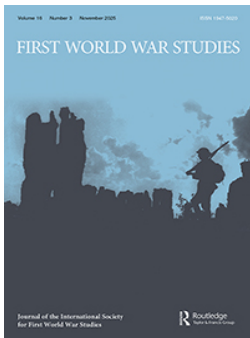


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Item Type	Journal article
Authors	Bremer, Sarah J
Citation	Bremer, S. (2026) Fit for work, unfit for care: collapse and the carceral logic of German POW camps, 1914–1918. <i>First World War Studies</i> . DOI: 10.1080/19475020.2026.2644927
DOI	10.1080/19475020.2026.2644927
Publisher	Taylor & Francis
Journal	First World War Studies
Download date	2026-05-18 21:44:29
License	https://creativecommons.org/licenses/by-nc-nd/4.0/
Link to Item	https://wlv.openrepository.com/handle/2436/626286



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To cite this article: Sarah Bremer (30 Mar 2026): Fit for Work, Unfit for Care: Collapse and the Carceral Logic of German POW Camps, 1914–1918, *First World War Studies*, DOI: [10.1080/19475020.2026.2644927](https://doi.org/10.1080/19475020.2026.2644927)

To link to this article: <https://doi.org/10.1080/19475020.2026.2644927>



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Fit for Work, Unfit for Care: Collapse and the Carceral Logic of German POW Camps, 1914–1918

Sarah Bremer 

Faculty of Arts, Business and Social Sciences, University of Wolverhampton, Wolverhampton, UK

ABSTRACT

This article examines the psychological consequences of captivity for British prisoners of war in German-administered camps during the First World War, situating their experience at the intersection of trauma studies, carceral theory, and military psychiatry. While trench warfare and shell shock have received sustained scholarly attention as sites of psychiatric injury, the mental toll of captivity has been treated as secondary or conceptually benign. Drawing on prisoner testimony, inspection reports, repatriation records, and medical assessments, the article shows that psychological collapse in captivity was rarely recognised as illness. Instead, deterioration was routinely reframed as disciplinary deviance, malingering, or failure of character within administrative systems oriented towards labour extraction rather than care. Collapse is used here not as a clinical diagnosis but as a cumulative process through which sustained coercion, hunger, exhaustion, and moral pressure eroded prisoners' capacity to endure captivity. This deterioration was experienced internally long before it became visible in the archive, appearing only when diminished capacity could no longer be absorbed within regimes of work, punishment, or neglect. By demonstrating how captivity generated psychological breakdown while simultaneously rendering it administratively invisible, the article repositions the prisoner of war at the centre of the history of wartime psychiatry and exposes the entanglement of discipline, productivity, and care in modern military medicine.

ARTICLE HISTORY

Received 22 October 2025
Accepted 9 March 2026

KEYWORDS

First World War; prisoners of war; trauma; forced labour; carcerality

Introduction

The psychological consequences of First World War captivity have long remained marginal within trauma studies. By contrast, trench warfare and shell shock have received sustained scholarly attention as sites of psychiatric injury. British and German medical authorities alike became familiar with shell shock as a contested category, and scholars including Peter Barham, Fiona Reid, Edgar Jones, Simon Wessely, Jay Winter, and Bernd Ulrich have traced how combat conditions generated distinctive psychiatric casualties and exposed tensions between care and discipline within military medicine. Yet within the administrative and diplomatic records governing prisoners of war, this diagnostic language is strikingly absent. In the Foreign Office prisoner-of-war

CONTACT Sarah Bremer  s.j.bremer@wlv.ac.uk

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correspondence (FO 383), shell shock does not appear as a routine category of explanation. Psychological injury in captivity was rarely named as such. Instead, distress was usually reframed through functional, euphemistic, or somatic descriptors that obscured both cause and consequence.

This article therefore uses the term ‘collapse’ deliberately and analytically. Collapse is not treated as a clinical diagnosis, nor as a single moment of psychological breakdown. Rather, it denotes a cumulative process through which sustained coercion, deprivation, and moral pressure progressively eroded a prisoner’s capacity to endure captivity. This process was uneven and individual: for some men it never reached a terminal point, while for others it culminated in an inability to continue labour or comply with routine discipline. Collapse was experienced internally as mounting strain and loss of agency, but became visible in the archive only when it crossed an administrative threshold – when diminished capacity could no longer be absorbed within regimes of labour, punishment, or neglect. Acts such as refusal to work, self-mutilation, or disciplinary infractions therefore do not mark the onset of collapse, but the point at which an already deteriorating condition forced institutional response. Unlike shell shock, which by mid-war had acquired a contested but recognisable diagnostic vocabulary, collapse in captivity unfolded largely outside established psychiatric categories, becoming visible only when it disrupted labour or discipline.

Crucially, when collapse did become visible, it was rarely treated as a medical need. Instead, both German and British institutions repeatedly reframed breakdown as deviance, malingering, or failure of character. This reframing contrasts sharply with the uneasy but expanding recognition of combat trauma, where breakdown increasingly triggered medical debate rather than immediate disciplinary sanction. The threshold for care was defined by utility rather than suffering: men were treated only insofar as they could be returned to labour. Collapsing soldiers were therefore processed through systems designed to preserve discipline, productivity, and institutional self-image. Psychological collapse was not merely an unfortunate by-product of captivity, but a predictable outcome of coercive regimes—one rendered historically invisible by the administrative frameworks that governed prisoners’ lives.

Captivity provides a particularly stark case through which to examine these dynamics. German regulations formally acknowledged the conditions required to sustain morale and health, promising parity between prisoners of war and soldiers housed in garrison barracks. Yet as shortages intensified and labour demands escalated, those standards collapsed in practice. The result was not merely material deprivation but an environment structurally guaranteed to erode mental and physical resilience. Within this system, breakdown was repeatedly reclassified as deviance rather than recognised as psychiatric injury. Vulnerability became administratively legible only when it disrupted labour or discipline, and even then it was processed through frameworks designed to preserve productivity and authority. Captivity thus exposes the limits of military medicine’s therapeutic mandate under conditions of coercion, scarcity, and institutional self-preservation.

The article draws on testimony, inspection reports, and repatriated medical assessments to reconstruct how collapse was managed, dismissed, or punished. The material is fragmentary, euphemistic, and often contradictory, and it is precisely this instability that is revealing. Rather than signalling evidentiary failure, inconsistency marks the

administrative work through which suffering was translated, contained, or denied. Men appear as ‘heart cases’, ‘unfit for work’, or ‘self-deluded’, their psychological distress recast in functional categories that carried disciplinary force. The POW camp thus emerges as a space that was simultaneously workplace, prison, and hospital, in which medical, disciplinary, and productive logics collided when men could no longer endure. The resulting evidentiary instability mirrors a broader asymmetry: while combat trauma generated disputes over diagnosis, captivity collapse often generated no such dispute at all, because it was administratively deflected before diagnosis could occur.

Recent scholarship by Heather Jones, Uta Hinz, Oliver Wilkinson, Jochen Oltmer, and others has transformed our understanding of the First World War prisoner experience, revealing the structures of German administration, the coercive logic of forced labour, and the cultural afterlives of captivity.¹ This article builds on that foundation but focuses specifically on British prisoners of war held under German control. Jones and Hinz have shown how violence and *Kriegsraison* – the doctrine that military necessity overrode legal and moral restraint – normalized exploitation, while Wilkinson has explored coping, solidarity, and ‘barbed-wire disease’, a term most closely associated with A. L. Vischer’s 1918–19 study of internment-related nervous disorder. Vischer’s formulation captured the psychological effects of prolonged confinement and uncertainty, but this article does not treat ‘barbed-wire disease’ as a diagnostic explanation for POW collapse; rather, it is used as a contemporaneous reference point within a broader landscape of captivity-related breakdown.² Read against the literature on trench trauma, this asymmetry is striking: while shell shock prompted sustained debate over causation, masculinity, and entitlement, captivity collapse rarely entered psychiatric discourse at all. Prisoners appear primarily as labourers or victims, seldom as men who broke down under sustained confinement. By contrast, the literature on trench trauma – Leese, Shephard, Jones and Wessely – has mapped the interplay of diagnosis, masculinity, and institutional response with great nuance, while Barham, Reid, Loughran and Linden have traced how post-war institutions managed, and often concealed, the psychiatric wreckage that followed.³ These insights apply powerfully to captivity, where breakdown was frequently reframed as malingering or sabotage and where stigma was sharpened by cultural expectations of stoic endurance. Works by Roper, Meyer, and Bourke show how masculinity and productivity shaped medical and moral judgements of mental illness, while Goffman, Foucault, Crewe, Jordan, Fassin & Rechtman and Fricker together frame captivity as a total institution that disciplined identity, enforced compliance, and reproduced stigma through surveillance, dependency, and epistemic injustice.⁴

Yet the mental and emotional toll of captivity itself remains largely in the shadows. For many men, captivity was a prolonged ordeal of forced labour, deprivation, and enforced separation, in which the body became the last site of protest. Collapse was therefore not simply a response to hardship, but a crisis repeatedly reframed by institutions as failure. This article addresses that gap by bringing POW historiography, trauma studies, and carceral theory into sustained dialogue. It foregrounds the psychological consequences of captivity within POW history, extends trauma studies by examining breakdown beyond the trenches, and applies carceral theory to show how institutions reframed collapse as deviance rather than illness. In doing so, it treats captivity-rooted collapse not as an extension of combat trauma, but as a structurally distinct form of psychological injury –

produced under coercive confinement and rendered illegible by administrative systems oriented towards discipline, productivity, and denial.

Sources and Methodology

This study employs a qualitative, source-led approach combining close reading, record linkage, and interpretive analysis. The evidence base spans British and German archives: War Office debriefs of repatriated prisoners (WO 161), Foreign Office correspondence on enemy treatment (FO 383), Royal Army Medical Corps (RAMC) medical debriefs conducted during repatriation, and German administrative and inspection records in the Bundesarchiv. Read together, these sources reveal the disjunction between experience and representation, showing captivity as a transnational system of control. The WO 161 material concerns predominantly British servicemen, though it also includes a small number of Dominion personnel; the analysis does not turn on imperial differentiation. These records differ markedly from those that underpin the historiography of combat trauma, where diagnosis, treatment, and recovery were more explicitly documented and contested.

The sources used here were produced for different institutional purposes and cannot be read as equivalent forms of evidence. Hospital records, repatriation reports, inspection memoranda, and post-war pension files were generated by different actors, at different moments, and under distinct administrative constraints. Medical records prioritised immediate physical function and labour fitness; repatriation documentation was shaped by diplomatic categories and eligibility criteria; pension files translated impairment into fixed classifications of attributability and degree. These materials are therefore not treated as directly comparable diagnostic records. Instead, they are read comparatively as administrative artefacts that reveal how bodily and psychological impairment was variously recognised, deferred, or reframed as the same individuals moved through different institutional settings over time.

Source selection follows three principles: direct access to prisoner and administrative voices; preservation of the medical and disciplinary frameworks through which breakdown was interpreted; and capacity for linkage across institutions – for example, comparing a man's WO 161 debrief with German inspection reports or British pension decisions. Triangulation is essential given the contradictions that characterise these records. Contradiction itself forms a central analytic tool. Testimony often clashes with inspection and medical reports that recast psychiatric collapse as malingering or sabotage. Rather than treating such inconsistencies as flaws, the analysis reads them as evidence of institutional reframing – how suffering was translated or suppressed within bureaucratic systems. The approach draws on Miranda Fricker's concept of epistemic injustice, particularly the credibility deficit imposed on marginalised voices.⁵ POW testimony, frequently discounted or reclassified, exemplifies structural silencing. Testimony is therefore read not as anecdote but as systemic evidence, revealing both experience and denial. Methodologically, close reading exposes euphemism, omission, and rhetorical framing, while record linkage identifies recurring patterns – hunger, overwork, 'barbed-wire disease' – as indicators of structural reality. Archival limitations are themselves instructive: censorship, translation, and official mediation reveal the mechanisms through which institutions managed collapse.

The theoretical framework draws on carceral and psychiatric sociology to guide the reading of these sources. Unlike trauma frameworks developed around combat exposure, these models allow captivity to be analysed as a sustained condition of control rather than a discrete shock. Goffman's concept of the 'total institution' and Foucault's analysis of disciplinary power inform the analysis of confinement, surveillance, and compliance; Crewe's notions of depth, weight, and tightness and Jordan's work on enforced residence help articulate the experiential pressures of prolonged captivity; Fassin and Rechtman and Fricker provide tools for analysing recognition, credibility, and institutional response. These models are used heuristically rather than anachronistically, and are applied only where corresponding mechanisms are visible in the sources.

Analysis: Institutional Framework and Its Cracks

Where combat psychiatry grappled with how to recognise breakdown without undermining discipline, captivity administration largely avoided the question by defining health in terms of utility from the outset. German War Ministry regulations issued in the opening months of the war explicitly mandated parity of treatment for prisoners of war with regard to accommodation, clothing, sanitation, and medical oversight. The *Bestimmungen über die Unterbringung der Kriegsgefangenen* modelled POW housing provision on the standards of German military barracks, specifying comparable layouts, equipment, and minimum space requirements.⁶ This framework establishes that neglect was not the system's stated premise, but a failure that emerged through erosion, labour demand, and administrative strain rather than formal design. Yet this ideal was never applied uniformly. As Heather Jones has shown, Russian prisoners were subjected from the outset to markedly harsher treatment, including deliberate neglect, and were never fully encompassed within this rhetoric of reciprocity.⁷ More fundamentally, as Uta Hinz has emphasised, the German camp system was never a monolith. From the beginning, it was shaped by overlapping jurisdictions, regional variation, and what she terms a 'confusion of competencies'.⁸ Although the War Ministry in Berlin issued regulations for the Reich as a whole, implementation rested with Deputy General Commands and, at camp level, with the organisational capacity – or indifference – of often elderly reserve officers. Regular conferences in Berlin and the introduction of camp inspections from October 1914 imposed a degree of formal coherence, but local arbitrariness persisted. Neutral inspections introduced from 1915 added a further layer of oversight, yet these too were uneven, frequently obstructed, and increasingly restricted after 1916. The result was a captivity regime in which high regulatory ambition coexisted with chronic enforcement failure – creating precisely the conditions under which physical deterioration and psychological collapse could advance without triggering institutional intervention.

This regulatory fragility was compounded by a broader British interpretive framework that rendered captivity itself psychologically innocuous. Contemporary legal and military commentators such as J. M. Spaight characterised imprisonment as benign, even restorative – a 'rest cure' removed from the pressures of the front.⁹ In parallel, Alfred Milner's late-war memoranda framed unwounded captivity as a moral and disciplinary failure rather than a legitimate site of injury.¹⁰ Read together, these assumptions foreclosed the conceptual possibility of captivity-induced psychological collapse: if imprisonment was presumed harmless and the unwounded captive already suspect, deterioration could only

be interpreted as malingering, weakness, or indiscipline – not institutional harm. Yet captivity was not a low-stakes or incidental experience. Of the approximately 176,000 British servicemen held prisoner in Germany during the war, more than 15,000 died in captivity.¹¹ This framing did not reflect the day-to-day assessment of captivity by British diplomatic and welfare officials. Foreign Office correspondence and Prisoners of War Committee papers repeatedly record concern, investigation, and protest, alongside frustration at German obstruction and the limits of neutral inspection. Officials recognised that prolonged captivity, forced labour, and deprivation imposed severe strain and sought to intervene through inspection, reprisal diplomacy, and relief channels. Yet these efforts unfolded within an interpretive order that denied captivity the status of traumatic injury. The result was structural dissonance: suffering was recognised, but rendered administratively illegible – processed through categories of discipline, utility, and credibility rather than care.

By the war's midpoint, the ideal of parity had given way to expediency. Hinz identifies 1915 as the decisive moment when German authorities reduced POW rations below those of their own troops in breach of the Hague Conventions, citing *Kriegsraison* (military necessity) as justification.¹² German officials increasingly framed harsher measures as acts of reciprocity, presenting restrictions on food, correspondence, and labour as responses to alleged Allied conduct. British Cabinet discussions in 1918 demonstrate clear awareness of this German rationale, but they did not concede its legitimacy. On the contrary, these discussions treated German claims of reciprocity as justificatory rhetoric rather than factual equivalence, reflecting British confidence that the overall treatment of German prisoners did not warrant such measures.¹³ The German camp inspection reports from July 1918 illustrate how structural pressures had by then overwhelmed the system. It recorded overcrowding, food shortages, and the diversion of prisoners to forced labour under deteriorating conditions.¹⁴ What began as a regulated framework aligned with barracks standards had devolved into a fragmented network of camps and labour detachments, governed less by humanitarian principle than by reprisal logic, administrative expediency, and ideological calculation.

The late-war inspection memoranda from September 1918 make the divergence painfully clear. One report noted that prisoners were receiving only one rest day every fourteen days, instead of weekly; another recorded working days stretching to 12–16 hours when marching time was included, despite the official limit of eight hours. Italians, in particular, were reported to be losing weight rapidly, their reduced rations unable to sustain heavy labour. The circulars admitted openly that if productivity was to be maintained, rations had to be 'adjusted to output' – a formulation that cast prisoner health solely in terms of labour efficiency.¹⁵ In such conditions, the rhetoric of parity collapsed: POWs were no longer housed and fed as soldiers, but sustained only so far as they could remain useful.

Thus, while the regulatory framework initially promised parity with military standards, the realities of decentralised authority, material scarcity, and the prioritisation of labour steadily undermined this aim. By 1918, the system no longer safeguarded prisoners' welfare as soldiers but sustained them only insofar as they remained productive. Within this context, psychological breakdown was not approached as a medical concern but was increasingly construed in disciplinary terms.

Discipline and the Pathologised Body

By the middle of the war, labour defined how breakdown was read: incapacity was not an illness to be treated but a disciplinary problem to be stamped out. Unlike shell shock, which increasingly triggered medical scrutiny even when doubted, incapacity in captivity was read almost exclusively as a disciplinary failure. On paper, German guard regulations looked civilised enough. The *Service and Guard Regulations (Dienst-und Wachvorschriften)* forbade insult, abuse, or even off-duty fraternisation with prisoners – ‘Any insult or mistreatment of prisoners . . . [is] prohibited’.¹⁶ Yet the same handbook, with its addenda, tightened work-site procedures, and a field memorandum from the POW camp Sennelager III, part of the Westphalian complex used for military training and prisoner distribution, said the quiet part out loud: ‘All work . . . must be fully accomplished . . . even by using force In case of resistance, the work must be done by resorting to punishments’.¹⁷ The logic was echoed in later orders. One memorandum insisted that marching time did not count as labour and told prisoners they had it ‘in their hands’ to shorten the working day – but only by working harder to meet a set quota, fixed at two-thirds the output of a free German labourer.¹⁸ Another, issued in September 1918, set an official limit of eight hours’ work (including long marches) but still divided prisoners into output ‘classes’ and left discipline for ‘under-performance’ in the hands of commandants.¹⁹ These regulations clothed compulsion in the rhetoric of fairness, presenting overwork as the prisoner’s choice and collapse as malingering or defiance.

That gap – decorum in camp, compulsion in the field – aligns exactly with prisoner testimony. Pte Arthur Leggett put it neatly: ‘The camp . . . is good, the trouble is being able to stop in it’. His account of the Mülheim quarry describes men locked in year-round, denied Sunday exercise, and never seeing beyond the pit. New captures were often sent straight to Kommandos before their parcels caught up; they grew weak under long hours and poor food, returning ‘with broken limbs’ or in rags – one gasping ‘I’ve just come from hell’ before dying that night.²⁰ CSM A.H. Bentley, at Münster II, confirmed the charade: fresh arrivals were encouraged to write home about kind treatment before being dispatched to labour units in France.²¹

Collapse was managed not with care but with disbelief, punishment, or forced return to work. The logic was made explicit in an order from Fourth Army HQ: if sickness was less than three weeks, treat locally; if three to six weeks, send to Liège (only after clearance from Brussels); if over six weeks or permanently unfit, send back to Germany.²² Medicine here follows not need but downtime. Within that regime, self-harm became both a desperate tactic and a punishable offence. Pte Henry G. Smith recalled L/Cpl Charles Crossman deliberately driving a pick into his foot while on a mining kommando; he was denied proper treatment and carried daily into the pit so output continued.²³ Pte Angus Johnstone, once healthy, mutilated his foot in despair at Poley coal mine (near Dortmund). A return to work followed cursory first aid; a subsequent head injury, untreated for days, proved fatal in December 1917. His commanding officer, Captain Lord James Murray, noted Johnstone’s ‘exceptionally fine character’ and concluded that only intolerable conditions could drive him to ‘such an act’.²⁴

Publicly, the German Foreign Office struck a different note. In July 1916, replying to British protests, it blandly denied that work in Westphalian coalfields counted as ‘heavy labour’. It was, they claimed, little more than shovelling in galleries ‘where the air is fresh

and the temperature normal'.²⁵ The contrast is telling. Labour came first; collapse, whether by breakdown or self-harm, was never legible as illness. Leggett's testimony helps explain why. In main camps, food and parcels might arrive, medical orderlies might function, and inspections could be staged, but the system's centre of gravity was outside the wire, where oversight thinned and output ruled. That is where self-harm could be reclassified as fraud, delirium as pretence, and even survival strategies as offences.

Medicine as Management

Capt. David R. E. Roberts, who acted as medical officer for British wounded at Quedlinburg (near the Harz Mountains, central Germany), left a stark account of how need was subordinated to expediency. In September 1918, he received 140 British prisoners transferred from forced labour at Trélon (near the Belgian border in northern France). They arrived emaciated, many so wasted that 'it was possible to encircle the thigh with the fore-finger and thumb'. Roberts described them as 'both mental and physical wrecks', and within three weeks, more than fifty had died. Post-mortems confirmed the cause as starvation and exposure. He repeatedly urged the German authorities to send the men to a properly equipped hospital, where lives might have been saved, but 'to all my protestations the Germans paid no attention'. Instead, the men had been shipped in horse-boxes for three days without blankets, then lodged in ordinary huts without fires, and issued only two blankets each. The outcome was predictable: men perished at 'an alarming and unnecessary rate'.²⁶ This stands in contrast to combat medicine, where psychiatric injury – however contested – could still legitimate withdrawal from duty rather than compel its continuation.

In captivity more generally, medical fitness was judged less by clinical need than by administrative convenience. German camp doctors, pressured to sustain labour quotas, routinely dismissed complaints that disrupted production. Capt. Hugh Moore described tubercular and wounded men denied evacuation until they were 'dangerous or incapacitated', while others with pneumonia were transported in open waggons or sent to shift munitions while still ill.²⁷ Even German physicians conceded that starvation and overwork were killing prisoners – yet the regime did not change.

The testimonies of repatriated prisoners reveal how neglect functioned as policy. Pte Bert Fallows described developing an abscess on his ankle that went untreated until blood poisoning set in; his foot was eventually amputated at Altdamm (near Stettin, then in Pomerania) in a makeshift hospital – a former beer hall crammed with bunks, lacking even basic bandages. He recalled a convoy of 140 wounded from Armentières arriving in April 1918, many still in their original field dressings; wounds festered with maggots, men died daily of lockjaw, and overcrowding forced existing patients out. Fallows's repatriation followed the recording of his amputation as a 'shot wound', a classification that avoided the labour-injury category excluded under German exchange policy.²⁸ Pte John Fuller, who lost a leg at Arras in April 1917, spent a year in captivity with amputees and unhealed cases who were never exchanged. At Langensalza, he saw 2000 wounded prisoners confined in overcrowded huts, many without dressings, sanitation, or proper medical attention; he estimated deaths in March 1918 exceeded amputations.²⁹ Pte Kenneth MacKenzie confirmed the scale: around 4000 wounded POWs arrived at Langensalza (in Thuringia, near Erfurt) in April 1918, many still in field dressings,

some set to work despite their injuries, and almost none receiving meaningful care.³⁰ Even inspection reports corroborated this picture. A neutral visit to Langensalza in spring 1918 admitted that wounded and amputee prisoners had been left unexchanged for months, despite being constantly under observation. Crucially, the inspector noted he was not permitted to speak with the men already selected for transfer – a restriction so striking that a British reviewer scrawled ‘why?’ in the margin.³¹ The staged nature of such inspections mirrored the prisoners’ testimony: visibility was managed, voices silenced, and systemic neglect allowed to persist.

Nor was this solely a late-war phenomenon. Pte Frank Woodier recalled Bohmte camp (near Osnabrück) in March 1915, where the ‘doctor’ was not a physician at all but a corporal from the German Veterinary Corps. Two Lincolnshire comrades, Fred Bush and Fred Jones, fell gravely ill but were left lying in straw in the barracks; the corporal refused hospital admission until men were, in Woodier’s words, ‘almost past recovery’.³² The episode underlines how far treatment could be subordinated to expediency: the sick were warehoused, not healed. Together, these accounts demonstrate that medical care was not withheld because it was impossible, but because the system was structured to deny it until labour capacity was exhausted or diplomatic embarrassment loomed. Collapse, even when visibly written on the body, was managed as an inconvenience to be concealed.

Despair, Protest and the Refusal of Labour

If punishment defined how collapse was handled, interpretation determined how it was understood. The same breakdowns that appeared in testimony as despair or illness were translated by institutions into categories of defiance. As Uta Hinz has shown, German labour policy towards POWs shifted dramatically during the war: early guidelines stressed voluntary work and therapeutic occupation, but by 1916 the system had hardened into one of classification, surveillance, and coercive deployment. Legal protections were steadily stripped away under the maxim *Not kennt kein Gebot* (‘necessity knows no law’).³³ What had once been tolerated as incapacity or reluctance was now interpreted as wilful sabotage. Refusal to work was punished through food sanctions, medical neglect, and transfer to punishment kommandos. In this new logic, breakdown itself could be reframed as resistance, a deviance to be stamped out rather than an illness to be treated.

The treatment of Pte Hutson makes this reframing brutally clear. At the Poley coal mine kommando he first sustained a poisoned finger in an accident; instead of hospitalisation, he was forced to continue working. When he lodged a complaint during a neutral inspection, he was punished with five days in the cells, then a further fourteen. In despair, he drove a pick into his own foot. Even then, he was carried into the mine daily so that output continued. Although a medical board passed him fit for exchange to Switzerland, he was held at Cottbus (south-east of Berlin) awaiting trial for refusing to return to Poley.³⁴ German authorities themselves registered how common such acts were. In June 1918, the Prussian War Ministry’s Sanitätsdepartement circulated a confidential warning to camp doctors about prisoners deliberately inducing inflammations and infections to avoid work. It listed the tactics: mustard poultices, soap injections, salt or petroleum rubbed into wounds.³⁵ The very need for such a circular demonstrates that self-harm was not isolated but widespread enough to alarm Berlin. Where the

ministry framed it as malingering, testimony like Hutson's reveals it as a form of survival and protest.

Even judicial proceedings reinforced this logic. The Cottbus trial lists record Hutson alongside other prisoners awaiting court martial for refusing to return to Kommandos, with the men themselves compelled to sign statements acknowledging that the penalty was death.³⁶ Refusal, collapse, and despair were not recognised as illness but translated into offences against labour discipline. In this framework, collapse was not a medical failure but an act of defiance, and so it was punished, denied, or euphemised out of existence – rendered invisible precisely because to acknowledge it would expose the system's own brutality.

Invisible Suffering and Administrative Narrowing

If collapse could be punished or recast as resistance, it could also be simply denied. The resulting invisibility differed from that affecting combat trauma, which was at least statistically and diagnostically tracked, even when morally contested. A final institutional strategy, visible on both sides of the wire, was to narrow recognition so tightly that psychological breakdown became administratively invisible. The problem was not a lack of evidence – men broke down daily – but rather the categories through which institutions chose to view them.

At the case level, the language of medical boards and service records reveals this narrowing. On repatriation lists and record-office returns produced as part of medical repatriation procedures, POWs were routinely recorded by medical boards and clerical staff under compressed categorical reasons such as 'N.A.D.' (recorded variously in the sources as 'Nothing Abnormal Discovered' in administrative returns and 'Nil Abnormal Detected' in hospital records) or vague descriptors such as 'mental'.³⁷ These formulae did not function as clinical diagnoses but as administratively necessary classifications within medical repatriation systems that required each returnee to be assigned a single, legible reason for processing.

While collective repatriation schemes based on date of capture or numerical exchange were governed by diplomatic eligibility criteria – often stratified by rank and rarely applicable to privates – the categories discussed here operated at a different administrative level. Their function was not to determine eligibility for return, but to record impairment once medical repatriation had been authorised. In doing so, they placed behaviour in a grey zone where it carried no entitlement to treatment or pension. Other euphemisms pushed collapse into somatic terms: 'heart trouble', 'nervous instability', or 'debility'. Pte Hutson, who had mutilated his foot at the Poley coal mine in despair, reappeared in pension files as a 'heart case' – a category that stripped away the history of captivity and self-harm. His pension card recorded only 'heart trouble', but the 1921 census lists him as a railway labourer, a manual occupation inconsistent with cardiac disease serious enough to have warranted early repatriation and discharge from the army.³⁸ The label was not a reflection of clinical reality but an institutional mechanism for translating psychological collapse into a sanitised, somatic administrative form.

At the policy level, the same logic operated more abstractly. In July 1917, E. Marriott Cooke and C. Hubert Bond set out a formula for deciding attributability: the task of the Board was to determine not whether a man was insane, but whether that insanity was

‘caused’ or ‘aggravated’ by military service.³⁹ This was not a diagnostic exercise, nor was it intended to be. Attributability functioned as a legal – administrative filter, not a clinical judgement, translating heterogeneous suffering into categories of liability rather than explanations of illness. The question of suffering dropped out of view; what mattered was causality in a narrow legal-administrative sense. A conference that same month formalised a schema of attribution, non-attribution, or aggravation, providing pension boards with a template for narrowing the field of recognition. Lunacy was acknowledged, but re-coded into a bureaucratic puzzle of liability.

Death certificates reveal the same pattern. Some German records state ‘Selbstmord’ (suicide) plainly; others use non-specific medical phrasing or provide no cause. Psychiatric collapse was translated into acceptable medical terminology that allowed institutions to acknowledge the death without acknowledging its cause. Pte. Edmonds, repatriated from Germany as a ‘mental’ case in 1918 and confined to Bridgend asylum, died in 1920. The GRO index records tuberculosis as the cause of death, a somatic diagnosis that obscures the psychiatric breakdown which had already consumed his final years.⁴⁰

Other cases highlight how a collapse can be acknowledged yet disowned. Pte Alsford, enlisted A1 in 1915, was captured in March 1918 and repatriated from Stendal in 1919. He was diagnosed the following year not with a war-related condition but with ‘constitutional psychopathic inferiority’. The judgement declared him 100% disabled yet not aggravated by war service, thereby excluding him from both pension entitlement and service patient status. The same state that had once certified him perfectly fit now recast him as congenitally defective. Over the subsequent decades, he was absorbed into the institutions of the Mental Deficiency Act, variously referred to as ‘Frederick Archibald’ in police gazettes and ‘Archie’ in his burial record.⁴¹ His trajectory demonstrates how incapacity could be both recognised and disowned, transformed from war trauma into defective character.

The problem was not only the euphemism but also the classification itself. As Edgar Jones, Ian Palmer and Simon Wessely have shown, pension files across conflicts cluster into recurrent ‘war syndromes’: debility, functional somatic disorders such as disordered action of the heart (DAH), and neuropsychiatric illness.⁴² In the First World War, neurasthenia and DAH predominated. These were functional diagnoses, defined by weakness, palpitations, fatigue, or sleeplessness – symptoms that mapped closely onto the breakdown of prisoners but carried none of the institutional stigma of psychosis. For men like Hutson, such labels rendered despair legible only as a physiological condition. They were not random, but culturally and bureaucratically determined categories, reflecting the medical profession’s preoccupation with functional heart disease as a way of naming suffering without acknowledging trauma. For prisoners, whose captivity already lacked heroic cultural capital, to be diagnosed with DAH or neurasthenia was a double erasure: their collapse was both medically ‘functional’ and institutionally unworthy.

The narrowing of vision extended beyond case files into the state’s official statistics. The *Official History: Medical Services – Casualties and Medical Statistics* presented ‘11 million odd battle and non-battle casualties’, drawing on over a million medical history cards from 1916–20. Yet the tables reduced complex, overlapping impairments into rigid categories of ‘wounds’ or ‘disease/injury’, implying an either/or distinction that

rarely held in practice. Pension data tells a different story: around 8% of claimants carried overlapping conditions – wounds plus gas, or wounds plus psychological collapse. The ratio of wounds to illness shifted from 1:4 in the Official History's admission data to 1:3 in pension claims, underlining how categorisation concealed lived realities. As Peter Hodgkinson's analysis shows, the Army's 'million card' study was less a neutral record than a planning tool for future wars: statistics explicitly designed to render impairment administratively legible for planning and forecasting purposes, rather than to preserve medical or experiential specificity at the level of the individual case.⁴³ The blindness here was structural – collapsing trauma into tidy tables that could not accommodate messier truths of breakdown, overlap, or chronic decline.

The cumulative effect is a record saturated with euphemism and absence. It was not that institutions failed to notice collapse; rather, they noticed in ways that allowed them to dismiss it. A man who self-harmed might be punished for defiance. A man who deteriorated in a British asylum might be ruled a pre-existing case. A man who starved to death could be said to have succumbed to heart failure. Each label neutralised suffering by relocating it outside the category of legitimate illness. This was not incidental blindness but a functional strategy. For the German authorities, to admit that captivity routinely broke men would have undermined claims that POWs were treated in parity with their own troops and exposed the forced-labour system as lethal. For the British state, acknowledging POW breakdown during the war as legitimate trauma would have expanded already-strained pension liabilities and risked conferring moral legitimacy on an experience culturally coded as passive and unheroic. Denial preserved the moral order of both systems. This position was not immutable. In the 1920s, some practitioners increasingly recognised captivity itself as a source of pensionable psychological injury, even in the absence of physical abuse, a shift that underscores how contested such recognition remained during the war itself.⁴⁴

Yet the silences speak as loudly as the euphemisms. Read across files, patterns emerge: suicides recorded as 'heart failure', amputations logged as 'shot wounds' to allow repatriation, asylum cases stripped of wartime context, pension denials severing the link between captivity and collapse. These were not isolated clerical quirks but systemic practices of reframing. In this sense, the blindness was double. Institutions were blind to the experience of collapse, but only because they had trained themselves to see differently: despair became malingering, breakdown became defect, recovery became utility. The result was that POW suffering was simultaneously hyper-visible – endlessly recorded in disciplinary notations, medical shorthand, and pension forms – and yet denied as trauma.

Discussion

Psychological collapse in German-administered captivity was neither accidental nor merely individual. It emerged from a regime that treated prisoners first as labour and only incidentally as patients, and it was then rendered administratively invisible. Read together, testimonies, camp memoranda, repatriation papers and diplomatic exchanges sketch a coherent system: suffering was translated into productivity, and breakdown into deviance. This pattern helps explain why captivity has remained peripheral in trauma historiography despite producing comparable long-term impairment.

At the level of practice, ‘fitness’ meant fitness for work. Regulations promised limits and parity, but marching time did not count as work, output targets fluctuated according to scarcity, and discipline followed shortfall. Testimony from the kommandos matches this administrative logic precisely: men were moved rather than treated, inspected rather than heard, and returned to labour until collapse or diplomatic risk forced a change. Medicine, in effect, became logistics. Carceral theory clarifies how captivity does its damage. A POW camp is at once a workplace, a prison, and a hospital. Goffman’s ‘total institution’ refers to the mortification of the self and the looping effect whereby complaints trigger new sanctions; staged inspections and censorship fit this pattern, as does carrying injured men back into pits rather than treating them (see Leggett; Hutson).⁴⁵ Crewe’s ‘tightness’ captures the felt pressure of uncertainty, delay, and arbitrary control – parcel dependence, floating quotas, and transfer to kommandos with no notice map directly onto his ‘depth/weight/tightness’ triad.⁴⁶ Foucault’s account of hierarchical observation, normalising judgement, and the examination is visible in output targets, medical boards that reduce men to ‘nothing abnormal discovered’ (N.A.D.)/‘Not yet diagnosed’ (N.Y.D.)/‘mental’, and the files that codify bodies as productive or deviant.⁴⁷ Placed inside a war economy short on timber, coal, and manpower, these logics made breakdown less an anomaly than a design. Indefinite enforced residence has psychiatric force in its own right: as Jordan shows, confinement restructures routine, time and agency, producing anxiety and dependency even without overt violence – and the Kommandos reproduced that logic in practice.⁴⁸

The German medical culture that informed this carceral logic was already steeped in moralised readings of neurosis. As Paul Lerner has shown in *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890–1930*, wartime psychiatry recast hysteria and war neuroses as failures of will, discipline, and national character rather than legitimate illnesses.⁴⁹ This framework blurred medicine and morality: weakness was construed as deviance, recovery as obedience, and cure as the restoration of productivity. Such assumptions underpinned the treatment of POW collapse, where unfitness for work was rendered a moral, not a medical, problem.

Recognition, however, was rationed. The paperwork of repatriation and medical boards relies on administrative shorthand – ‘N.A.D.’, ‘N.Y.D.’, ‘mental’ – that avoids diagnostic precision and keeps men in a grey zone where entitlement can be denied. This is not mere clerical habit but a politics of credibility: POW testimony arrives with a built-in credibility deficit – an instance of epistemic injustice in Fricker’s sense – so euphemism becomes administratively safer than diagnosis.⁵⁰ Nor was ‘trauma’ a neutral category: as Fassin and Rechtman argue, what counts as trauma is historically made and institutionally negotiated, which is precisely what these files display.⁵¹ Even when a record states *Selbstmord* (suicide) plainly, surrounding correspondence works to make the circumstances banal – unfortunate, regrettable, but not incriminating for the state. Cultural expectations did the rest. Trench trauma carries heroic capital; captivity does not. That asymmetry shaped both German and British responses. German authorities folded breakdown into discipline and output, while British authorities narrowed questions to legal attribution: not ‘is he suffering?’ but ‘is it caused or aggravated by service?’ The paradox follows: men could be judged 100% disabled and yet somehow not the war’s responsibility.

Within this regime, some prisoners used the only instrument left to them – the body. Acts of self-harm and, in extremis, suicide appear in the sources as attempts at agency where refusal had been made illegible. Berlin's circulars warning of induced infections, courts martial lists for 'refusal to work', and the routine carrying of injured men back into pits are not outliers; they describe a landscape in which despair is recoded as fraud and collapse as defiance. Official statistics further narrowed recognition. The Army's 'million card' study and published tables reduced complex and overlapping impairments into administratively legible categories – typically wound or disease – designed for accounting rather than diagnosis. Where combat trauma produced new statistical categories, captivity collapse was absorbed into existing ones, disappearing not through absence but through administrative compression. Pension data nevertheless reveal overlap, while case files record functional labels such as DAH or neurasthenia serving as placeholders for forms of distress that could not be stabilised within contemporary medical or administrative vocabularies.

Conclusion

Psychological collapse in German-administered captivity was not anomalous within the regime that produced it. It was the predictable output of a system that treated prisoners as labour first and patients – if at all – second, then wrote their suffering out of view. Across testimonies, camp orders, repatriation papers, and diplomatic files, the same pattern recurs: breakdown was translated into deviance, euphemism, or silence.

Three claims summarise the analysis presented here. First, collapse was structurally produced. Regulations promised parity and limits, but practice delivered quotas, floating hours, and punishment for shortfalls. Medicine became logistics. Cases from quarries, coalpits and timber parties show men moved, not treated; inspected, not heard; returned to output until collapse or diplomatic exposure forced a decision. Second, recognition was deliberately constrained. The bureaucratic lexicon – 'N.A.D.', 'N.Y.D.', 'mental' – operated in a context where diagnostic precision was unavailable. The narrowing described here did not reflect the concealment of agreed diagnoses, but the operation of administrative systems under conditions of psychiatric uncertainty, where stable terminology was lacking and standardisation was nonetheless required. This confined men to a grey zone where entitlement could be denied. This was less clerical inertia than an institutional politics of credibility: POW testimony, already suspect, carried a built-in deficit that made euphemism safer than acknowledgement. 'Trauma' itself was not a neutral term; as Fassin and Rechtman show, it was historically negotiated and institutionally policed. Even when files record *Selbstmord* (suicide) plainly, the accompanying correspondence renders it routine – unfortunate but administratively unremarkable. Third, denial travelled fastest at institutional intersections. Where rank, labour status, and psychiatric uncertainty converged, the record thinned markedly. Cases that did not fit stable administrative categories were documented minimally, translated into euphemism, or displaced across files without sustained explanation. This paucity is not a gap to be patched with inference; it is itself part of the finding. Certain forms of breakdown were administratively inconvenient, and were managed accordingly – through silence, procedural deferral, or categorical flattening rather than recognition.

These conclusions matter beyond the microhistory of individual cases. They press trauma studies to move captivity from the margins to the centre, and they insist that carceral theory belongs in military history. A POW camp is simultaneously a workplace, a prison and a hospital; only by holding those logics together can we explain why breakdown was both produced and erased. Classic frames (Goffman's total institution, Foucault's discipline) help at the level of mechanism; contemporary prison sociology and carceral geography sharpen the texture. The evidence supports them where it counts: hierarchical observation in output tallies and staged inspections; 'tightness' in parcel-dependence and abrupt transfers; the looping of complaint into sanction in punishment for speaking up.

Taken together, these findings do not imply perfect visibility. Writing the history of wartime trauma from captivity rather than the trenches exposes not a marginal phenomenon, but a blind spot produced by the moral, diagnostic, and administrative priorities of military medicine itself. The archive that records POW collapse is staged, euphemistic, and often contradictory. That is precisely the point. These contradictions are evidence of how institutions managed suffering: inspections performed as theatre, causes of death tidied, diagnoses flattened, boards convened to parse liability rather than need. The safest generalisation the material supports is also the most consequential: inconsistency and euphemism were routine; admission was occasional; denial was functional. The core point, however, is already clear. The system knew what it would take to keep men well, but under pressure, it chose to keep them working instead. When the inevitable collapses came, they were tidied into forms that did not count. The archive did not fail to notice these prisoners. It noticed them in ways that made them disappear.

Notes

1. Jones, *Violence Against Prisoners of War*; Hinz, *Gefangen im Großen Krieg*; Wilkinson, *British Prisoners of War*; and Oltmer, *Kriegsgefangene Im Europa*.
2. Stibbe, "Out of Sight"; and Vischer, *Barbed Wire Disease*.
3. Leese, *Shell Shock Traumatic Neurosis*; Shephard, *A War of Nerves*; Jones and Wessely, *Shell Shock to PTSD*; Barham, *Forgotten Lunatics*; Reid, *Broken Men*; Loughran, *Shell-Shock and Medical Culture*; and Linden, *They Called it Shell Shock*.
4. Roper, *The Secret Battle*; Meyer, *Men of War*; Bourke, *Dismembering the Male*; Fricker, *Epistemic Injustice*; Goffman, *Asylums*; Foucault, *Discipline and Punish*; Crewe, "Depth, Weight, Tightness"; Jordan, "The Prison Setting"; and Fassin and Rechtman, *The Empire of Trauma*.
5. Fricker, *Epistemic Injustice*.
6. *Bestimmungen über die Unterbringung von Kriegsgefangenen*, (Bundesarchiv-Militärarchiv, Freiburg, PH 3/242).[Hereafter BA-MA].
7. Jones, *Violence Against Prisoners of War*, 54.
8. Hinz, *Gefangen im Großen Krieg*, 71–90.
9. Spaight, *War Rights on Land*, 265.
10. Alfred Milner, *Prisoners of War*, memorandum by the Army Council, 31 May 1918, CAB 24/53/15. (The National Archives: Kew). [hereafter TNA].
11. War Office, *Statistics of the Military Effort*, 329–31.
12. Hinz, *Gefangen im Großen Krieg*, 215–47.
13. "Treatment of British Prisoners of War in Germany and in the Occupied Territories," Memorandum by the Secretary of State for Foreign Affairs, 2 October 1918, CAB 24/50/64, TNA.

14. *Tätigkeitsbericht der Inspektion der Kriegsgefangenenlager XII.–XIX. A.–K. Juli 1918*, (Württembergische Landesbibliothek, Stuttgart).
15. Armeekommando 4, memorandum, 13 September 1918, PH 5 II/452, BA-MA.
16. Dienst- und Wachvorschriften, 1916, PH 5 II/452, BA; Records of the Department of State relating to World War I and its termination, 1914–29, Political relations: prisoners of war, 1915, M367/289, (U.S. National Archives and Records Administration).
17. Ibid.
18. FO 383/391, fol. 85071, TNA.
19. *Arbeitszeit und Behandlung der Kriegsgefangenen*. 13 September 1918, PH 5 II/452, BA-MA.
20. Pte A Leggett, WO 161/100/222, TNA.
21. CSM. Bentley, FO 383/391, Fol: 84830, TNA.
22. Fourth Army HQ, Mézières telegram, 1918, PH 5 II/452, BA-MA.
23. FO 383/391, folio: 93749, TNA.
24. Ibid.
25. FO 383/157, Folio: 145656, TNA.
26. Capt. David R. E. Roberts, WO 161/97/70, TNA.
27. Capt. Hugh Moore, WO 161/97/72, TNA.
28. Pte Bert Fallows, 1917, WO 161/100/257, TNA; Kriegsministerium, *Ausschliessung Kriegsgefangener*, 22 Apr. 1917, BA-MA.
29. FO 383/391, Folio: 83922, TNA.
30. Ibid: folio: 88639.
31. Ibid: folio: 91314.
32. Ibid: folio: 94490.
33. Hinz, *Gefangen im Großen Krieg*, 252, 254–64.
34. FO 383/391, Folio: 93749, TNA.
35. Kriegsministerium, Sanitätsdepartement circular on simulated illness among POWs, 10 June 1918, PH 5 II/453, BA-MA.
36. FO 383/391, Folio: 93749, TNA.
37. See ICRC Archives, Prisoners of the First World War (1914–1918) Database: repatriation and release lists for British POWs, April–November 1918 (R 51271; R 51380; R 52262), digitised images, accessed 4 October 2025.
38. Thomas Hutson, pension record card, Western Front Association, ref. 113/0431/Hut-Hyb; 1921 census, Edinburgh (Wardlaw Place), NRS, Census 685/814/14.
39. Ministry of Pensions, *Lunacy cases (men): question of attributability*, PIN 15/862, TNA.
40. ICRC Archives, Prisoners of the First World War (1914–1918) Database, R 51571; death certificate of Norman Walter Edmonds, 16 March 1920, Bridgend, GRO, Q1 1920, 11a/1046.
41. “Pte Archibald Frederick Alford,” Army Form Z22, WO 363, TNA; *Police Gazette*, 16 September 1931 TNA; 1939 Register, Borocourt Certified Institution, RG 101/2212J, TNA; GRO Death Index, vol. 20, p. 2375; Rose Hill Cemetery burial register G2:263.
42. Jones, Palmer, and Wessely, “War Pensions (1900–1945),” 374–9.
43. Hodgkinson, *The Western Front Association Pension Ledger*.
44. For discussion of the post-war debate over captivity-induced psychological injury, see Vance, *Objects of Concern*.
45. Goffman, *Asylums*, Chapter 1.
46. Crewe, “Depth, Weight, Tightness,” 509–29.
47. Foucault, *Discipline and Punish*, Chapter 2.
48. Jordan, “The Prison Setting,” 1061–6.
49. Lerner, *Hysterical Men*, 126, 145. “Active treatment” prioritised restoring labour capacity rather than emotional health; by 1918, psychiatric cure was equated with rapid reintegration into “regulated work”.
50. Fricker, *Epistemic Injustice*, Chapters 1, 2 and 7.
51. Fassin and Rechtman, *The Empire of Trauma*, 42–3, 246, 277–9.

Acknowledgments

The author thanks Dr Simon Constantine for his supervision and comments on earlier drafts.

Data availability statement

All archival material cited is publicly available in The National Archives (UK), the Bundesarchiv (Germany), and the International Committee of the Red Cross archives, Geneva.

Disclosure statement

No potential conflict of interest was reported by the authors.

ORCID

Sarah Bremer  <http://orcid.org/0009-0009-4069-0310>

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