

The Strange, Second Death of Lewis Yealland

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Volume 103, Number 2, Fall 2011

URI: <https://id.erudit.org/iderudit/1065449ar>

DOI: <https://doi.org/10.7202/1065449ar>

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Publisher(s)

The Ontario Historical Society

ISSN

0030-2953 (print)

2371-4654 (digital)

[Explore this journal](#)

Cite this article

Duffy, D. (2011). The Strange, Second Death of Lewis Yealland. *Ontario History*, 103(2), 127–149. <https://doi.org/10.7202/1065449ar>

Article abstract

Lewis Ralph Yealland (1885-1954), a graduate of University of Western Ontario's medical school, migrated to the imperial capital in 1915, where he worked on shell-shock cases at the Queen's Square hospital. His efforts won him the praise of his superiors, and he published a survey of his cases and the therapies he employed in 1918. He spent the remainder of his career as a Harley Street physician, specializing in the treatment of alcoholism. UWO granted him an honorary degree in 1948. Then, beginning in 1985, his reputation began its posthumous disintegration. Scholars, a prominent novelist, and a filmmaker alike viewed him and his electroshock therapies as barbarous. Yet a carefully contextualized account of his practices compels us to revise this recent revisionism. Neither an attempt at advocacy nor a venture in setting the record straight, my treatment of Yealland and his work on shell-shock provides an alternative reading to a subject that contemporary discourse made up its mind about too quickly.



The Strange, Second Death of Lewis Yealland

by Dennis Duffy

Queen's Square Hospital, London, England, January 1917: a mute man in khaki uniform sits in a dark room, lit only by the bulbs affixed to an electrical battery. The other man, the one in the white lab coat, the man in charge, wants that silent soldier to talk. Previous attempts—featuring electric shocks to neck and throat, “hot plates” affixed to the back of his mouth, and burning cigarette ends applied to the tip of his tongue—have failed to break the silence of the man in khaki.

The doctor in the white coat assures the 24-year-old private that he will not be leaving the room until he talks. A jolt to

the back of his throat makes him jump far enough to detach the wires from the battery. Army medical doctor James Walsh, in a post-war commentary considered the pain from the electric current “as severe...as anything we know. ... the sting of a whip, no matter how vigorously employed ... [is] almost nothing compared with the sudden severe shock of a faradic current.”¹ The private is now tied down, and a weaker current courses through his body, “more or less continuously” for an hour. Treatment continues for the next three hours. The subject first regains the power to make guttural “ahs.” Later, he will pace around the room, groaning out

¹ Quoted in Tom Brown, “Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War,” in Charles G. Roland, *Health, Disease and Medicine. Essays in Canadian History*. (Toronto: Clarke Irwin for the Hannah Institute for the History of Medicine, 1983). 320.

Abstract

Lewis Ralph Yealland (1885-1954), a graduate of University of Western Ontario's medical school, migrated to the imperial capital in 1915, where he worked on shell-shock cases at the Queen's Square hospital. His efforts won him the praise of his superiors, and he published a survey of his cases and the therapies he employed in 1918. He spent the remainder of his career as a Harley Street physician, specializing in the treatment of alcoholism. UWO granted him an honorary degree in 1948. Then, beginning in 1985, his reputation began its posthumous disintegration. Scholars, a prominent novelist, and a filmmaker alike viewed him and his electroshock therapies as barbarous. Yet a carefully contextualized account of his practices compels us to revise this recent revisionism. Neither an attempt at advocacy nor a venture in setting the record straight, my treatment of Yealland and his work on shell-shock provides an alternative reading to a subject that contemporary discourse made up its mind about too quickly.

Résumé: *Lewis Ralph Yealland (1885-1954), diplômé de l'école de médecine de l'University of Western Ontario, a émigré en 1915 à Londres, où il a traité à l'hôpital de Queen's Square les victimes de psychoses traumatiques provoquées par éclatement d'obus. Ses travaux ont été loués par ses supérieurs, et en 1918 il a publié un aperçu des cas qu'il avait traités et des thérapies qu'il avait utilisées. Il a passé le reste de sa carrière dans Harley Street comme médecin spécialisé dans le traitement de l'alcoolisme. UWO lui a accordé un diplôme honoraire en 1948. Mais à partir de 1985, sa réputation a commencé à se ternir. Des érudits, un romancier connu, et un cinéaste l'ont tous traité de barbare à cause de son utilisation de l'électrochoc dans ses thérapies. Cependant, une étude bien contextualisée de ses pratiques nous oblige à remettre en question ce révisionisme récent. Sans vouloir le défendre, et sans prétendre rétablir la vérité, j'offre dans mon traitement de Yealland et de ses travaux une interprétation alternative d'un sujet sur lequel nos contemporains ont peut-être tranché trop rapidement.*

those sounds, until it is time for stronger shocks to the outside of his neck. He then begins to ask for water. Repeated applications of electricity get him to the point of sustained speech, the presentation

marred by shaking in the left arm. More current is delivered to the arm, and then to the other three limbs. They restore the private to the point where he can call himself "a champion." The doctor agrees, stating that the man is also "a hero." He can now return to the Western Front as a fighting man, a soldier rescued from the effects of a debilitating wound whose exact nature and etiology no one in the medical profession is quite certain about.²

This account of a medical treatment for a condition often described as shell shock has not been lifted from the testimony of a mad doctor. What I have just paraphrased is one of many stories told by that man in the white coat whom some have seen as the tormentor of the man clad in khaki: Dr. Lewis Ralph Yealland (1885-1954), a 1912 graduate of the University of Western Ontario's medical

school. Yealland wrote up this case and others because he considered them all to be therapeutic triumphs, worthy of inclusion in his 1918 monograph, *Hysterical Disorders of Warfare*. However question-

² This incident appears in Lewis R. Yealland, *Hysterical Disorders of Warfare*. (London: Macmillan, 1918), 7-15 (Case A1). Online: <<http://ia341029.us.archive.org/1/items/hystericaldisord00yealuoft/hystericaldisord00yealuoft.pdf>

able such therapeutic practices may appear to us now, we cannot begin to consider this moment in overseas Ontario medical history without first considering three principal forces shaping this recorded encounter between physician and patient: the nature of the condition under treatment, the training of the medical worker applying such treatment, and the wartime system shaping both doctor and patient and the choices they made. This background can in turn enable us to scrutinize the subsequent, posthumous, multi-media demolition of Lewis Yealland's reputation. Does he in fact deserve Elaine Showalter's description of him as "the worst of the military psychiatrists"?³ I contend that we will find instead a scientific worker plodding his way through a series of cultural minefields—questions involving widespread anxieties about gender, social class and the foundations of psychiatric practice—in search of an effective treatment for a condition whose very definition lay adrift in fluidity and contestation. What we call the fog of war does not occur only on the battlefield.

Examining Lewis Yealland's scientific and medical background acquaints us with the tools and training that he brought to his work. Then a survey emphasizing the problematically-defined, combat-induced disorder that he sought to treat demonstrates the urgent, compelling and pragmatic nature of the task that the system in which Yealland worked determined for its practitioners.

Next appears a discussion of the specific means—the practice of what was then known as "faradism"—that Yealland employed, one that the medical practice of his time endorsed and often recommended. An examination of the specific assaults upon Yealland's reputation as a medical worker focuses principally upon Pat Barker's widely-read novel *Regeneration* (1991). Its carefully-nuanced, yet highly melodramatized (I will explain this paradox) treatment of Yealland's work heralded the subsequent historical commentary that has consigned him to a bad-doctors' file. My final section examines the evidence itself—the documentation that Yealland provided and that was used to hang him—and presents the case for a reading of that evidence that is less adversarial and, I contend, more impartial and contextualized in nature.

My enterprise here began with an interest in Yealland himself that grew out of my realization of his Canadian origins. That in turn led to a hunch that there might have been more to him and his work than the villainy that contemporary discourse found there. My research-driven conviction that this was in fact the case led me to the assembling of this argument, not quite an exercise in advocacy, nor an attempt to set the record straight. Instead, it is an exercise in providing an alternative reading to a matter that contemporary discourse seems to have made up its mind about.

³ Elaine Showalter: *The Female Malady. Women, Madness, and English Culture, 1830—1980*. (New York: Pantheon Books, 1985). 181.

I

What did Lewis Yealland bring with him from Ontario to what everyone called the Queen's Square Hospital (now the National Hospital for Neurology and Neurosurgery)? He had followed thousands of other Canadians to the U.K.: there was a war on, and Canada had become part of it. He came to his new job as a civilian, one whose Ontario training, education and practice had readied him for the role that he was to play in this conflict. He was the offspring of Empire's pairings: his British-born father had come to London, ON to pursue his career in journalism. In 1878, Frederick Truscott Yealland (1851-1935) had married Ellen Lewis Howie (1851-1950), who had been born on a ship *en route* to Canada from St. Kitts.⁴ The Dickens-loving F.T. Yealland became a prominent newspaperman in London, editing over a thirty-year span the evening edition of both the *London Free Press* and *The Echo*.⁵ His son, Lewis Ralph, born on 11 June 1885, attended St. George's (public) School and the University of Western Ontario. He graduated from its medical school in

1912. Despite his residence in the imperial capital from 1915 until the end of his life, his ties to Western proved strong enough for him to serve as its representative on the executive of the Conference of Universities of the British Empire/Commonwealth.⁶ This service earned him an honorary D.Sc. from his alma mater in 1948. Possibly on account of his father's role in hometown newspapers, Yealland's professional achievements were covered there despite his overseas residence.

A history of Western's medical faculty mentions Yealland's internships in Hamilton, ON and New York following graduation, postponing his neurological training until his 1915 arrival at the National Hospital for Nervous Diseases, Queen's Square, London UK. More detailed sources, however, underline his Ontario occupational training in the treatment of the mentally ill.⁷ Dr. Nelson H. Beemer, Medical Superintendent of Hospital for the Insane in Mimico, noted the arrival of Dr. Louis (sic.) Yealland in his Annual Report for 1913.⁸ His Mimico appointment lay within a relatively new, showplace location in a lakeside setting, dotted with airy cottage-like

⁴ Yealland genealogy: <http://www.cyberus.ca/~mikebur/yealland2.htm>. Mr. John Yealland proved of considerable help to me in exploring this topic.

⁵ "F.P. Yealland Is Called By Death," *London Evening Free Press*, 9 February 1938, 1.

⁶ Murray L. Barr, *A Century of Medicine at Western: A Centennial History of the Faculty of Medicine*, UWO (London, ON: UWO, 1977), 242-43. "Yealland, Lewis Ralph," *Canadian Who's Who* 6 (1954-56), 1138. My thanks to Ms. Anne Daniel of the UWO Archives for assisting me in gathering information of Yealland's early years, and to Ms. Gabbi Zaldin of Victoria College's Pratt Library.

⁷ I am indebted to Dr. John Court, Librarian and Archivist at Toronto's Centre for Addiction and Mental Health not only for supplying me with information about Yealland's time within the Ontario system, but for extending to me his interpretation of Yealland's work there.

⁸ Then a Toronto suburb, now a neighbourhood, Mimico saw the large hospital become the Lakeshore facility of the Ontario (Mental) Hospital system. The site, with many of the original pavilions remodeled into classrooms, now houses the Lakeshore campus of Humber College of Arts and Technology.



L.R. Yealland. Photo from *Faculty of Medicine Biographical Scrapbooks, The University of Western Ontario Archives, A09-074-001*.

pavilions for men and women. Yealland was one of four physicians there, and as a junior would have been attending and observing a wide range of patients under the supervision of his seniors. Beemer's 1916 Report notes that in late 1915, Yealland, succumbing to "greater attractions offered by the service of the military hospitals," came to London. His son, Dr. M.F.T. Yealland insists that his father accepted the position—offered to him by the Dean of U.W.O. medical school—on

very short notice.⁹ Positioned at what would have seemed the medical world's center, the arena where the care of those whom we now regard as the psychically wounded had come to assume a major role in hospital practice, Yealland had to have been aware of new horizons in his field. Historian Tom Brown points out that the war was proving an "extremely important catalyst" in psychiatry's development; what he terms the "Therapeutic State ... was first forged in the crucible of the Great War."¹⁰ No longer immersed in the routines of civilian mental illness in a low-status professional setting—psychiatrists worked in state institutions on government salaries and with involuntary and lower-class patients—Lewis Yealland worked now amid the human wreckage generated by the war.¹¹ Whatever he had learned in the care of Ontario's domestic casualties would be applied to dealing with some of what a later official report called "the thousand and one ills of modern trench warfare"¹² What was Dr. Lewis Yealland bringing to that struggle?

Yealland's training at Western medical school relied upon William Alanson White's classic textbook, *Outlines of Psychiatry*, a work whose successive editions ruled the classroom from 1907 to 1935.¹³ He found there a treatise marked by clar-

⁹ Letter, M.F.T. Yealland to Robert Coldstream, 14 December 1997. My thanks to Dr. Susan Yealland, Lewis R. Yealland's daughter-in-law, for this and other family items and information.

¹⁰ Tom Brown, "Shell Shock," 322-24.

¹¹ Desmond Morton, "Military Medicine and State Medicine. Historical Notes on the Canadian Army Medical Corps in the First World War, 1914-1919" in *Canadian Health Care and the State. A Century of Evolution*, Christopher David Naylor, ed. (Montreal and Kingston: McGill-Queens University Press, 1992), 48.

¹² *Report of the War Office Committee of Enquiry Into "Shell-Shock"*, 1922, Reprint. (London: Imperial War Museum, 2004), 94.

¹³ Martin Grotjahn, review of *Outlines of Psychiatry*, *International Journal of Psychoanalysis* 19 (1938:

ity and thoroughness, one that walked a student through a series of definitions and applications situating the practice of psychiatry within the body's stimulus-and-response mechanisms. That is, Yealland was trained in what we now know as the "somatic" school of psychiatry, during the final period of its professional sway. Psychiatry's purpose: reinforcing the development of "the most complete mental life," one "which best adjusts the individual, both passively and actively ... to the conditions of his environment.... The mental life is carried on within relatively narrow limits;" Psychiatry's aim is to restore the patient to living within the scope of those limitations. "The interference with the adjustment of the individual with his environment is therefore a disorder..." (16).¹⁴ Such an emphasis on a patient's adjustment to his environment implicitly legitimates the state's engagement in industrialized warfare, with all its trying conditions.

"Talk therapy," that is, the psychoanalytic approach would acquire a new and dominant position in the period following the Great War. It would come

to dominate the psychiatric profession's practices until the emergence of the psychotropic drug-therapies during the '60s. But Yealland's training and practice emphasized instead that mental illness originated in somatic injury, in material and physiological rather than psychological aspects of the human organism.¹⁵ Pragmatic in its approach—"The study of psychiatry is therefore primarily a study of disordered function and must be conducted not only in the autopsy room but in the psychological laboratory" (26); "Ideas cannot exist alone; what does exist is a mental state constellated by events in the environment and related to those events" (17)—White's *Outlines* erects its guidelines atop a closely-articulated skeleton of anatomical and neurological study.¹⁶ A psychosis is "the resultant ... of a conflict ... between unsatisfied instinctive desires which have been repressed into the region of the unconscious, and the conscious, voluntarily directed tendencies of the individual" (20). In order to resolve this conflict, a physician relies upon his insight, empathy and objectiv-

252-53). <http://www.pep-web.org/document.php?id=ijp.019.0252a>. Also, interview with John Court, 11 February 2010. ¹⁴ A viewpoint shared by the British anthropologist-psychotherapist W.H.R. Rivers whose practices, as we shall see are often positioned as the antithesis of Yealland's.

¹⁵ Surveys of this broad topic can be found in Anthony Babington, *Shell-Shock. A History of the Changing Attitudes to War Neurosis* (London: Leo Cooper, 1997); Wendy Holden, *Shell Shock*. (London: Channel Four Books, 1998) and in Showalter, *Female Malady*, 167-94. The rise of "evidence-based medicine" in our own time underscores the cyclical and seemingly adventitious (rather than fixed and enduring) modes of psychiatry's defining of and therapies for mental illness. In this aspect of its world view, psychiatry would appear to embrace a post-modern, dialectical mode of experience rather than the fixed, modernist outlook marking our popular views of scientific medicine. See also Louis Menand, "The Depression Debate," *New Yorker*, 1 March 2010. 155-70.

¹⁶ William A. White, *Outlines of Psychiatry*, 8th Ed. (Washington [D.C.]: Nervous and Mental Disease Publishing Co., 1921 [1903]) Nervous and Mental Disease Monograph Series No. 1.

ity. On the one hand, he must display “an absolute lack of critique” toward the patient, who has “blamed” or “laughed at himself” too often (54). On the other, the would-be healer need not “indulge” in sympathy. It is *understanding* that the patient seeks, and within that understanding, sympathy is enfolded.

This emotionally austere approach, material rather than psychological in orientation, suited a system stretched to its limits by what was seen as a new kind of battle wound. “Shell shock” was a condition then thought to originate from a soldier’s close-at-hand exposure to high explosive, and the consequent *physiological* disturbance that resulted. Something, we might now say, like the head injuries caused by contact sports, even among helmeted players. That newly-defined designation for a relatively new kind of combat casualty determined Lewis Yealland’s medical practice for several years. It produced his sole book-length publication, a record of his medical interventions against that condition. That report posthumously destroyed his good name as a healer.

II

Though it is now a truism that the Great War was primarily an artillery

war, it is sobering to see that the literature on shell shock seems as extensive as the discourse about shell fire.¹⁷ Colonel Charles Myers, who invented the term and later published a book on the condition at the beginning of the Second World War eventually discarded the term.¹⁸ By 1922, the War Office Report on the condition admitted that the term had become obsolete, but understood that so alliterative and handy a term would likely endure. Its non-professional usage continues to this day.¹⁹

Small wonder: the psychic branding of the individual by the conditions of modern, industrialized combat has been a fact of soldiers’ lives since at least the U.S. Civil War. It was then called “nostalgia,” the urge to absent oneself from the battlefield and all its agonies and anxieties, a condition often displaying itself through uncontrollable and disabling physical symptoms. Like some protean confidence man, the condition changed its name with its every appearance. “Hysteria,” “neurasthenia,” “soldier’s heart,” “shell shock,” “war neurosis,” “combat fatigue,” “PTSD”: the nomenclature—some technical, some demotic—seems as mutable as the street-drug name of the week. Official statistics for the Brit-

¹⁷ Clicking on “shell shock” in the Scholars’ Portal database discloses 705 entries in the social sciences category, 255 in the natural sciences, and 345 in the humanities. Even assuming considerable overlap, these figures indicate how widespread is the interest in the condition, and how durable the term that no longer possesses any medical validity.

¹⁸ Charles S. Myers, *Shell Shock in France 1914-1918. (Based on a War Diary)* (Cambridge: Cambridge University Press, 1940). For his coinage of the term: “A contribution to the study of shellshock. Being an account of the cases of loss of memory, vision, smell and taste admitted to the Duchess of Westminster’s Army Hospital, Le Touquet,” *Lancet* 13 February 1915, 316-20. See also Hans Binneveld, *From Shellshock to Combat Stress. A Comparative History of Military Psychiatry*. Trans. John O’Kane. (Amsterdam: Amsterdam University Press, 1997), 84-85.

¹⁹ *Report of the War Office Committee of Enquiry Into “Shell-Shock,”* 1922, 5. I well recall the use

ish Expeditionary Force (which included Canadian troops) attributed 21,549 casualties to “Functional diseases of the nervous system (including neurasthenia and shell-shock).”²⁰ By 1917, war neuroses accounted for one-seventh of those discharged on the grounds of disability. The after-care and pension costs proved astronomical. What had been going on? In a word, the Western Front.

Consider the conditions governing every combatant there. Death could pounce by means of both random or directed artillery and small arms fire. Lurking in a trench between offensives was no guarantee of safety. Programmed enemy bombardment, and/or random shelling and sniping took their toll. Shells fell behind the front lines, they fell wherever troops assembled, they fell anywhere they could reach. They even fell into the same shell hole that they had already made. Gas attacks did not simply vanish in the breeze. The toxic substances lingered in the air, some of them even soaking into the soil, released every time that soil was disturbed, so that soldier throwing himself violently upon the ground in order to avoid an oncoming shell might inhale the old but potent fumes. Then you could drown in the mud formed by the ceaseless activity and the persistent rain.

Then came the louse-ridden discomforts of trench life: the broken sleep, the bad, often undercooked or nearly-spoiled food, the clothing inadequate to keep out the rain and chill, the resultant colds and infections, the lice, the omnipresent rats, the shit piled up in the trenches because men were too fearful or too strained to find comfort in a rearward latrine. All these—and many more discomforts and jagged lapses from everyday comforts and amenities—wore down even the most stouthearted.

Shell shock as the name suggests, at first seemed like other wounds, a reaction to a specific insult to the organism. Only later, when terms like “hysteria” and “neurasthenia” became commonplace, was it redefined and seen as the culmination of a process of grinding attrition, one of what the post-war War Office report termed one of “the thousand and one ills of modern trench warfare.”²¹

By 1915, when the cases began to accumulate, only a few bitter stalwarts like Lord Kitchener assumed that the war was going to lurch on for nearly four more years. Shell shock, like the war itself was undergoing a redefinition. The familiar assumption that no one was prepared for the heavy casualties that modern warfare would exact is not so. The soldiers knew

of the term in the late 1940s to describe traumatized Second World War veterans, and a recent number of a popular history journal employs the term on both its cover and within throughout a 24-page section on the subject: Tim Cook, “The Great War of the Mind,” *Canada’s History*, June-July 2010, 18-27.

²⁰ T.J. Mitchell and G.M. Smith, *Medical Services Casualties and Medical Statistics of the Great War. Official History of the Great War* (London: H.M. Stationary Office, 1931), 285. In view of the common assertion that shell shock or similar disorders produced one-seventh of the BEF’s casualties, I must assume that these official figures apply to the incurables, those discharged on medical grounds.

²¹ *Report of the War Office Committee of Enquiry Into “Shell-Shock,”* 94.

this, and had attempted to plan for it.²² They knew the superiority that the man in the rifle pit held over his attacker, and they also knew the power of massed artillery and the machine gun's capacity for destruction. All these factors, they assumed, would make for a war of brief, very costly, yet nonetheless decisive engagements, rather than the years-long bloodbath of gradual and deadly attrition confronting them. What they hadn't planned for was the resilience of the societies who were waging this kind of war. Yet the souls of many soldiers proved to be more fragile than their nation's resolve.

The medical and command system called the near-catatonic response to prolonged exposure to such combat "shell shock" because it manifested itself in bizarre behaviour, the sort of behaviour that we commonly associate with men under extreme pressure. Such people seem "out of their minds," "off their rockers," "barking mad" or whatever the current terminology labels them. Their symptoms: muteness, uncontrollable twitching, paralysis or jerky limb movements, a thousand-yard stare. All or one of these to a degree unfitted the soldier for any further active role in combat. No further words are needed. Simply click your way to <[\[youtube.com/watch?v=RRv56gsqkzs\]\(http://www.youtube.com/watch?v=RRv56gsqkzs\)> or <<http://www.youtube.com/watch?v=SS1dO0JC2EE&NR=1>> and do not blink at what you find there.](http://www.</p>
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Men rendered unfit for further combat by wounds that did not mark the body as bullets or shell fire did, but that seemed nonetheless real, were at first simply discharged. The depleted ranks could be filled up with new drafts. But the slaughter of the 1916 Somme campaign (with that notorious First Day figure of 57,470 casualties for the BEF) fully engaged the system of command into demanding some sort of diagnosis, treatment and rehabilitation of psychic casualties, however contemporary medical practice defined those terms.²³ Even special hospitals for the condition became established. Yet those who ran the hospitals remained bewildered. Major Colin Kerr Russell, C.A.M.C., who directed the Granville Special Hospital at Ramsgate, remained skeptical about the condition throughout the war and after its conclusion. How actually did one reliably distinguish shell shock from malingering? His unease never quite subsided, and as late as 1939 Russell repeated his observation that disciplined units submitted far lower figures on shell shock than did slack ones.²⁴

²² Tim Travers, *The killing ground: the British Army, the western front, and the emergence of modern warfare, 1900-1918* (London, Boston: Allen & Unwin, 1987).

²³ A 1915 *vade mecum*, pocket-sized handbook illustrates a growing sense of bewilderment at a phenomenon impossible to ignore. Wilfred Harris' *Nerve Injuries and Shock* in the Oxford Medical Primers series spends its final 22 pages discussing "Nervous Shock Following Cerebral Injury." It seems an appendix to the rest of the handbook, which deals in a matter-of-fact way with the conventional methods for palliating cranial and head injuries. This final chapter however, finds the writer recommending nothing more detailed than "suggestion" and rest. Wilfred Harris, *Nerve Injuries and Shock* (Oxford and London: Henry Frowde and Hodder and Stoughton, 1915), 101-23.

²⁴ Russell, Colin Kerr. "A Study of Certain Psychogenetic Conditions among Soldiers,"

Russell's puzzlement was widespread, a fact conveyed starkly in a voluminous compendium of shell shock cases and their treatment. Nothing better discloses the condition's mysterious origin and the desperate search for an effective cure than the list of therapies tried: hydrotherapy; drugs; faradism, hypnotism; induced fatigue; isolation; lumbar puncture; mechanotherapy; narcosis; occupational therapy; pseudooperations; faith, rationalization, explanation, "tracing back," reassurance, re-education; studied neglect; psychotherapy and recovery without medical treatment.²⁵

The demands of the new warfare were inescapable—9,000 members of the CEF were diagnosed with shell shock overall—and could not be met if large-scale disablements became a norm.²⁶ A medical system lay under siege from a plague that threatened the assemblage of doctors recruited from mental hospitals, neurological hospitals and a "group of insufficiently trained volunteers." The authorities for a while hoped that, if ignored,

the condition would simply go away, attempting a cover-up through discouraging publication of relevant articles in the *BMJ* and *RAMC* journals.²⁷ If, as a Great War military doctor who later became Winston Churchill's personal physician put it, "Men wear out in war like clothes," then how were they to be re-outfitted?²⁸ What was to be done to get soldiers, officers and men alike, back into combat, back from the blankness and psychic death, and from that spiritual wasteland where the trenches had buried them in the first place? Could one "cure" a leper well enough to send him back into the charnel house that had first infected him?

III

Lewis Yealland landed in this medical morass—a widespread combat injury whose nature, origins and treatment were unclear—after a brief period of caring for the mentally ill within Ontario's institutionalized settings. Hindsight now informs us that streams of social and cultural anxieties fed that swamp that shell

CMA Journal 7 (1917), 704-20; "Psychogenetic Conditions in Soldiers, Their Aetiology, Treatment and Final Disposal," *Canadian Medical Week* (1918), 227-37; "The Nature of the War Neuroses," *CMA Journal* 41 (Dec. 1939), 549-64.

²⁵ E. E. Southard, *Shell Shock and Other Neuropsychiatric Problems. Presented in Five Hundred and Eighty-Nine Case Histories from the War Literature 1914-1918* (Boston: W. M. Leonard, 1919), index, 19-20.

²⁶ Tom Brown, "Shell Shock," 315-16, 309. Lt. G.N. Kirkwood, Medical officer to the 97th brigade, 11th Border reg't., 32nd Division reported following the 1 July disaster on the Somme that his entire unit was shell-shocked; he was sent home after a Court of Inquiry (Peter Leese, *Shell Shock. Traumatic Neurosis and the British Soldiers of the First World War* [London: Palgrave Macmillan, 2002]), 28.

²⁷ Ian R. Whitehead, *Doctors in the Great War*. (London: Leo Cooper, 1999), 169-70. See also, Edgar Jones, "Doctors and trauma in the First World War: the response of British psychiatrists," Peter Gray and Kendrick Oliver, eds. *The Memory of Catastrophe* (Manchester: Manchester University Press, 2004), 91-105.

²⁸ Lord Moran (Charles McMoran Wilson), *The Anatomy of Courage* (London: Constable, 1945), 70.

shock had created. Had the lines between masculinity and its opposite become blurred? Certainly Sir Andrew MacPhail who directed Canada's medical war effort, thought so, writing in his 1925 official history that shell shock's origins lay in "childishness and femininity." He concluded that, "Against such there is no remedy."²⁹ So did the condition originate then in individuals bereft of social support, men damaged beyond repair by ancestral alcoholism and bad upbringings? Captain Wright's experience suggested this to him.³⁰ As if class and gender bias were not adding sufficient opacity to scientific observation, one sort of approach to psychic injury was now contending against another. Thus a present-day observer blames with hindsight "the somatic orthodoxy of late nineteenth-century medicine" for the confusion over treatment methods.³¹ As with so many wartime ironies—the machine gun that could deliver such a defensive advantage peaking before the tank's offensive potential could be realized; the subjection of soldiers to inglorious, passive endurance of trench life at a time when culture defined masculinity

in activist, heroic terms—the War's encompassing nature inflated peacetime problems into catastrophes. Familiar arguments over masculinity, social class and medical practices sprung into a clump like iron filings at the beckoning of shell shock's magnetic force.

In this fog of war, and in the absence of the defined and prescribed procedures marking so many other military and medical activities, a newcomer would naturally rely on procedures that he knew from experience. As late as 1917, a C.A.M.C. captain attempted to harness his data, to classify the forms that shell shock took. Yet he found that it resisted rigid definition.³² Decades after the war, a decorated medical officer twice mentioned in dispatches, recalled in his memoir that his treatment of shell shocked men supplied him with no hard and fast remedies: "functional nervous disturbances may, and very often do, respond in dramatic and inexplicable fashion to methods which are simple, unorthodox and, worst of all, unscientific."³³ Whatever worked, whatever returned injured soldiers to the killing fields in the promptest and most

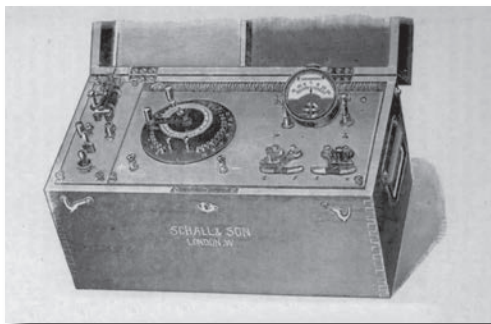
²⁹ Sir Andrew MacPhail, *The Medical Services*. Official History of the Canadian Forces in the Great War. (Ottawa: King's Printer, 1925), 278.

³⁰ H.P. Wright, "Suggestions for a Further Classification of Cases of So-Called Shell Shock," *CMA Journal* 7 (1917), 629-35. Sir Frederick Mott's handbook, *War Neuroses and Shell Shock* (Oxford and London: Henry Frowde; Hodder & Stoughton, 1919), opined that "The vast majority of the psycho-neurotic cases studied were among soldiers who had a neuropathic or psychopathic soil" (110). See also, Edmund Ryan, "A Case of Shell Shock" *Bulletin of the Ontario Hospitals for the Insane* 9 #1 (Oct. 1915), 10-15.

³¹ Thomas E. Brown, "Dr. Ernest Jones, Psychoanalysis, and the Canadian Medical Profession, 1908-1913," in *Medicine in Canadian Society. Historical Perspectives*, S.E.D. Shortt, ed. (Montreal: McGill-Queen's University Press, 1981), 351.

³² H.P. Wright, "Suggestions."

³³ Henry Yellowlees, *Frames of Mind* (London: William Kimber, 1957), 157. His war record: "Henry Yellowlees," *Lancet* 17 April 1971, 813.



Combined galvanic and faradic battery with double cell collector and de Watteville comutator. From Ethel May Magill, "Notes of Galvanism and Faradism" (1916).

efficient manner: these would have been the criteria by which the system judged a physician's efforts. The peacetime, public system had furnished and trained Lewis Yealland in using a number of therapies. Through his record that he penned, we know the one he employed at Queen's Square: faradism.

Faradism—"the application of alternating electrical current for therapeutic purposes"—was an accepted and often highly sought remedy for a host of nervous disorders and complaints.³⁴ The Ontario system had trained Lewis Yealland in the use of faradism. It had become a standby for a range of illnesses from "female complaints" to diphtheria.³⁵ A private hospital in Ontario, the Homewood Retreat in Guelph, announced its up-to-dateness by citing its faradic facilities, providing even a photograph of them in use.³⁶ As

early as 1916, a newly-minted military hospital in Coburg was equipped with faradic machinery, presumably stemming from the institution's former role as a mental hospital.³⁷ In March of that same year, Ethel Magill, chief radiographer at London's Endell Street military hospital, presented a 258-page handbook on electricity's medical usage, indicating that such treatments were in widespread use in military settings. Demand for the text necessitated a reprint within six months. The manual's numerous images of the instruments such therapy employed may appear primitive and even quaint to our present-day sensibilities. No matter; the handbook indicates how widespread, even quotidian, was the usage of the "wire-brush" treatment then. Magill's chapter on the therapeutic uses of faradic shock begins with a list of the ailments for which such treatment is appropriate. Heading the list are "hysteria" and "neurasthenia," the new, technical terminology for what had previously been known as shell shock.³⁸ These terms also served

³⁴ Free Online Dictionary < <http://www.thefreedictionary.com/faradism> >.

³⁵ J.T.H. Connor and Felicity Pope, "A Shocking Business: The Technology and Practice of Electrotherapeutics in Canada, 1840s to 1940s," *Material History Review* 49 (Spring 1999), 60-70; G. A. Tye, "Diphtheria" *Canada Lancet* 17 #12 (August 1885), 351-54. I am indebted to Ms. Dana Kuszelewski of the Gerstein Science Centre library at the University of Toronto for bringing this, and numerous other articles to my attention.

³⁶ Cheryl Krasnick Warsh, *Moments of Unreason. The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal and Kingston: McGill-Queen's University Press, 1989), 150-53.

³⁷ "Editorial Notes," *Bulletin of the Ontario Hospitals for the Insane* 9 #4 (July 1916), 1-2.

³⁸ Ethel M. Magill, *Notes on Galvanism and Faradism*. (London: H.K. Lewis, 1916), 136.

as indicators of social standing: officers were neurasthenic, other ranks, hysterical. Magill's handbook posits faradism as a democratic cure for both sorts of patients, irrespective of social origin.

The most respected medical handbook of the time—Sir William Osler's *Principles and Practices of Medicine*—stipulated that the use of faradism for nervous disorders required a humane physician: "very much depends upon the tact, patience and, above all, the personality of the physician; the man counts more than the method."³⁹ Colonel E. Farquhar Buzzard, later raised to the peerage, and one of the most prominent physicians of his time, implied that these personal qualities lay at the heart of Yealland's success with faradism, which he enthusiastically endorsed in his preface to *Hysterical Disorders of Warfare*. "The ['medical man'] must possess sympathy, understanding, tact, imperturbable good temper and untiring determination, in addition to a sense of humour and the ability to meet unlooked for situations as they arise with ready decision."⁴⁰ However pedestrian

in tone and insight Lewis Yealland's first publication may have seemed, the fact remains that his war work at Queen's Square propelled this provincial newcomer into the attention and esteem of his superiors.⁴¹ Yealland's first report on his faradic methods listed future Nobel laureate E.D. Adrian (later raised to the Peerage) as its primary author.⁴² Canada's Granville hospital for psychiatric cases in Ramsgate claimed a 70% success rate through the use of Yealland's faradic treatments.⁴³ Buzzard's preface made it clear that as far as he was concerned, the virtues of Yealland's faradic treatments lay in their relative quickness in handling "a matter of some urgency." "The time-honoured employment of a faradic battery as an implement of suggestion is at least as efficacious as hypnosis or ether-anaesthesia." Buzzard regards it as an "open question" whether "a more prolonged and a more reasoned education" [read "psychoanalytic"] could produce "a more beneficial and more lasting effect" (v-vii). All things considered, the medical establishment that he represented remained

³⁹ Sir William Osler, *The Principles and Practice of Medicine. Designed for the use of practitioners and students of medicine*, 8th Edition. (New York and London: D. Appleton, 1915), 1105.

⁴⁰ Col. E. Farquhar Buzzard, "Preface" to Lewis R. Yealland, *Hysterical Disorders of Warfare*. (London: Macmillan, 1918), vi. The book is available online: <<http://ia341029.us.archive.org/1/items/hystericaldisord00yealuoft/hystericaldisord00yealuoft.pdf>>. For Buzzard: Frank Honigsbaum, "Buzzard, Sir (Edward) Farquhar," *Oxford Dictionary of National Biography*. <http://www.oxforddnb.com/view/article/32226>.

⁴¹ Lewis R. Yealland, "A Psychiatric Analysis of a Letter of a Dementia Praecox," *Bulletin of the Ontario Hospital for the Insane* 9 #2 (Jan. 1916), 25-32.

⁴² E.D. Adrian and L.R. Yealland, "The Treatment of Some Common War Neuroses," *Lancet* (9 June 1917), 867-72. Adrian's 1977 "Munk's Roll" obituary speaks of his work on shell shock that employed "electrical stimuli and vigorous suggestion," but never mentions Yealland. See "Adrian, Lord (Edgar Douglas)," *Munk's Roll* VII (1995), 3-4.

⁴³ Desmond Morton, "Military Medicine and State Medicine. Historical Notes on the Canadian Army Medical Corps in the First World War, 1914-1919" in *Canadian Health Care and the State. A*

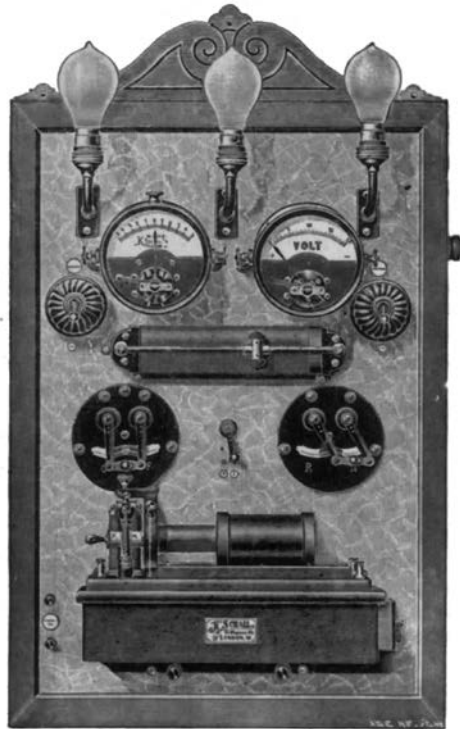
Combined switchboard. From Ethel May Magill, "Notes of Galvanism and Faradism" (1916).

undisturbed by Yealland's methods and joyous at his results. As an eminent military physician, later knighted, robustly termed the process, "[r]e-education reinforced by electricity" could serve as an effective treatment for war neuroses.⁴⁴

As late as 1939, a *British Medical Journal* commended faradic methods for treating large numbers of patients where expenditure of time and energy played a role.⁴⁵ The article's artful wording makes it clear that faradism seemed a mass solution for a mass problem, that is, a method for treating Other Ranks rather than officers, which was the situation that obtained. Yealland's 1917 *Lancet* article had made no bones about the nature of his treatments.

"The current can be made extremely painful if it is necessary to supply the disciplinary element which must be invoked if the patient is one of those who prefer not to recover, and it can be made strong enough to break down the unconscious barriers to sensation in the most profound functional anaesthesia" (869).

"The patient is never allowed any say in the matter. He is not asked whether he can raise



his paralyzed arm or not; he is ordered to raise it, and told that he can do it perfectly if he tries" (870).⁴⁶

"It is better to begin with a current strong enough to be painful" (871).

This forthrightness makes all the more apparent the system's support of Yealland's therapies; it was axiomatic—as

Century of Evolution, Christopher David Naylor, ed. (Montreal and Kingston: McGill-Queens University Press, 1992), 49. Colin K. Russell, medical head of the facility, listed a precise figure of 71.4% back to full duty, 16.1% for temporary base duty and 12.5% for a medical discharge. Russell also claims that the figures would have been even more impressive, had his patients arrived from the front sooner than they did: Russell, "The Nature of the War Neuroses," *CMA Journal* 41 (Dec. 1939), 554.

⁴⁴ Frederick Mott, *War Neuroses and Shell Shock* (Oxford and London: Henry Frowde; Hodder & Stoughton, 1919), 278-79.

⁴⁵ Frederick Dillon, "Neuroses Among Combatant Troops in the Great War," *British Medical Journal*, 8 July 1939, 66.

⁴⁶ Yealland's conviction about the therapeutic value of the physician's distancing from the patient's distress, echoes that of a standard textbook of that time, William White's *Outlines of Psychiatry*: "Sympathy is likewise not to be indulged in. The patient does not want it and it is not helpful." (54)

in dentistry, for example—that pain was inseparable from any successful medical intervention. Colonel Buzzard assertively endorsed Yealland’s reliance on a somatic rather than a psychological approach to shell shock. In retrospect, is that endorsement a counter-barrage to Montague David Eder’s 1917 book-length salvo in the service of psychological methods of treatment?⁴⁷ Whether or not of his own volition, Lewis Yealland became pressed into service in London on one side of a conflict that was being waged throughout the psychiatric world. We know which side eventually won. That victory of the psychological treatment of combat stress did not prevent Lewis Yealland from a successful career in the years following the war. He maintained a successful Harley Street medical practice, where he was known for treating alcoholism and epilepsy. A consultant at the Prince of Wales’ General Hospital, he was elected a fellow of the Royal College of Physicians and Surgeons. He voted Conservative and joined an evangelical congregation. His daughter-in-law remembers him as “a kindly grey-haired man with a twinkle in his eye and a great sense of humour,” while his son recalled him as “a very kind and generous person” who bought a house for his parents, paid for a nephew to attend medical school and supported his mother financially after the death of

his father. He remembered what it was to have been poor, and could waive his fees for patients who fell under that label.⁴⁸ His 1954 *Lancet* obituary refers to his treatments for epilepsy, his skills as a diagnostician in cases of brain tumor and his “delightful personality.”⁴⁹ Then in 1985, everything fell apart, and Lewis Yealland’s reputation unravelled.

IV

The process of dissolution began in 1985 with Elaine Showalter’s influential *The Female Malady*. Her study of the social and cultural climate around the concept of hysteria involved a compelling discussion of the term as it came to be applied to the shell-shocked. For Showalter, Yealland and the beloved Dr. W.H. Rivers—chief proponent of the psychological rather than the somatic approach, head of the Craiglockhart clinic that sheltered Siegfried Sassoon from the military authorities—form a convenient dramatic contrast. In her gaze at these “two poles of psychiatric modernism,” no doubt is left about the current that most attracts. “[T]he worst of the military psychiatrists,” Lewis Yealland looms as a demonized figure, the foil to the humane Rivers.⁵⁰

The novelist Pat Barker’s Booker-nominated novel *Regeneration* (1991), and the film made of it six years later (*Be-*

⁴⁷ *War-Shock. The Psycho-Neuroses in War. Psychology and Treatment* (London: Heinemann, 1917).

⁴⁸ “Yealland, Lewis Ralph,” *Canadian Who’s Who* 1954-56, 1138; Susan Yealland, email to author of 6 March 2010; letter, Dr. M.F.T. Yealland to Robert Coldstream, 14 December 1997. My thanks to Ms. Yealland for supplying me with these documents and other personal information.

⁴⁹ “Lewis Ralph Yealland,” *The Lancet*, 15 March 1954, 577-78.

⁵⁰ Showalter, *Female Malady*, 176, 181.

hind the Lines, 1997), played however the major role in Yealland's second death. The way in which this happened is somewhat paradoxical in nature, as my account will demonstrate. Barker follows Showalter's dichotomy when she employs Lewis Yealland as the foil to Captain W.H. Rivers (1864-1922), the novel's real-life hero (its fictional lead, Billy Prior, need not concern us here). Rivers, a medical doctor with a pioneering interest in social and cultural anthropology, began his war work at the Mughull military hospital for war neuroses.⁵¹ Commissioned Captain in 1916, he was sent to the Craiglockhart military hospital outside Edinburgh, where the work that brought him to the attention of later writers took place. It does no disservice to his reputation and his genuine claims to prominence as a healer of broken men to note that it was his patients who elevated him. His work with such famed literary figures as Siegfried Sassoon, Robert Graves and Wilfred Owen ensured that his reputation would swell in proportion with the critical and fictional discourse focused upon them. To the extent that any one person saved Sassoon from paying the normal consequences for his conscientious disobedience to military regulations and his public questioning of the conduct of the war, Rivers was that man. His treatment

of his charges followed what would come to be seen as a psychoanalytic method, which relied upon rest and the therapeutic recounting of the experience which led to the officer's (for Craiglockhart was a hospital for officers alone) unfitness for duty. Without getting lost in the story of Sassoon, Graves and Owen (all of whom appear in the novel), Rivers' methods rested upon his insistence that his charges were suffering from illness rather than moral vacuity. They were invalids, not malingerers.⁵² That is, Rivers supported a psychological rather than a somatic explanation for the ills afflicting his patients and, as we all know, that side won the therapeutic battle and commands the field still.

Melodrama rests upon a set of clearly-defined dichotomies; *Regeneration* slips into this mode when Yealland comes upon the scene. The novel's narrative voice has not been shy about previously editorializing; for example, a lengthy paragraph reports on the set of cultural factors—especially masculinism—inhibiting the acceptance of Rivers' modes of treatment. Sentences such as these—

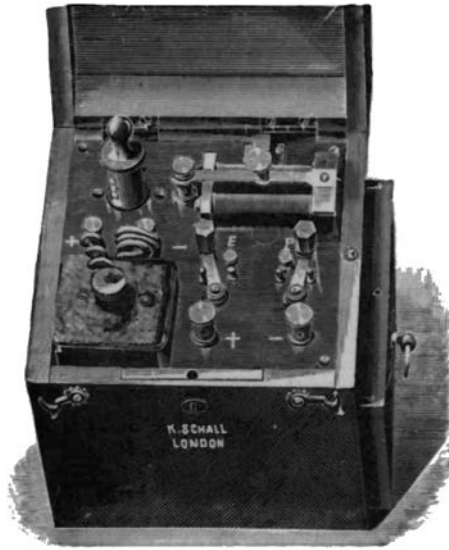
Certainly the rigorous repression of emotion and desire had been the constant theme of his adult life. In advising his young patients to abandon the attempt at repression and to let themselves *feel* the pity and terror their

⁵¹ We lack a full-scale biography of Rivers, and I have relied largely upon Richard Slobodin's *Rivers* (Phoenix Mill, Gloucestershire: Sutton Publishing, 1997 [1978]). The text originated as a portion of a doctoral dissertation on Rivers' life and work.

⁵² Rivers and his literary patients: Miranda Seymour, *Robert Graves. Life on the Edge* (Toronto: Doubleday Canada, 1995), 64-70; Dominic Hibberd, *Wilfred Owen. A New Biography* (London: Weidenfeld and Nicolson, 2002), 243-83; Siegfried Sassoon, *Memoirs of an Infantry Officer* (London: Faber & Faber, 1930), 172-92; Jean Moorcroft Wilson, *Siegfried Sassoon, The Making of a War Poet. A Biography (1886-1918)* (New York: Routledge, 1999), 388-417.

war experience inevitably evoked, he was excavating the ground he stood on (48; emphasis in original)—

resemble the remarks of a cultural historian rather than the imaginatively conveyed insights of the novelist.⁵³ A narrative so fixed in its purpose of displaying a cultural pivot point and the heroicized figure snapped at such a gestural moment, introduces Lewis Yealland in the manner of a stock figure. He enters as a bustling agent of institutional power rather than as a character conveying the individuality and emotional complexity accorded Rivers.⁵⁴ Thus Yealland enters—preceded as if in a courtly masque by a deformed victim of shell shock—with the trappings of the powerful medical man as two juniors accompany him. Given Yealland's rela-



Dr. Spamer's coil. From Ethel May Magill, "Notes of Galvanism and Faradism" (1916).

tive youth and lack of seniority, and the fact that his first publication about his methods of treatment in fact had a more senior figure as its principal author, this retinue may appear fanciful. Yet it sets the stage for the highly dramatic depiction of Yealland's power-mad, legalized torture of the mute soldier. The novelist pushes Yealland's published insistence upon the authority that the physician must bring to the scene (and his superior's support of that aura) to an extreme, leaving the Yealland of the novel a sadistic dominator who can only bark orders and enact controlling drills over his patient/victim.

'I do not like your smile, Yealland said. 'I find it most objectionable. Sit down.'

Callan sat.

'This will not take a moment,' Yealland said.

⁵³ Rivers' endorsement of the social value of psychic repression is a matter of record. See his 1917 paper, "The Repression of War Experience," in his *Instinct and the Unconscious. A Contribution to a Biological Theory of the Psycho-Neurosis* (Cambridge: Cambridge University Press, 1924), Appendix III, 185-204. A later version of this, which Barker lists in her "Author's Note," appears as "An Address upon the Repression of War Experience" in *The Lancet*, 191 (4927), 2 February 1918, 173-77. The latter makes clear Rivers' view that the horrors of combat broke through the psyche's normal defenses, and that the therapeutic relieving of such experiences enabled the patient—for the most part—to re-repress them and go on living normally. Rivers goes on to emphasize that such treatments do not work for many patients, who remain incurably damaged. A classic psychiatric textbook of the time supports these views: White's *Outlines of Psychiatry* (quoted above), 54.

⁵⁴ Yealland and his methods appear chiefly on pages 223-33 of the text (Pat Barker, *Regeneration*. (New York: Penguin Plume Books, 1993). Giles McKinnon, *Behind the Lines* (Artisan DVD 1997) depicts these in Scene 15 of the DVD. Both focus upon Case A1 of *Hysterical Disorders*, paraphrased in the opening to this essay.

'Smile.'

Callan smiled and the key electrode was applied to the side of his mouth. When he was finally permitted to stand up again, he no longer smiled.

'Are you not pleased to be cured?' Yealland repeated.

Yes, sir.'

'Nothing else?'

A fractional hesitation. Then Callan realized what was required and came smartly to the salute. 'Thank you, sir' (233).

Thus, the Lewis Yealland who is Showalter's "very worst" of military psychiatrists, a figure dropped in out of nowhere into the novel's world, but whom Barker has fleshed out for a moment with all the devices of the fictional narrator.

While this is not the novel's final mention of Lewis Yealland, we need to lift our eyes from the page and consider the critical response this scene has generated. A set of notes on the novel for students underlines the darkness of the Yealland character, who

serves a larger allegorical purpose ... a metaphor for the control the government exerts over its people. Unsympathetic to individual cases, the state continues in its 'aims,' fighting a war that seems purposeless and sacrificing helpless men. Like the state, Yealland does not consider the consequences of his actions.⁵⁵

A twenty-first century medical historian, writing for an audience composed of others besides students, disparages Yealland on religious grounds. Yealland's errors (among them, "overdramatization") are the result of his evangelical religious practices.⁵⁶ Yealland emerges here as an agent of a secular state whose religious fanaticism nonetheless powers his shock therapies upon the bodies of helpless, combat-fatigued private soldiers. Even Peter Leese's more nuanced account of Yealland's practices—after due obeisance to Showalter—feebly vindicates the physician by noting that his methods were, (fortunately for all concerned) not widely shared among the profession.⁵⁷ In such a climate of critical opinion a medical-journal reviewer of *Regeneration* can offhandedly dismiss Yealland's methods as "brutal."⁵⁸ Edgar Jones attempts a more balanced view, but his circumspect allusion to the fact that "some [doctors] overzealous in their duties or driven by an exaggerated sense of patriotism, themselves became oppressors" compels him to classify Yealland as a figure split between his benign personality and his toxic practices, a man whose "personality stood curiously at variance with his treatments."⁵⁹

⁵⁵ "Sparknotes: Regeneration: Analysis of Major Characters," <http://www.sparknotes.com/lit/regeneration/canalysis.html#Dr.-Lewis-Yealland>

⁵⁶ Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, Massachusetts, Harvard University Press, 2001), 77-78.

⁵⁷ Peter Leese, *Shell shock: traumatic neurosis and the British soldiers of the First World War* (New York: Palgrave Macmillan, 2002), 74. See above for evidence of the widespread usage of faradism, indicative that Yealland's was not a fringe position.

⁵⁸ Tony Smith, "Regeneration," *British Medical Journal* vol. 312 (4 May 1996), 1171.

⁵⁹ Edgar Jones, "Doctors and trauma in the First World War: the response of British military psychiatrists," Peter Gray and Kendrick Oliver, eds. *The Memory of Catastrophe* (Manchester: Manchester University Press, 2004), 92, 99.

Yet these positions, to the extent that they rely upon *Regeneration* as their source, acknowledged or not, fail to do the novel justice. Herein lies the paradox that I have mentioned: despite the novel's melodramatic snapshot of Yealland, it nonetheless eventually employs him as a counterpart rather than as a foil, giving Barker's account a complexity that obviously not all the readers caught. For her fictional Rivers comes to understand that, while their methods may differ, he shares with Yealland a dedication to refitting the broken patient into the war machine:

[J]ust as Yealland silenced the unconscious protest of *his* patients by removing the paralysis, the deafness, the blindness, the muteness that stood between them and the war, so, in an infinitely more gentle way, *he* silenced *his* patients; for the stammerings, the nightmares, the tremors, the memory lapses, of officers were just as much unwitting protest as the grosser maladies of the men (238; emphasis in original).

Such a revelation may be far from an endorsement of Yealland and his methods as depicted in the novel. But the passage does draw Yealland out of moral quarantine and relocate him within a circle of complicity that includes the novel's hero. It explains why Pat Barker herself, in a later interview, acknowledged the kinship between Rivers and Yealland.⁶⁰ In the final analysis however, Yealland's reputation cannot be restored simply because a novelist who used him as a dummy explains how nuanced her usage in fact is. Yet the admission, and the often-ignored

portion of the novel supporting it, does help us understand that much of what we take for historical memory is in fact the result of imaginative fabrication.

Nothing better captures this blurring of the boundary between fact and fiction like the cover of Slobokin's brief biography of Rivers, for it bears an image from the film version of *Regeneration*, an image of Dr. Rivers as portrayed by the actor Alan Price. The historical Rivers was not an ill-favoured man, but he lacked the looks and presence of a film actor. The viewer's experience resembles that of picking up a biography of Abraham Lincoln, and finding the face of Henry Fonda on the jacket. Who is being written about here, and what is his ontological status? And if Alan Price is somehow Rivers, then the beefy man who plays Yealland in the film, who looks at least 20 years older than the actual Lewis Yealland of that period, who is he? Novelists and filmmakers do not owe their audience a meticulous, historically precise version of their subjects. Yet *Regeneration's* depiction of Lewis Yealland—both in print and film—has reached an audience far wider than accounts written by historians and scholars. The agreement as to Yealland's inhumanity marking all these treatments argues that our contemporary cultural discourse's outline of Yealland's features lacks the nuanced understanding that a grasp of historical context delivers.

All the accounts of Yealland's posthumous reputation that I have surveyed rest

⁶⁰ Pat Barker and Rob Nixon, "An Interview with Pat Barker," *Contemporary Literature*, Vol. 45, No. 1 (Spring, 2004), 19. This view also informs Alan Young, *The Harmony of Illusions...Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995), 71.

upon a set of dichotomies seemingly impervious to boundary break and border blur. Yet a revisionist historian's account of the relationship between distressed soldiers and their bewildered medical caregivers calls for a perspective less intent upon dichotomies and more observant of blending polarities. The image of helpless soldiers stretched out by their doctors upon a rack of pain cannot be sustained, according to Mark Osborne Humphries. His "Rest, Relax and Get Well" contends that the familiar, discrete dichotomies (officers/men; talk therapy/shock therapy) cannot resist scrutiny. Nor can the "effective literary device" that this dichotomy provides substitute for historical reflection. All parties in the therapeutic transaction—doctors, patients, the military—"struggled for power, autonomy and control. None had a monopoly. ... For the vast majority of Canadian soldiers, the treatment experience was egalitarian and humane."⁶¹ Whether or not Lewis Yealland was a participant in that majority community we will never determine. But the perspective that Humphries' article employs can steer us away from definitive judgements.

V

This is why I wish to conclude my discussion with my own reading of a neglected portion of the evidence that Yealland provided against himself in his *Hysterical Disorders of Warfare*. For it is striking that the very first case to appear there—the most dramatic and shocking in the

book—is the one most used against him. But what about the numerous other case accounts? What can we make of them?

Two cases described in Chapter VII repay examination. Begin by remembering that he was dealing generally with afflicted men impatient with their sufferings, men willing to trade the prospect of waiting out the war safely in hospital for an end to the twitchings and shakings, the muteness and the distorted gait that tormented them. The first, labeled G2, involves a 24 year-old whose "shakiness" (involuntary tremors)—the result of a shellburst over his head—had earned him a military discharge. Yealland's efforts were therefore not geared to returning the ex-soldier to the line. He listened non-committally to the patient's complaints, which in addition to tremors, included fantasies "of an indecent nature." Sternly reproving the soldier, Yealland forced him to commit to answer "yes" if he was seeking a cure. Using a weak current, Yealland passed a roller electrode over both arms. When the tremor subsided, he removed the electrode. When the tremor renewed itself, a stronger current made it subside.

Then began the treatment through interview of the "indecent delusions," which the patient came to agree were illusory, and which he then asserted that he had banished by trusting the commands of the physician who had cured the tremor in his arm. When the doctor urged him never to "discuss such subjects again with anybody; do not entertain them in your mind for a moment," the patient

⁶¹ Mark Osborne Humphries, with Kellen Kurchinski, "Rest, Relax and Get Well: A Re-Conceptualisation of Great War Shell Shock Treatment," *War and Society* 27 No. 2 (October 2008), 110.

agreed. As Yealland put it, “I have every reason to believe that the whole effect of the treatment was to introduce healthier elements into his mind” (180-87).

What have we seen here? Assume that the indecent images involved sexual behavior (the patient’s assertion that while in another the hospital he had witnessed such acts suggests this). Somehow the trust engendered by the successful therapy for his tremors laid the private soldier open to the doctor’s power of suggestion, enabling him to repress those discomforting images, at least for the present. Because the pathologizing of those delusions so violates our present-day sexual ethic, viewing the scene objectively renders it a test case for *us*. Can we set aside our own sexual politics and concentrate on what has happened here? A patient, for whatever reason uncomfortable with his physical and psychic condition, underwent a somatic treatment that in turn enabled him to cope with what both men saw as an inner disturbance. Was the “cure” permanent? Did it rather lead to a lifetime of desperate concealment? Who can say? The fact remains: the physician conscientiously treated both body *and* mind. He employed both mechanical and talk therapy in an effort to restore a troubled man to at least a semblance of peace, and possibly to some degree of serenity.

Let us consider another case, G3. Some sense of the unpredictability of the effects of shellfire on the individ-

ual—and the unreliability of the term shell shock—comes home to us when we read that the 19-year-old private’s distress was triggered by a shell burst some sixty feet from him. His resultant “fits” earned him a discharge two months later. Ironically, civilian life heightened his tremors, stammering and seizures: the air raids of September and October 1917 triggered his earlier symptoms. Arriving at Yealland’s office in the evening, restrained by two other soldiers, and with a nurse holding a tongue depressor to his mouth, the man was sweating profusely and rolling his head about. After the man had been made to sit, and had sufficiently recovered from the incident to rub his eyes in a daze, Yealland offered to cure his fits. He then carefully explained his procedure: he would bring on another attack by the application of a mild current, and then cure it by the application of a stronger one.⁶² And this is what happened. Following the promised seizure, the patient was given a strong current to the front of his body, while being told to sit and stop his shaking. He did so, and while dazed told to “Look bright” while another shock went to his abdomen.

Again a procedure was outlined: it was time to cure the tremor and the stammer by another application of electric current. Applying a “gentle faradism” along the spine, Yealland urged the patient to “keep himself steady.” Then the current was applied to the patient’s trem-

⁶² This inducement of a seizure in order to treat the condition provoking that seizure explains why Yealland figures as a pioneer of Electro-Convulsive Therapy in Gerald Milner’s 1999 letter to the *Medical Journal of Australia* “The present status of electroconvulsive therapy: a systematic review.” v.171 #11-12 (December 1999), 11-12: *eMJA* < http://www.mja.com.au/public/issues/171_11_061299/milner/milner.html > . My thanks to Dr. Andrew Baines for supplying me with this information, along with encouragement.

bling arms, and then to his legs until the tremors ceased. So did the stammer. His walk was normal. Was he cured? “He remained in the hospital for two months after this, and up to the time of his discharge there was no recurrence of the fits.” Yealland then concludes, and we can almost see him slapping his hands together, that “The patient received fifteen minutes’ treatment” (187-89).

However smug the conclusion, the fact remains that a patient in deep distress found his condition significantly alleviated and even cured for at least sixty days by a physician’s self-confident, reassuring and carefully-explained use of electrical therapy. Yealland’s case notes generally support the conclusions drawn in *Hysterical Disorders*: faradism worked. That is, it enabled the patient to function normally enough to be discharged from hospital.⁶³ That fact alone renders simplistic any abrupt dismissal of his therapies. Responding to Yealland’s accounts of faradic successes with unthinking abhorrence fails to match up with the facts before us. Could it be that the remarkable personal qualities commended by Col. Buzzard actually existed? Could Lewis Yealland’s second death be the result of justice denied?

Our own era has its biases. Anti-psychiatry is now an intellectual industry.

K. Portland Frank’s 1979 *Anti-Psychiatry Bibliography and Resource Guide*, 160 pages in length, contains hundreds of entries.⁶⁴ Clicking *Scholars Portal* for post-1980 publications under the heading of “anti-psychiatry” produces 173 hits. Within such a climate, reading the Yealland that nobody else read compels my conclusion that the historical and imaginative record needs, if not correction, at least amplification. A factual past—as opposed to a dramatized one—burnishes smooth all the jagged, dichotomous edges of present-day imaginative narrative, integrating former polarities within continuities. We know in part and we prophesy in part, I believe, out of a sense of frustration at the seeming implacability, the dismal recurrence of the aftershocks concomitant with modern warfare. Casting blame at past practices can offer a temporary respite from present-day anxieties.

No one employing Yealland’s methods could elude present-day criticism. But his efforts must be placed amid a social context of public and professional perplexity and frustration. Call it the fog of war. His own publication—part of a somaticist’s rejoinder to the emergent psychologists whose views would prevail—occasioned his posthumous shredding. Yealland helped assemble the firing squad that he

⁶³ The twelve reports, selected at random by a research assistant from voluminous case files found in Rockefeller Medical Library of the UCL Institute of Neurology & National Hospital for Neurology and Neurosurgery in Queen’s Square London are filed under the chief physician’s name, that of a Doctor Collins, with Lewis Yealland appearing as the “House Physician.” All notes consulted concern males; military rank and national origins are sometimes supplied, as is a designation of the condition under treatment. The Library discourages the use of names. My thanks to Alex Jurczynski for his assistance.

⁶⁴ K. Portland Frank, *The Anti-Psychiatry Bibliography and Resource Guide*. 2nd ed. (Vancouver: Press Gang, 1979).

stood before. Our memory should justly con- sider our culture's definition of combat's
 sign him to the list as another, very psychic wounding and its elusive cure,
 late casualty of the Great War that so al- problems besetting us still.⁶⁵

⁶⁵ Consider Daniel Baird's recent thoughtful, non-academic account of our current perplexity about the specific origins and treatment of the psychic wounds experienced by contemporary combat veterans: "Treatment helps instill a sense of control, but in a way it never ends: one has to remain vigilant, wary of triggers and relapses into old habits and patterns of behaviour. ... I'm not optimistic that the sense of self-doubt and brokenness, the sense of one's very self as shaky ... ever goes away" ("The Enemy Inside," *The Walrus*: 7 #6 [July/August 2010], 49).

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