it as well as you," Samuels explained, no doubt hoping to capitalize on the weight of psychiatrist's expertise as much as his knowledge on the topic. He assured Salmon that the

[33] Letter from Thomas Salmon to Arthur Samuels, July 29, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

effort would be worthwhile and implied that anything the doctor wrote would be reprinted across the United States.[34]

Salmon saw the opportunity as too good to pass up. Upon receiving Samuels's third letter, he immediately dashed off a telegram. "Will send article neuroses," he wrote, "very important stop indiscriminate publicity and use of term shell shock at home." As soon as the telegram went out, Salmon sat down to write a longer letter that very day. "I am terribly pressed by work," he admitted, but the chance to present the public with an accurate accounting of war neurosis, "seems to me so very important that I must try to find the time to write a short article such as you suggest." For Salmon, this article could provide an opportunity to address some of the concerns he had about the public misunderstanding about shell shock; a misunderstanding which he felt was detrimental to the patients he was charged with caring for in Europe.[35]

Salmon's October 24, 1918 response to Samuels serves as a succinct summary of the former's views on two important aspects of the professional understanding of shell shock during WWI. First, it delineated Salmon's concern that lay confusion about the physical versus the psychological antecedents of the condition was contributing to the severity of the condition of American soldiers in Europe. "Some of the indiscriminate publicity on 'shell shock'… is reaching the A.E.F., with very unfortunate results," he complained. In his opinion, the publicity "confirms in their belief a lot of our most difficult patients who are determined to see in their nervous condition the effects of some external cause rather than the operation of unhealthful mental reactions or abnormal suggestibility." American military psychiatrists were working hard to dissuade U.S. troops of this notion he contended, and regrettably, newspapers from home only

[34] Letter from Arthur Samuels to Thomas Salmon, August 19, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.; Letter from Arthur Samuels to Thomas Salmon, September 9, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

[35] Cable Message from Thomas Salmon to Arthur Samuels, October 24, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.; Letter from Thomas Salmon to Arthur Samuels, October 24, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

seemed to reinforce it. This drove Salmon to emphasize the second concern of psychiatrists overseas, which was that shell shock or war neurosis was only curable when a soldier relinquished any belief that the condition was permanent. If newspapers shattered this notion through irresponsible reporting, Salmon feared that the recovery of American soldiers would be negatively affected. He did not mince words in his warning to Samuels.

> It would be an unmitigated misfortune if our soldiers, recently cured of hysterical speech disorders, gaits, tremors or tics, or readjusted in their mental attitude toward the difficulties war presents to them, should return to the United States and find there the public – more particularly their own circle of family and friends – deeply imbued with the idea that exposure to shell fire brings about change in men's brains that take months of treatment recover from… I am quite sure that, under such circumstances, neurotic symptoms would reappear.[36]

Thomas Salmon believed Samuels and *Carry On* could provide mental health professionals with an avenue to inform the public and correct misperceptions about shell shock. He did eventually complete an article for Samuels, which appeared after the war in the June 1919 issue of the magazine. With the fighting over, Salmon and other psychiatrists were now focused on rehabilitation, but he still chastised the public for its continued use of "shell shock" instead of the preferred "war neurosis." The condition had to be properly named, he argued, if it was to be properly treated, and doctors and concerned family members were doing the sufferer no favors by failing to accurately identify the illness for what it was: a mental illness, not a physical wound.[37]

Pearce Bailey was equally frustrated by the media's continued use of the shell shock label, but while Salmon worked to harness the power of newspapers to educate the public, Bailey

[36] Letter from Thomas Salmon to Arthur Samuels, October 24, 1918, Thomas Salmon Papers, Box 2, Folder 4, ODL.

[37] Thomas Salmon, "The Wounded in Mind," *Carry On* 1 (July 1919): 3-6.

tried to shape the popular discourse through censorship. From his office in Washington, D.C., Bailey was well situated to see the unfolding media discussion of psychiatric casualties and he did not like what he saw. He had always been wary of the public interest in shell shock and he had urged his colleagues to proceed with caution when enlisting popular support. When, in the fall of 1917, Salmon suggested that the employees of Y.M.C.A.s be given more training on shell shock, Bailey pushed back. He agreed that medical professionals needed to cultivate a better understanding of the condition, but he considered it unnecessary – and perhaps even dangerous – for the public to be so informed, lest they begin to develop hysterical symptoms themselves.[38]

Bailey's displeasure came to a head in February 1918 when *The Washington Post* ran a short piece announcing that two Americans had been killed in an artillery barrage. The article noted that nine Americans were also wounded in the attack and "one suffered shell shock." He cut out the article and mailed it to Salmon in France, sending his letter by way of the Office of the Chief Surgeon so that General Bradley would see it as well. Along with the article, Bailey included a terse note directing Salmon to take steps to stop the dissemination of "shell shock" among U.S. forces in Europe. "It is considered highly desirable to eliminate the expression of 'shell shock' from all reports give to the general public," Bailey wrote. "It would seriously interfere with the administrative control of the war neuroses if the term 'shell shock' obtained the currency in reference to our troops that it has done in England."[39]

Salmon's response attempted to placate Bailey. "This matter has been borne in mind," he assured his colleague. He informed Bailey that the Chief Surgeon's Office would shortly be

[38] Letter from E.L. Munson to Thomas Salmon, November 30, 1917, General 710 (Shell Shock), Box 396, General Correspondence, 1917-1927, Records of the Office of the Surgeon General (Army), Record Group 112, National Archives at College Park, College Park, Maryland. Hereafter RG 112, NARA II

[39] "Americans Answer Barrage," *The Washington Post*, February 4, 1918.; Letter from Pearce Bailey to Thomas Salmon, February 4, 1918, General 710 (Shell Shock 1918-1921), Box 395, General 710 (Nephritis), General Correspondence 1917-1927, RG 112, NARA II.

issuing updated nomenclature for diseases and injuries and among the list was a paragraph directing doctors to eschew "shell shock" in favor of "concussion of the brain or spinal cord," "psychoneurosis," or "exhaustion." "This measure will prevent the official use of the undesirable term," Salmon wrote. As for its more colloquial use among troops, Salmon was less optimistic that a change could be effected. "The popular use of the term 'shell shock among soldiers can only be prevented by giving as much currency as possible to the official designation," he noted.[40]

Bailey took a further step to stop the spread of the phrase in the popular press. He wrote to George Creel, the powerful chairman of the Committee on Public Information (CPI). President Wilson created the CPI in April 1917, not as a bureau of censorship, but to generate pro-American propaganda. Faced with a burgeoning immigrant population – no small number of whom were German – and a country now at war, the president wanted to foster national unity. Creel, himself a journalist, used his office to publish news articles and pamphlets all designed to explain American involvement in Europe in a positive light. His most successful initiative was enlisting a cadre of citizens to give four-minute pro-war presentations in their communities. These "Four-Minute Men," as they were popularly known, spoke with citizens across the country.[41]

Though positive propaganda was the stated goal of the CPI, it did ultimately oversee efforts to censor the American press in the name of unity and national security. George Creel and the CPI had no legal authority to gag the media in the United States; so instead, it administered what it called a "voluntary censorship." CPI encouraged journalists and editors to self-censor based upon a set of guidelines provided by the committee. While on its face this

[40] 2nd Ind. From Thomas Salmon to the Chief Surgeon of the AEF, March 15, 1918, General 710 (Shell Shock 1918-1921), Box 395, General 710 (Nephritis), General Correspondence 1917-1927, RG 112, NARA II.

[41] Kennedy, *Over Here*, 60-61.

seemed like a benign request, the CPI did have some leverage to strongly encourage "voluntary" participation. The CPI worked closely with law enforcement agencies and the Department of Justice, who were empowered to levy fines and imprisonment under the Espionage Act. Historians James Mock and Cedric Larson state that the majority of newspapers followed the guidelines laid down by CPI, but whether they did so out of patriotism, intimidation, or a combination of both is unclear.[42]

Bailey wrote to Creel on February 4, 1918 regarding the same *Washington Post* article that he had forwarded to Salmon. "It is considered highly desirable to eliminate the expression of 'shell shock' from all reports given to the general public," he told Creel. Failure to do so, he warned "would seriously interfere with the administrative control of the war neuroses." Creel personally responded to Bailey a few days later, writing "with regard to your letter in the matter of the use of the term 'shell shock,' the Cable Censorship has been given instructions to bar this term absolutely. I trust that this meets your need." Mollified, Bailey forwarded Creel's response to the National Committee on Mental Hygiene as well. His satisfaction was short lived, however, when the *Washington Post* again made mention of shell shock on February 11. He wrote once again to Creel, conceding "probably there has not yet been time enough for this order to become operative" but reiterating "it really will be quite disastrous to the effective management of nervous conditions" if the media continued to use "shells shock."[43]

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[42] James R. Mock and Cedric Larson, *Words that Won the War: How the Creel Committee on Public Information Mobilized American Opinion Towards Winning the World War* (Princeton: University of Princeton Press, 1939), 11, 42-47.

[43] Letter from Pearce Bailey to George Creel, February 4, 1918, General 710 (Shell Shock 1918-1921), Box 395, General 710 (Nephritis), General Correspondence 1917-1927, RG 112, NARA II.; Letter from George Creel to Pearce Bailey, February 8, 1918, General 710 (Shell Shock 1918-1921), Box 395, General 710 (Nephritis), General Correspondence 1917-1927, RG 112, NARA II.; Letter from Pearce Bailey to George Creel, February 11, 1918, General 710 (Shell Shock 1918-1921), Box 395, General 710 (Nephritis), General Correspondence 1917-1927, RG 112, NARA II.

Unfortunately for Bailey, the phrase "shell shock" continued to appear in the national press. Eventually, he conceded defeat. While he was striking up a correspondence with Thomas Salmon in France in late 1918, Arthur Samuels also wrote to Bailey on Salmon's recommendation. Samuels's introductory letter to Bailey arrived almost two weeks after the armistice, but Samuels still sought the latter's help to educate the public about the inaccuracy of "shell shock." Bailey demurred, writing that a recent attempt to provide information about "shell shock" to the *Saturday Evening Post* and *The Ladies' Home Journal* had been rebuffed. "Either it is not popular, or else they are afraid of it," he complained. He also indicated that he no longer supported trying to eradicate "shell shock" from the popular discourse. Bailey described a forthcoming article on war neurosis he had written for the *Journal of the American Medical Association*. Crafted just after his visit to the American line in France, Bailey's article summarized the current professional understanding of the psychological trauma of war, including the consensus that war neurosis was a nervous disorder and not a physical condition. Additionally, Bailey argued in the piece that the phrase "shell shock" had "entered too deep into the language to be done away with." Doctors would just have to work around it, he stated. Now, weeks later and with the war seemingly concluded, Bailey admitted to Samuels that he regarded the article with something akin to embarrassment, saying that "the whole thing is academic and historic, and if I had to do it over again I would not write it." However, he stood by his assertion that any attempts by psychiatrists to convince the public to drop "shell shock" were futile. "I shared Colonel Salmon's view at one time that the term 'shell shock' should be done away with" he told Samuels. Bailey still considered the phrase "undesirable," but he now believed it was no longer "practicable" to try and eradicate it. Therefore, he "could not very well approve an article which had for its purpose doing away with the term."[44]

[44] Letter from Arthur Samuels to Pearce Bailey, November 23, 1918, General 710 (Shell Shock 1918-1921), Box

Thomas Salmon and Pearce Bailey represent two different approaches to dealing with public interest in shell shock. Each recognized the sizeable popular interest in the condition and both expressed frustration when American media seemed to further misconceptions about the nature and cause of the illness. Whereas Thomas Salmon sought to reach the public and change their perceptions about war neurosis through education, Bailey tried to limit public conversation by banning the use of the phrase "shell shock" in U.S. newspapers. Ultimately, neither proved satisfied with the result, with Salmon still attempting to reform the public in 1919 and Bailey concluding that such an effort was useless.

Conclusion

The technological marvels that characterized World War I were not confined to the battlefield. The communication revolution of the start of the twentieth century contributed to the rise of a powerful national media with a vast reach. Journalists became important arbiters of popular thought and newspapers became platforms on which the public could debate and even construct a shared understanding of the events of the day. This phenomenon was especially evident during WWI, when the news media brought the fighting in Europe into the home of any interested American.

American mental health experts were not blind to the growing power of newspapers to shape the public mind. As psychiatrists and neurologists tried to push an agenda of national mental hygiene, leaders in the profession advocated forming ties with the local community to

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395, General 710 (Nephritis), General Correspondence 1917-1927, RG 112, NARA II.; Letter from Pearce Bailey to Arthur Samuels, November 25, 1918, General 710 (Shell Shock 1918-1921), Box 395, General 710 (Nephritis), General Correspondence 1917-1927, RG 112, NARA II.; Bailey's regretted *JAMA* article can be found at Pearce Bailey, "War Neuroses, Shell Shock and Nervousness in Soldiers," *Journal of the American Medical Association* 71 (1918) 2148-2153.

further their goals. Such interaction, they believed, would benefit the movement and its participants alike. When war broke out in 1914 and American newspapers published startling accounts of soldiers suffering from psychological breakdown, psychiatrists in the United States had an ideal opportunity to help guide public perception and inform popular understanding about a condition that was devastating to so many men.

However, despite the growing desire of American psychiatrists to utilize the media to improve their connection to the public, their efforts during WWI to shape popular understanding about war neurosis were mostly unsuccessful. Instead of harnessing the authority of their field – strengthened in recent years by professionalization and further legitimized by the recognition of military psychiatry by the United States military – the mental health community languished in passivity. Even the limited goal of shifting the popular nomenclature from "shell shock" to "war neurosis" proved insurmountable. Newspapers fanned the flames of public interest in shell shock from 1914 until after the war's conclusion, but the press did so without guidance from mental health professionals. Just as they did during the Spanish American War, journalists scoured medical journals for reports about the soldiers' mental suffering instead of providing testimony directly from the psychiatrists themselves. They quoted the accounts of soldiers and reported on rumor, but their direct collaboration with organized military psychiatry was limited. The result was an American public left confused about the nature of psychological suffering in WWI.

Psychiatrists bitterly complained about the public's failure to understand the nuances of war neurosis, but they did so among themselves in the form of pleas for greater public education during their conferences or in the pages of their medical journals. Mental health professionals during WWI took a greater interest in the public understanding of the psychological trauma of war than they did during the previous wars, especially once they grew concerned that popular

misconceptions regarding the condition could inhibit the successful treatment of sufferers. However, the profession could not agree on a course of action to remedy the public misunderstanding, as exemplified by the drastically different approaches of the two leaders of American military psychiatry: Thomas Salmon and Pearce Bailey. Ultimately, the war ended before the mental health community in the United States formed a coherent response to the public interest in war neurosis.

CONCLUSION

Despite recognition in 1918 by both the mental health community and the public of the seriousness of shell shock, the United States failed to create an enduring understanding of the condition that lasted after World War I. This was because the intersections of the popular and professional discourses on war neurosis never resulted in the construction of a shared disease identity around the symptoms reported by soldiers. The popular media had carried reports about shell shock during the war but it often published accounts without the input of mental health experts. This caused the public to express confusion over the cause, symptoms, and treatments of the disorder. By failing to mount a concerted effort to educate the public, mental health professionals such as Pearce Bailey had only themselves to blame when the popular understanding of the condition did not reflect the beliefs held by psychiatrists.

The consequences of this failure went beyond simply the frustration of a few doctors, however. A lack of a shared understanding about shell shock meant that the nation did not have an organized approach to dealing with those psychiatric casualties whose symptoms lingered even after the war ended. Psychiatrists had contended that war neurosis was a curable condition that would cease to trouble the sufferer once the war was over and he returned home. Reality proved this supposition incorrect. By 1942, neuropsychiatric cases from WWI comprised more than half of the patients under treatment at the Veterans Administration. Between the ending of

the last war in 1918 and the start of the next one in 1941, the United States had spent over $1 billion dollars on the care of this particular set of veterans alone.[45]

With no clear idea about shell shock and no guidance from the mental health community, in the immediate aftermath of war the public crafted images of veterans with psychiatric complaints as either dangerous or greedy for government pensions. Absent guidance from the experts, Americans questioned the legitimacy of the complaints of war neurotics that persisted after the last soldiers had left France. Over time, popular opinion evolved and people came to view these veterans with greater sympathy, particularly during the struggle of the Great Depression. However, the failure by the nation to reach an agreement about the nature of shell shock during the war – and its lasting impact afterwards – meant that many veterans had suffered neglect and stigma as a result.[46]

The mental health community also devoted little attention to the issue of shell shock after the war because their focus was elsewhere in the 1920s and 1930s. During the interwar period the profession underwent another profound shift as more professionals embraced the tenets of Freud's psychoanalysis. Interest in war neurosis was supplanted by broader discussions of the new dynamic psychiatry, which sought to mine a patient's earliest experiences in order to understand his or her present complaint. The cause of military psychiatry was further hurt by the

[45] William C. Menninger, *Psychiatry in a Troubled World: Yesterday's War and Today's Challenge* (New York: MacMillan Company, 1948), 267, n.3. $1 billion in Constant Dollars is approximately $1.8 trillion. Menninger cites the Director of the Claims Statistics Service of the Veterans Administration as the source of his information. He writes that the final figure represents the amount spent on hospitalizations of neuropsychiatric patients between 1919 and 1941, estimated at $332 million.. Furthermore, by 1941 the U.S. government had paid out approximately $728.4 million in pensions to veterans with service-connected neuropsychiatric disorders and a further $92.9 million in non-service connected pensions.

[46] For a discussion of this transition see Annessa Stanger, "Healing the Soldier, Restoring the Nation: Representations of Shell Shock in the USA During and After the First World War," *Journal of Contemporary History* 49 (2014): 255-274. Thomas Salmon was a notable exception here. He worked closely with the American Legion to recreate the image of the war neurotic as a war-hero. However, his death in 1927 in a car accident prevented him from continuing with this cause.

deaths of both Thomas Salmon and Pearce Bailey in the 1920s. Without its strongest advocates, this new field of military medicine slowly decayed in the face of pressure by the government to shrink the size of the U.S. armed forces. The lack of professional interest in military psychiatry displayed by doctors and military leaders would have a dire effect when the United States found itself mobilizing for war once again in the 1940s.[47]

The lack of a shared understanding between the public and the professionals about the nature of war-related psychological trauma was not unique to the post-WWI period. The dearth of interest shown by mental health practitioners during the Civil War and the Spanish American War prevented the development of a rigorous professional discourse on psychiatric disorders in the soldiers who participated in those conflicts. Psychiatrists, content to limit their reach only as far as the walls of their asylums, declined involvement in either war. However, it is unclear whether or not their direct participation would have been of any benefit to the soldiers in question. The medical conception of the etiology of mental illness during the Civil War was such that psychiatrists did not even think to consider trauma as a causative factor in the symptoms presented by soldiers.

The closest medical experts came to accepting war-related mental breakdown during the Civil War was their recognition of nostalgia. They contended, however, that this disease was not a result of the horror of war, but instead a consequence of a man's intense longing for home. This led doctors such as J. Theodore Calhoun to recommend more war and more exposure to battle as a means to cure the afflicted. When psychiatrists in the 1860s did encounter soldiers, such as at the Government Hospital for the Insane, they applied diagnostic nomenclature such as "melancholy" or "mania" that reflected their current understanding of the characteristics of

[47] An excellent summary of the mental health profession's transition to dynamic psychiatry can be found in Allan Horowitz's *Creating Mental Illness* (2002). For a description of the key facets of dynamic psychiatry see Allan Horowitz, *Creating Mental Illness* (Chicago: The University of Chicago Press, 2002), 40.

insanity. They did not try to uncover whether or not a soldier's war experience had led to his admission and they did not consistently use the diagnosis of nostalgia that had gained popularity among military doctors.

Civil War soldiers, on the other hand, frequently deployed the term nostalgia in their recollections of the war as a means to depict the particular suffering they had experienced. In doing so, they helped solidify the condition in popular memory in a way that the psychiatric discourse did not. The professional discussion of nostalgia during the war was very limited and it all but ceased in the years following the conflict's conclusion. However, the presence of evocative descriptions of nostalgia within unit histories and other reminiscences published by Civil War veterans meant that the term and its connection to war persisted in the national consciousness.

It is not surprising, then, that after U.S. soldiers left for Cuba and then the Philippines at the end of the century, nostalgia quickly gained prominence in the public sphere once again. When battlefield surgeons began to report concerning psychological symptoms among the men they treated, journalists began to draw similarities to early accounts of nostalgia from the Civil War. Medical experts in the United States did not consider nostalgia a significant threat to the American fighting force. However, the public, fed by sensationalist journalism, continued to believe that the epidemic of nostalgia was severe. By the end of the war Americans had reshaped the identity of nostalgia from a simple longing for home to a condition that produced a dangerous insanity in soldiers.

Just as they had with shell shock during WWI, the public in 1902 drew conclusions about nostalgia based on media reports from frontline doctors and snippets taken directly from medical journals. Doctors privately expressed frustration at the intense popular interest in nostalgia, but made no overt efforts to correct what they considered a nation-wide misperception about the

illness. With no sustained interaction between mental health professionals and laymen, nostalgia, like shell shock, passed into history.

A persistent trope in histories of American combat psychiatry is "rediscovery." After each war, until arguably the conclusion of Vietnam, psychiatrists had to relearn or rediscover the lessons about psychological trauma that had been so hard won in the previous conflict. William Menninger, who served in Thomas Salmon's former role as the Chief Consultant in Neuropsychiatry during the Second World War, complained about this phenomenon in his reflections on military psychiatry in WWII. "Despite the fact that the lessons learned in World War I were plainly and clearly recorded," he wrote, "there was in 1941 no effective preparation or plan for the use of psychiatry by the Army in World War II." He pointed out that the psychiatrists of WWI had documented their processes in careful detail in the official history of neuropsychiatry during the war, but remarked, "judging from the lack of effect of the psychiatric experience of World War I, the history volume seems to have rested quietly on the shelf between 1929 and 1941." He could not help but make the snide observation, "paradoxically enough, it was used a guide by the British Army."[48]

For a process to be rediscovered implies that is has been forgotten. Psychiatrists had to relearn forward psychiatry during WWII because they had neglected to learn – or forgotten – the lessons of military psychiatry during WWI. This same phenomenon happened between the Civil War and the Spanish American War. There was no military psychiatry for mental health practitioners to have forgotten in this instance, but they did neglect to see the parallels between the nostalgia discussed by battlefield surgeons during the Civil War and the symptoms now being observed almost four decades later. The public made these connections but the

[48] Menninger, *Psychiatry in a Troubled World,* 10. See also Franklin D. Jones, "Military Psychiatry Since World War II," in *American Psychiatry After World War II (1944-1994),* ed. Roy W. Menninger and John C. Nemiah (Washington: American Psychiatric Press, Inc., 2000), 3-36.

professionals did not. With no agreed upon identity to characterize nostalgia – its causes, its symptoms, its treatments – it was easy for it to be forgotten.

Thus, when American psychiatrists mobilized for WWI they "discovered" war could have a deleterious effect on the mind, despite the fact that similar concerns had flourished less than two decades earlier. In the previous wars the professional understanding of the etiology of mental illness did not allow for trauma-related psychiatric breakdown, which explains why the mental health community so easily cast nostalgia aside, in spite of popular interest in the disorder. By the start of WWI, however, psychiatrists were beginning to look more closely at the effects of trauma on the mind and they were prepared in 1918 to accept the reality of a psychiatric breakdown caused by war. Professional understanding and recognition of a disease is key to the construction of its identity.

It is equally important for the public to offer this acceptance and recognition as well. The mental health community had formed closer ties with laymen through their efforts at professionalization at the turn of the century. Unlike the previous two wars, a precedent for open communication existed between the public and psychiatrists. In fact, at the start of the war, leaders in the profession were encouraging even more interaction between psychiatrists and the rest of the county. But this sharing of knowledge did not materialize during WWI due to the failure of military psychiatrists to present a unified message about shell shock. As a result, a gap in understanding between the popular and the professional conceptions of shell shock developed and prevented the formation of a shared understanding of the psychological trauma of war yet again.

The failure of psychiatrists and laymen between 1861 and 1918 to work together to develop a coherent construct of the effects of war on the mind explains why subsequent generations had to rediscover this harsh reality over and over again. Such a shared paradigm

would have given disorders like nostalgia and shell shock a validity that would have made them more enduring in both the public and the professional spheres. Absent this shared understanding, it was easy for these diagnoses and the insight they offered into the trauma of combat to disappear until called upon during the next war.

Historians tend to focus on the consequences of military psychiatry's constant need to relearn the lessons of the previous war. They should also be examining why these failures occurred in the first place. Such research allows us to better understand how ideas about psychological trauma evolved over the last hundred years. Additionally it helps historians to address one of the most interesting questions in the study of the history of psychological trauma: if we accept that the existence of psychological trauma has been constant through time and not just a phenomenon of the last century and a half, why did the American Psychiatric Association only recognize post-traumatic stress disorder in 1980? Why not codify it in 1920 or 1946?

There are undoubtedly many reasons why this was the case, including changing professional understandings about mental illness and the role of trauma. However, historians need to scrutinize how the professional and public discourses on psychological trauma during and after the wars of the twentieth century interacted – or failed to interact – in the construction of shared understanding of war-related mental illness. Doing so would shed light on the significance of 1980, but it would also help contextualize the experiences of soldiers, psychiatrists, and the public in previous, and even current, wars as well.

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