World War I led to large numbers of formerly healthy young men returning to Britain with various disabilities, ranging from ‘shell-shock’ to paraplegia. This article explains the factors that affected the rehabilitation of these men. Areas to be mentioned include: aspects of treatment, state and charity provision for the war wounded, functional restoration, pension allocation, training and employment. The impact each of these factors had on rehabilitation of the war wounded will be discussed.

Keywords: World War I, British, disabled soldiers, war wounded, rehabilitation

The First World War saw injuries on a greater scale with graver severity than ever previously witnessed. This increased morbidity was due to use of more advanced weaponry, including heavy artillery fire, machine guns and poisonous gases, which led to a wide range of impairments including limb mutilations, blindness and psychological effects such as “shell-shock” (1). It is estimated that over 1,640,000 British soldiers were wounded, nearly 30% of all British troops (2). Many factors affected the rehabilitation of these soldiers, including state provision for disabled soldiers, attitudes toward society, treatment and training of the soldiers.

At the time of World War I, men and women had clearly defined roles in society. Women were envisaged as dependent on men and their roles were domestic and maternal (3). Men were seen as the bread-winners and notions of masculinity meant they were expected to be physically and psychologically strong (4). Men who became soldiers were considered brave and manly; entering into war enabled a man to show his masculinity (5). Those disabled by war were therefore seen as different from disabled civilians. They “drew some of their identity from the way in which they became impaired.” (6) Many people felt that injured ex-servicemen were active sufferers and disabled civilians were passive sufferers. This opinion led to uneven healthcare funding and services between the civilian disabled and the injured ex-serviceman. For example, servicemen who lost a limb were entitled to artificial limbs through the state whereas this entitlement was not available for civilians (1).

In addition to the positive effect this distinction had on funding for ex-servicemen, it also gave them greater training and employment opportunities which aided rehabilitation. Many people believed disabled veterans could retain their masculine identity and remain self-supporting if given, and willing to undertake, the right training and employment prospects (7). St Dunstan’s, set up in 1915 for the war-blinded, was a key charity involved in training men and encouraging re-employment. The founder, Sir Arthur Pearson, firmly believed that, “blindness could be overcome,” and, was “not a permanent state of dependency.” (8) In addition to training for employment to enable independence, St Dunstan’s also facilitated rehabilitation with exercise, such as rowing and swimming. Although these were positive aspects of the ideals of masculinity and encouraged rehabilitation, these ideals also impacted negatively on some aspects of rehabilitation at St Dunstan’s. First, the responsibility for independence was placed upon the individual and if a man could not cope with
the regime he was seen as weak and lacking in character (8). Second, ideas of independence and war-blinded being different from blind civilians affected implementation of aid. Arthur Pearson strongly believed in the philosophy of “walking alone” and felt guide dogs suggested dependency and would lead to blind ex-servicemen being comparable with blind beggars and their companion dogs. Other aids, such as white sticks, were also shunned by St Dunstan’s as they were felt to go against the ideas of inner strength and made men stand out and appear feeble (8).

These ideas of masculinity also had an impact on rehabilitation of shell-shock sufferers. Men were expected to repress their emotions, “Men who broke down, or cried, or admitted to feeling fear were sissies, weaklings, failures” (9). When men began to suffer mental breakdown early on in the war, doctors were perplexed and diagnosed these men as insane, sending them to lunatic asylums with little chance of recovery. As the number of cases of breakdown increased it became more widely recognized and in 1915, in the Lancet, Dr Charles Myers labeled the term shell-shock (9). Despite this new medical label, the disorder maintained an effeminate connotation. This negatively impacted treatment and rehabilitation options. Some members of the state and medical professionals were of the belief that those who were shell-shocked were malingerers and were feigning their symptoms. Not only would they then not receive treatment, they could be sentenced to death by firing squad. However, as the war continued it was generally accepted that most of these men did have a mental disorder. Ideas of masculinity still had an effect on some treatments and rehabilitation methods. For example, some officers and doctors felt that shell-shock was a sign of weakness that required strict discipline and “routines of physical hardening.” (4) These beliefs led to men who had left the front line being told they were to return and continue to fight in order to overcome their fear (10). These men therefore were not given any form of rehabilitation and had to continue with their duties. An unpleasant treatment method, “faradization,” came about due to perceptions of weakness and the need for a quick cure to enable soldiers back to fight as soon as possible. This involved applying electric shocks to the patient to try and cure them by stimulating nerve endings. There were other treatment methods which were less focused around ideas of shell-shock being due to weakness. For example, some believed shell-shock was a form of mental exhaustion rather than breakdown. This view suggested rest as a cure, thus some men were sent to hospitals or houses to recover (9). Psychotherapy was also used as treatment and involved feeling analysis, re-education and occupation of the patient’s mind to try and prevent relapse and promote rehabilitation (10).

After initial treatment, there was a lack of provision for rehabilitation of shell-shocked soldiers. It was hard for doctors to assess psychological disability as there were no standard criteria established for physical disability. Therefore, a subjective view of an often unsympathetic examination board decided what pension, if any, the state would allocate these ex-servicemen. Also, the head of the Special Medical Board, which was set up to re-evaluate men who had been given temporary pensions, “dismissed psychoanalysis as mere quackery.” (11) The lack of state provision led to voluntary services, such as the Red Cross, organizing specialist centers for treatment and rehabilitation of shell-shocked men. These were not sufficient, however, for the large number of soldiers returning with psychological problems. Left without adequate state assistance many of these men felt hopeless and alienated from society (11).

Although the state did not provide well for shell-shocked soldiers, it was generally felt by the public and war veterans that rehabilitation of the war-wounded was the state’s responsibility. Whilst awaiting discharge, disabled soldiers were treated in military hospitals (12). Once discharged, “Commentators agreed it was the responsibility of the state, supplemented by the efforts of its citizenry, to provide for the disabled.” (13) Before 1915, disabled ex-servicemen were reliant on voluntary services such as the Soldiers’ and Sailors’ Help Society (1). In 1915, however, the state began to provide pensions and in 1917 set up the Ministry of Pensions to organize funds (14). In addition to allocating pensions, the ministry also intended to deal with further treatment, training and
employment (15).

With regard to pensions, in 1915 the amount allocated was decided on loss of earning capacity. This system led to problems rehabilitating ex-servicemen into employment as they feared they would lose their pension if they returned to work. When the Ministry of Pensions took over, it awarded pensions on degree of disablement to prevent idleness (12). There were still problems, however, in pension allocation. There were numerous war veterans to deal with and the ministry was unwilling to award pensions to the cases that it could avoid, for example, in cases where war aggravated rather than caused medical conditions (13). Also, diseased ex-servicemen were given less sympathy than maimed as, “His body did not show signs of injury.” (1) This lack of sympathy resulted in diseased ex-servicemen, and also shell-shocked men, having greater difficulty acquiring pensions. Pension committees were harsh in awarding pensions and regarded all war-wounded with suspicion and as possible malingerers. Furthermore, even when pensions were awarded they were low, “calculated only to keep a man from destitution.” (1)

With respect to men who required further treatment after discharge, the state made arrangements with hospitals for beds and allocation of outpatient appointments for the war-wounded (16). In addition, annexes were attached to some hospitals to allow more soldiers to be treated (12). As previously mentioned, the state also provided prostheses to men who had lost limbs. Despite the fact the state provided treatment, they did not provide for all cases. Those who needed longer term treatment, such as paraplegics and the war-blinded, were least likely to be provided for. Some were left to private charities such as St Dunstan’s for the war-blinded and Roehampton, the largest artificial limb-fitting centre (13).

The Ministry of Pensions also intended to organize training and employment for ex-servicemen. Training would only be given to men unable to resume their old occupation due to disability. It was not compulsory as it was felt men would only participate fully if they were willing and chose to do so (12). Although this may have been a reasonable argument, it contributed to the low take-up rate of training schemes. It was estimated that, “between 50 and 60 per cent of the war-disabled would benefit from retraining courses,” but, “only 15 per cent proved willing to attend them.” (1) This was due to the factors such as reluctance to move away from home, not wanting to undergo further discipline and the high number of well paid jobs offered for unskilled laborers straight after the war. Men taking up these jobs encountered problems as they were only temporary. Thus when they were laid off they would have difficulty finding work as they were not trained for any skilled occupations (17). It was not just the fact that men were unwilling that led to the low numbers of ex-servicemen being trained; the Ministry of Pensions contributed to the problem. When men applied for training they found it was often full or were told they did not qualify due to technical reasons (11). In early 1920 the government had only trained around 13,000 disabled men while 60,000 more were thought to be eligible. Then in 1922 the training program closed completely (13).

State provisions for the war disabled were unsatisfactory. The state saw philanthropy as a way of not having to allocate as many resources into rehabilitation of disabled ex-servicemen. This meant that some former servicemen fared better than others depending on where they lived and their access to charities.

Many charities were involved in rehabilitation of ex-servicemen and undertook a lot of the work including treatment, training and employment. Charities were especially prominent in the management of the severely disabled who needed longer term care, for example, paraplegic and limbless ex-servicemen (13). The Queen Mary’s Star and Garter home for paraplegics was established to care for and rehabilitate paraplegic ex-servicemen by light work such as knitting (18). Curative workshops were also established alongside orthopedic hospitals and encouraged rehabilitation of soldiers by use of massage, gym equipment, and manual work to aid psychological and physical restoration. The first curative workshop was set up at Shepherd’s Bush Hospital in 1916 and was largely the work of King Manuel,
who raised funds privately. By 1918 there were 16 throughout Britain which enabled rehabilitation of many men (19). The Soldier’s and Sailor’s Help Society also trained disabled men in their workshops as they had been doing since the Boer War. Roehampton and Brighton hospitals for limbless soldiers instructed men in various occupations such as carpentry, shoe-making and electrical work (18). Chailey and Agnes Hunt’s Orthopedic Hospital, which was formerly for crippled children, began to take in wounded soldiers. Each soldier was paired with a child to boost their morale and inspire them. The men also undertook manual tasks and training at curative workshops to allow them to work, which was how “the dismembered could become full citizens again” (20).

Although charities tried to provide many retraining opportunities, there were still employment problems as many men did not undergo training. Moreover, those who had undergone training still struggled to find employment (13). The lack of employment for disabled ex-servicemen led to Henry Rothband proposing a scheme, the King’s National Roll Scheme (KNRS), whereby, “every company in England and Wales with over ten employees (had) to ensure that no less than 5 per cent of their workforce comprised disabled ex-servicemen” (21). The government was initially reluctant to implement the KNRS, but towards the end of 1918 they realized employment problems were worsening and a large number of disabled ex-servicemen were set to remain unemployed. This encouraged the state to establish the scheme in September 1919. Employers had to choose to undertake the scheme but were encouraged by its advertisement as a way of honoring those who gave so much for their country, into society.

Many factors affected rehabilitation of men wounded during World War I. One of the main factors was the fact that the state was reluctant to take full responsibility for this immense task. This reluctance produced a system where there was no central control over matters such as treatment, training and employment. Voluntary services filled the gaps as best they could. For example the Red Cross set up the homes for the shell-shocked soldiers to remedy the lacking state programs in this area. Although beneficial, this effort was not adequate for a large number of men needing assistance in re-integration. Charities put forth a laudable effort, but were unable to deal with the staggering number of men who required rehabilitation. Voluntary services felt that the state should accept their duty and take over the full role with the organization of treatment, training, and employment for all disabled ex-servicemen where necessary. If the state had taken complete responsibility, this would have led to greater success in rehabilitating the war-wounded, who gave so much for their country, into society.

Jenny du Feu is a 4th year medical student at the University of Aberdeen. She can be contacted for comment at j.dufe06@aberdeen.ac.uk.

References
Factors Influencing Rehabilitation of British Soldiers after World War I. du Feu.


