Stomach for the peace: psychosomatic disorders in UK veterans and civilians, 1945-55

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'Peptic ulcers are much rarer now than they used to be', observed Dr Frank Assinder, a general practitioner in Carshalton Beeches, Surrey, when he was asked to recall the early days of the National Health Service, adding that 'nervous dyspepsia was a common diagnosis'.[1] In the aftermath of the Second World War, family doctors became increasingly concerned by the apparent spread of ailments, such as indigestion, rheumatism and skin rashes, throughout the population.[2] Few of these symptoms could be ignored because they might indicate the presence of serious or developing pathology. Indeed, stomach disorders rose up the health agenda of the late 1940s and early 1950s as health officials identified an epidemic of peptic ulcer. Evidence of perforation from post-mortem studies confirmed that this was, in part, the outcome of a verifiable disease process.[3] Given that men of working age seemed particularly vulnerable, the Medical Research Council commissioned a report from Richard Doll (1912-2005) and Francis Avery Jones (1910-1998) into *Occupational Factors in the Aetiology of Gastric and Duodenal Ulcers*.[4] Published in 1951, this authoritative study ruled out social class as a causal variable but concluded that those in jobs with responsibilities for others were at elevated risk. Doll and Jones were undecided whether it was the nature of the work itself or the personality of the employee that was the determining factor. In the pre-war period, Walter Cannon (1871-1945) had provided a physiological account of the relationship between emotion and physical states, while from the mid-1950s the burgeoning concept of stress was supported by endocrinological evidence from Hans Selye (1907-1982).[5] A growing number of doctors with an interest in psychosomatic medicine believed that changes to the environment, or ways that individuals interacted with it, played an important part in the spread of gastrointestinal disorders. The 'day-to-day

experience of the consulting room and surgery tells its own story', reported a team of family doctors. Their study of six general practices led them to conclude that the role played by stress 'as an important contributory cause of disease' was beyond doubt.[6]

Historians, in particular Paul Addison and David Kynaston, have explored the cultural impact of the Second World War on British society, evoking a nation coming to terms with the material and psychological effects of the conflict but also seeking to adapt its institutions and economy to a new world order.[7] Considerable research has been conducted into the design and development of public health systems, together with the impact of state welfare on families during this period.[8] Alan Allport has analysed the demobilisation of conscripted servicemen, many of whom encountered problems adjusting from an adventurous or high-risk lifestyle to the mundane disciplines of office and factory employment.[9] Although much has been learned about stressors affecting civilians and soldiers during the conflict itself,[10] less has been written on the mechanisms that individuals employed to cope with the memories of terrifying experiences whilst returning to peacetime routines of work and recreation. This, in turn, raises the question to what extent were ailments seen in primary care a product of a process of adjustment and rehabilitation? The changing culture of somatisation has become a central question for historians as they seek to understand the relationship between psychological and physical elements in common illnesses.[11] Following Gerald Grob's historical survey of peptic ulcer in America, medical historians have taken an increasing interest in stomach disorders.[12] Ian Miller in particular studied the British experience of stomach illness from the nineteenth century to 1945, identifying a series of discourses that culminated in a stress model of causation.[13]

This chapter explores the apparent spread of stomach disorders throughout Britain in the aftermath of the Second World War. It asks how these illnesses were explained by contemporaries, why gastrointestinal complaints appeared so common and to what extent

they can be interpreted as a bodily manifestation of traumatic memories. The 1950s witnessed the increasing identification of 'stress' as a physiological phenomenon tied to modern living. Armed with a new scientific model for functional symptoms (that is those without demonstrable organic basis), doctors who had a research interest in psychosomatic medicine sought to explain duodenal ulcer and nervous dyspepsia in terms of worry and workplace pressures.

Wartime context

The need to conscript a mass citizen army had brought stomach disorders to the top of the health agenda. By December 1940, an editorial in the *British Medical Journal* noted that peptic ulcer had become a significant cause of invalidity from the British Expeditionary Force,[14] such that the military authorities feared for the fighting strength of the army. Urgent studies were undertaken not only of servicemen invalided from France but also of those hospitalised in the UK during training and anti-invasion duties. Many of the hypotheses explored in 1940-41 continued to frame post-war debates. For example, the heavier nature and high meat content of army food was proposed as a cause, together with the fact that soldiers on exercise had irregular mealtimes.[15] A further causal hypothesis was excessive smoking by servicemen, encouraged by a free issue of cigarettes. Yet there was a serious and compelling objection to these hypotheses. Sir Henry Tidy (1877-1960), a physician with a special interest in ulcer, argued discounted active duty and army food as causal factors because 'peptic ulcer and all dyspeptic disturbances were noticeably rare' during the First World War when similar stresses had operated, and indeed when a similar diet was served.[16] Population data supported this case: only 709 soldiers had been discharged from the British army by the end of 1915 with peptic ulcer compared with 23,574 at the end of 1941.[17] This observation, and the failure to establish a statistical association with smoking,[18] encouraged

physicians to explore the idea that particular personality types were vulnerable to stomach disorders.

In the pre-war period, Daniel T. Davies, a physician at the Royal Free Hospital, and A. Macbeth Wilson, a psychiatrist at the Tavistock Clinic, collaborated to investigate the personal histories of ulcer patients.[19] They found that in 84% of cases an anxiety-provoking event, such as change of job, death of a close relative or unemployment, had preceded the illness. In a follow-up study of patients who had suffered internal bleeding or perforation, they concluded that ‘unusual emotional tension’ was associated with these medical emergencies and that patients had been ‘harassed and worried by their responsibilities and by environmental changes’.[20] After the outbreak of war, personality became increasingly implicated as studies of particular groups of servicemen showed different rates of stomach illness. Submariners, for example, appeared almost immune to peptic ulcer, an observation explained by a selection programme designed to identify the fittest and most robust sailors.[21]

Of particular significance for the post-war period was a study conducted by J.N. Morris, a physician, and Richard Titmuss (1907-1973), an expert in social policy, that reported an association between employment rates and the incidence of stomach disorder.[22] They found that deaths from perforated ulcer had fallen during the early 1930s in those areas that experienced high unemployment. However, as the economy recovered bringing new jobs, ulcer mortality rose, apparently as a consequence of the return to work. Industrial and commercial employment was associated with the burgeoning concept of stress to which the ulcer personality was considered vulnerable. Morris and Titmuss concluded that ‘it is hard to resist the conclusion that urban life nowadays is an ideal soil for the flowering of the ulcer temperament’.[23] They appear to have judged that a richer diet and greater consumption of cigarettes and alcohol associated with a return to work were secondary to personality. For the period 1939 to 1941, Morris and Titmuss believed that the significant rise in ulcer mortality

for males was a consequence of 'heavy air attacks'. However, women in urban areas had been exposed to the same dangers as men and yet their mortality from ulcer fell over the same period.[24] Sir Arthur Hurst (1879-1944), who had founded the Gastroenterology Club in 1937 as a vehicle for specialists to exchange information,[25] concluded that worry in conjunction with rising alcohol and cigarette consumption lay at the heart of the epidemic: 'the constant anxiety of the years between the two great wars, which led to the steady rise in the incidence of gastric disorders, can be fully realised only by those whose memories go back to the care-free days before 1914'.[26] Major C.A. Hinds Howell, based in a British Army hospital, argued that servicemen who broke down with an ulcer possessed a 'constitutional weakness'; in civilian life they were 'only just able to accommodate themselves to their home environment', but they lacked the resources to cope with the extra demands of a military lifestyle.[27]

Furthermore, in 1942 a US study funded by the Rockefeller Foundation of 80 randomly selected patients with peptic ulcer appeared to show that pathological changes and symptoms were correlated with strong emotion, chiefly fear and anxiety. George Draper (1880-1959), its author, argued that 'lesions of peptic ulcer are associated with psychic traumata as definitely as inappropriate food'.[28] Having concluded that dietary factors were secondary, Draper recommended that treatment pay less attention to the lesion itself and focus on psychological re-education to wean the patient from 'the mother principle and re-establish his self respect'.[29] A key figure in the growing field of constitutional medicine, Draper and his US colleague Abraham Myerson (1881-1948) believed that chronic diseases, such as peptic ulcer, hypertension, rheumatoid arthritis and asthma, were either a consequence of adaptation to modern industrial life or illnesses in which homeostatic attempts to adapt to environmental stress had disturbed the stability of mind and body.[30] Equally, Hans Selye drew on wartime reports of peptic ulcer to support his account of a

'general adaptation syndrome'.[31] The reported increase in the incidence of perforation after air-raids, he believed, could be explained in terms of an adreno-cortico defence reaction, comparable to that produced in animals 'by exposure to stress'.[32] By creating episodes of intense emotion, the Second World War offered doctors with a research interest in psychosomatic medicine regular opportunities to study the impact of stress on health and well-being.

The conflict also established a strong cultural association between stomach disorders and combat. 'Guts' was a popular term for courage, while the phrase 'no stomach for the fight' meant cowardice. The US Air Force, when stationed in the UK, had coined the term 'lack of intestinal fortitude' as an official euphemism for loss of will power.[33] Suspected ulcer was also recognised as an escape route for servicemen wishing to avoid hazardous duties and it was popularly, but erroneously, believed that swallowing chewing gum before a barium meal X-ray would simulate ulceration.[34] Thus, by 1945 the connection between the stomach, military service and emotion had found an established place in British culture, while ulcer, a painful disorder and potential cause of death without an effective treatment, was a source of apprehension and dread throughout the population.

The clinical picture

Yet, when Britain again found itself at peace, and the stresses of conflict ceased, stomach disorders continued to spread, deaths from perforated ulcer rising until the mid-1950s.[35] Reports by family doctors from the post-war period suggested that patients were often troubled by indigestion and abdominal pains. Dr John Fry (1922-1994), a Beckenham GP, systematically collected data from every patient contact and found that the most common presentations in the period 1952 to 1956 were digestive disorders (12%), skin disorders (10%) and psychoneuroses (8.5%).[36] In addition, Fry reported an increased incidence of peptic ulcer in men over 30 and under 60, but believed that the illness was over diagnosed

because only 21% went on to have surgical treatment; most patients, he observed, 'manage quite well' with alkalis and diet. More puzzling still was the fact that cases seemed to recover naturally with time. Fry proposed that the natural history of duodenal ulcer includes 'a natural and spontaneous cure with advancing age'.[37] Given the unreliability of the various tests for duodenal ulcer (barium meal, occult bloods and fractional test meal), it was surprising that Fry did not speculate whether such cases were false positives. Fry also found that women reported only marginally lower levels of digestive symptoms,[38] despite the fact that the incidence of peptic ulcer, established by post-mortem studies, was significantly lower in females.[39] This finding was supported by the national morbidity survey of 1956-57, which suggested that gender was a powerful predictor of ulcer but not disorders of stomach function.[40] Smoking was considered the crucial factor (a 1949 survey showed that 79% of males smoked but only 38% of women who on average smoked half the consumption of men), compounded by the belief that a worried male would smoke more heavily.[41] In contrast to psychoneuroses, indigestion and abdominal pain were culturally acceptable symptoms not least because multiple interpretations were possible including stress, poor diet, over-work or a somatic expression of painful emotion.

Not only did individual doctors identify patterns of illness, the developing science of statistics and a need to monitor a state-funded health service encouraged national surveys of morbidity. In 1950 Dr William Logan, chief medical statistician of the General Register Office, had recruited ten English GPs for a three-year pilot study. This revealed 'wide differences between practices' and demonstrated the need for a large representative survey.[42] With the co-operation of Dr R.J.F.H. Pinsent, chairman of the research committee of the College of General Practitioners, Logan recruited family doctors in England and Wales to collect patient data in a standardised manner. Reliant on volunteers, who received no extra payment for the additional work involved, Logan encountered difficulties assembling a

geographically representative sample.[43] Initially, 176 GPs based at 110 practices were recruited but when Logan identified gaps in Lancashire and the extreme North, the composition of the sample was modified.[44] In the event, 108 practices (representing 410,000 patients) agreed to collect standardised data to provide an overview of ‘communal ill-health’ in the English and Welsh population.[45]

Over twelve months in 1955-56, GPs recorded every consultation by diagnosis on pre-printed cards which were then posted to the General Register Office at Somerset House for analysis.[46] Without efficient computers, the data collection and analysis was laborious. Not until April 1957 had the data been punched manually into 650,000 machine-readable cards and calculations of rates could begin.[47] The first report of symptom and diagnostic statistics took two years to collate. Additional reports followed at two-yearly intervals.[48] Among the most common presentations were: abdominal pain and disorders (2.6%), dyspepsia (0.9%) and peptic ulcer (0.8%), compared with psychoneurotic disorders (5.1%) and skin disorders (6.5%). Although significant regional variation was recorded for ‘disorders of the function of the stomach’ (from 6.8% in the East and West Ridings, 5.9% in London and the southeast to only 2.9% in the south of England) there was no clear explanation for these differences.[49] Geographical variation was also reported for ‘psycho-somatic disorders’ by region but with no explicable pattern: Northern (4.2%), London and the southeast (2.8%) and Wales (0.9%).[50] It is possible that these variations reflected underlying population factors, such as income, patterns of employment and age distribution.

How, then, did contemporaries interpret these patterns of illness? Desmond O’Neill, a psychiatrist at St Mary’s Hospital, Paddington, and a key mover in the Society for Psychosomatic Research, believed that dyspepsia was in the main a ‘stress disorder’.[51] By that he meant a disorder caused by an emotional interaction precipitated by a crisis in the patient’s life. The symptoms would resolve, O’Neill argued, ‘when the situation changes for

the better, or the patient learns to adapt to it without undue tension'.[52] He was less persuasive in explaining how a psychological conflict was translated into physical symptoms ('a response-complex'), but suggested that the area of the body unconsciously 'chosen' to express this conflict was in part determined by family history: 'dyspepsia often seems to run in families... it is always difficult, however, to separate the influence of inheritance from that of family environment'.[53] Apart from pointing to unhealthy eating habits, O'Neill was unable to explain why so many stress disorders focused on the stomach, rather than other areas of the body.[54] In popular culture indigestion was associated with stress in situations where emotions could not be expressed openly. For example, Joe Lampton, the principal figure in the best-selling novel *Room and the Top* (1957), observed, 'there was a bad taste in my mouth, the indigestion which always attacks me when I'm angry'.[55]

Arthur Hurst believed that a 'constitutional tendency', based on both physiology and personality, predisposed individuals towards an ulcer.[56] Treatment, he argued, had to effect a significant change in the 'conditions of life'. In essence, this required a rigid adherence to a prescribed diet (no longer than two hours between meals, only foods that can be chewed into a mush, no more than six cigarettes a day and avoidance of alcohol). During periods of overwork or 'mental stress', Hurst recommended, 'one day or half-day a week should be spent resting in bed or on a couch', whilst any minor infection should be addressed by remaining in 'bed on a light diet' until completely recovered.[57] Today, this programme reads like a hypochondriac's charter, but it pre-dated the therapeutic revolution and the discovery of effective medicines that accelerated recovery times. It was, nevertheless, a regime that appealed to anxious or neurasthenic patients seeking to avoid stressful situations.

The need to ration basic foodstuffs during the Second World War had exercised a major impact on the nation's diet and in the post-war period restrictions tightened still further. A balance of payments crisis that limited the ability of the UK to purchase imported

foodstuffs led to cuts in summer and autumn 1947 and the introduction of potato rationing. Although bread rationing ended in July 1948, the milk ration was cut to 2.5 pints a week in September 1949.[58] Significantly the regular consumption of milk along with biscuits between main meals was a key recommendation for the management of duodenal ulcer,[59] whilst one of the most popular over-the-counter medicines to treat indigestion was 'Milk of Magnesia'. Thus rationing and stomach disorders occupied a central place in British post-war culture.

National Health Service: clinical context and policy

To what extent was the epidemic of stomach disorders, indeed of psychosomatic illnesses in general, the result of changes to the provision and funding of state health and welfare facilities; that is new ways of recording medical data, the creation of a heath service free at the point of demand and a general public encouraged to demand treatments as a reward for enduring six years of war. In June 1938, the Ministry of Health had been tasked with setting up an Emergency Medical Service to provide free hospital and out-patient treatment for civilians injured or sick as a result of air-raids.[60] The private health service lacked the capacity to cope with the expected rush of casualties and large buildings were commandeered to serve as hospitals, while nurses and ancillary staff recruited to create a nationwide service.[61] In November 1942, Sir William Beveridge (1879-1963) published his report on the welfare of Britain and set an agenda for a more interventionist state. Designed to address 'want, disease, ignorance, squalor and idleness',[62] proposals for reconstruction and reform in the post-war period included a unified system of compulsory social insurance that would fund unemployment, injury, maternity and sickness benefit.[63] Sir John Anderson, speaking for the government in the Commons in February 1943, announced the acceptance of a 'comprehensive health service to ensure that for every citizen there is available whatever medical treatment he needs in whatever form he needs it' offered without charge or a means test.[64] The promise of welfare reform was offered in part to maintain the fighting spirit but

also because the plan met with popular support. Moreover, government funding directed at improving acute and casualty services offered by the Emergency Medical Service offered a tangible model for a more broadly-based National Health Service.[65] Once the war was over, people felt entitled to make full use of free medical facilities and both family doctors and hospital out-patients found themselves crowded with patients seeking advice and treatment, creating long waiting lists.[66] Titmuss also believed that the changes, together with a general erosion of deference to authority, fostered a more 'questioning and critical attitude to medical care' among patients.[67]

Despite a lack of capacity, surveys conducted in the mid-1950s found that the NHS was well-regarded and GPs were trusted. However, this goodwill allowed successive governments to neglect the health service and chronic under-funding and regional inequalities were allowed to persist.[68] Over-worked family doctors often had little time for each patient. Most did not offer an appointment system leading to queues and a potential barrier to attendance.[69] General practitioners tended to avoid psychological issues. In 1951-52 supported by the Nuffield Provincial Hospitals Trust, Stephen Taylor (1910-1988) conducted a qualitative survey of ninety-four family doctors in thirty practices.[70] The study had been prompted by trenchant criticisms of British general practice published in the *Lancet* by J.S. Collings, a visiting Australian doctor.[71] In the published version of his report, Taylor revealed a curious mistrust of psychiatric diagnosis in primary care, arguing that 'there is substantial truth in the hypothesis that the better the clinician, the less often does he diagnose neurosis.[72] This implied that a patient who presented with a physical symptom, and one that might indicate a serious illness, was much more likely to gain the attention of his GP than one who reported low mood or general anxiety. Persistent and painful dyspepsia could imply an ulcer and a family doctor would risk a charge of negligence if he dismissed the patient without an investigation and follow-up appointment. Furthermore, patients were routinely asked about

their bowel habits. It was believed, though without foundation, that constipation or the retention of products had toxic side effects.[73] This preoccupation with gastrointestinal function sent a powerful message to patients that abdominal pains would be taken seriously. Indeed, a patient suffering from severe indigestion probably believed that this merited a day or so off work and needed the doctor's official sanction.

Referral to a hospital out-patient department was unlikely to have offered the dyspeptic patient a more nuanced explanation of their symptoms. Fyfe Robertson, a reporter for the *Picture Post*, observed in 1954 that 'too many patients feel that to too many out-patient doctors they are not *people* at all, but card numbers and diseases'.[74] 'Autocratic behaviour among hospital staffs', Titmuss believed, 'with behind them a long tradition deriving from military discipline... is thereby strengthened by the invasion of scientific techniques, by increasing specialisation and the growth of professional solidarities'.[75] The birth of the NHS also coincided with the dawn of a golden age of high-technology medicine. Notable advances included the growing availability of natural and synthetic antibiotics, anticoagulants, reliable blood transfusion, innovations in anaesthesia, diagnostic X-radiology and electrocardiography as well as more refined techniques of pathological investigation and mechanisation in the operating theatre. Such innovations transformed the capacities of hospital medicine and created conditions for the proliferation of medical and surgical specialties.[76] New science-based treatments scarcely promoted a listening culture of empathy. Furthermore, the growth of specialist departments in district general hospitals, hailed as one of the achievements of the early NHS,[77] hindered the development of psychosomatic medicine. The increasing number of focused expert opinions discouraged an over-view and often led to a sequence of referrals as each consultant could find no recognisable pathology within their sub-speciality.

Psychosomatic interpretations

In 1941 Arthur Hurst argued that the increased incidence of duodenal ulcer was in part a function of improved investigative techniques: 'the deformity of the bulb in duodenal ulcer was not recognised with the X-rays before 1920, and even the clinical diagnosis dated only from about 1908'.[78] This prompts the question whether the apparent epidemic of psychosomatic illness was, in fact, a reflection of new ways of thinking about disease? In a 1943 paper to the *Lancet*, James Lorimer Halliday (1898-1983), a Scottish regional medical officer, defined psychosomatic illness as 'a bodily disorder whose nature can be appreciated only when emotional disturbances are investigated in addition to physical disturbances'.[79] Britain, Halliday believed, had undergone a 'psychosomatic transition': the spread of illnesses formerly characteristic of the middle aged and elderly into a younger population and disorders once characteristic of females becoming increasingly common in males.[80] Diseases showing an upward trend, he argued, were precipitated by 'upsetting events' and suggested that the psychological effects of a changed environment were the cause. He identified a wide variety of common disorders to which this interpretation applied and believed that psychological factors could not only precipitate an illness but also have an impact on its course and duration. Whilst Halliday made no overt reference to war, he acknowledged that 'an emotionally upsetting external event or a period of abnormal stress' could act as a trigger.[81] The psychosomatic transition was of concern because it was identified as a significant and growing cause of sickness absence.[82] In essence, Halliday argued believed that the health and fertility of the nation was in terminal decline because 'psychosomatic affections' (such as asthma, rheumatism and peptic ulcer) were set in inexorable rise because people were increasingly consumed by anxiety and other pathological emotions.[83]

Whilst the explanation proposed by Halliday did not meet with broad approval, it did reflect a growing interest in the relationship between emotions and bodily states. This, in turn, followed the foundation of departments of psychological medicine in leading

universities, drawing psychiatrists into the education of medical students and multi-disciplinary research projects.[84] The psychoanalyst John Rickman argued that these developments added ‘a new dimension to the medical interview’.[85] The problem for most doctors, however, was a lack of clinical time to implement this approach. Furthermore, financial constraints imposed on the newly-formed NHS prevented the expansion of psychiatric services in the post-war period, leaving the detection and initial treatment of psychosomatic illness to family doctors.[86]

Set up in January 1955 under the presidency of Dr John Hambling, a Canterbury physician, the Society for Psychosomatic Research sought to bring clinicians together from a wide range of disciplines to understand ‘the human organism in health and disease’.[87] In the 1958 edition of *A Textbook of Psychiatry*, David Henderson observed that ‘psycho-somatic medicine’ was both ‘a method of clinical approach to all patients’ and a way of interpreting ‘a group of physical diseases or syndromes’.[88] War, he argued, not only increased the incidence of such disorders but also developed understanding of ‘these principles’ because fear and anxiety ‘are among the commonest causes of the physical discomforts for which medical advice is sought’.[89] Henderson illustrated the change in clinical practice that these ideas prompted: ‘in the past it has commonly happened that symptoms referred to by the patient as indigestion were accepted as such by the doctor and labelled as “dyspepsia” which was then treated as a disease *sui generis*’.[90] Now, if the doctor had time, he would explore whether an emotional conflict had triggered the pain and attempt to resolve the underlying cause rather than merely treat the symptom.

These ideas found expression in the Medical Research Council report from Richard Doll and Francis Avery Jones into *The Aetiology of Gastric and Duodenal Ulcers* published in 1951. Their survey of 6,047 men and women found that social class could not explain why some people with dyspepsia developed ulcers while others did not. Nevertheless, Doll and

Avery Jones believed that occupation was a significant risk factor. Jobs associated with a high incidence included doctors, foremen and business executives (‘responsible positions in industry’), while farm workers, clerical and administrative staff were at low risk. Although ‘anxiety over work was complained of more frequently by men with proved ulcers than by men without symptoms of dyspepsia’, the authors remained uncertain whether stress itself was the aetiological factor, or whether it was the outcome of a particular personality type, one prone to diligence and worry.[91] They developed the pre-war hypothesis that individual characteristics explained differences in rates:

> The duodenal ulcer subject has frequently been described as an over-conscientious, hard-working, ambitious type of man, and it is reasonable to assume that it is this type who would most readily complain of anxiety from over work, and who would tend to become appointed to positions of responsibility. It is considered... that men with this conscientious type of personality are particularly prone to develop duodenal ulcers.[92]

Although the 1958 edition of Henderson and Gillespie’s *Textbook of Psychiatry* placed duodenal ulcer in the category of physical illness, the authors added ‘emotional factors are believed to be of decisive importance’.[93] In 1959, two American cardiologists, Meyer Friedman (1910-2001) and Ray H. Rosenman, applied this model to explain variations in rates of cardiovascular disease. Their Type A personality, characterised by ambition and competitive drive, was considered at particular risk.[94] Thus, as notions of constitutional medicine spread, an individual’s innate qualities and patterns of behaviour were associated with a range of significant health hazards.

Impact of the war

Official histories have argued that the transition from war to peace was managed successfully avoiding the large number of war-pension claims for shell shock that followed

the First World War. 'Up to the end of 1948', Titmuss concluded, 'no evidence was forthcoming to suggest that there had been any dramatic increase in neurotic illnesses or mental disorders in Britain'.[95] Planned demobilisation, full employment, advances in psychological treatment and an interventionist government have been cited as reasons for the containment of traumatic memory. However, during the conflict itself, a number of psychiatrists had argued that the health effects of the conflict might not be revealed until the return of peace. Aubrey Lewis, employed by the government to survey the psychological impact of air raids warned that the full effect of 'war-related stress' might be delayed and that 'the evil harvest may be reaped afterwards'.[96] Equally, a national survey conducted in 1943 by Dr C.P. Blacker found that many directors of psychiatric clinics believed a 'latent neurosis' existed in the civilian population. Whether this developed into overt psychological or psycho-somatic disorder after the war was dependent on 'the social and economic conditions… and the moral atmosphere which prevailed'.[97] Thus, an hypothesis considered by contemporaries to explain the epidemic of stomach disorders was that the offer of financial compensation through the war pension system and the creation of a free health service encouraged people to make the most of their symptoms. In 1943, the burden of proof had been reversed in favour of the claimant, with the increasing likelihood that an application to the Ministry of Pensions would be successful.[98] Whilst the majority of individuals presenting to their GP with dyspepsia or a suspected duodenal ulcer were not in receipt of a war pension, they may nevertheless have felt entitled to officially-sanctioned time off work or other state benefits.

Joanna Bourke has proposed an alternative hypothesis to explain the apparent epidemic of psychosomatic illness in the immediate post-war period. She has argued that the decline of tangible external threats after 1945, together with the therapeutic revolution, contributed to the rise of generalised anxiety in British society.[99] Whereas in the past a

frightened individual might turn to the community or a religious institution for advice and support, emotion became increasingly focused on the individual, rather than the herd. No longer threatened by invasion or aerial assault and with a small but growing range of effective medicines supplied free of charge, a culture of anxiety developed in post-war Britain which found expression in psychosomatic illnesses. The 1950s occupied a transitional position: traumatic experience remained fresh in the memory and former members of the armed forces and emergency services often struggled to adjust to routine peacetime roles. To what extent, then, were indigestion and stomach pain bodily expressions of emotional conflicts? This is, of course, an unanswerable question but it is instructive to try to assess popular responses to the war.

The government itself was concerned about the health of some returning soldiers and in particular those who had been prisoners-of-war. During the course of 1943, British military authorities had become increasingly aware of problems with repatriated officers. Although returned to duty, high rates of invalidity and disciplinary incidents in men with excellent military records suggested that imprisonment had adverse consequences.[100] In the summer of 1945, the government unveiled a national rehabilitation programme. Re-education and employment were the focus of the twenty 'Civil Resettlement Units' (CRUs) set up by the War Office,[101] while the Royal Air Force opened a number of 'Resettlement Training Centres'. Brigadier H.A. Sandiford, director of army psychiatry, believed that 'resocialisation' was the aim and that 'finding a suitable job' was both the most important therapy and outcome.[102] A CRU course took a month but could be extended. It included factory visits and social activities to bring the former prisoner-of-war into contact with 'institutions, individuals and situations towards which he was often burdened with feelings of mistrust and suspicion'.[103] Week-end leave was designed to bridge the gap between army and home life. The intention of providing each unit with a resident psychiatrist was not met

due to staff shortages. Symptoms and changed behaviour were interpreted as a consequence of poor nutrition and confinement, together with insufficient time to adapt to widespread social and cultural changes that had occurred during their imprisonment.[104]

Anecdotal reports from the post-war years offered evidence of demoralisation amongst the civilian population. Christopher Isherwood visiting Britain during the winter freeze of 1946-47 wrote that Londoners 'didn't seem depressed or sullen' though 'their faces were still wartime faces, lined and tired'.[105] Accounts in Mass-Observation diaries provided conflicting evidence: Edie Rutherford a Sheffield housewife and clerk wrote in May 1947, 'folk are not in a despairing mind, in spite of all', while a month earlier Maggie Blunt, a publicity officer in Slough, recorded 'our nerves are on edge, our anxieties and depressions enormous'.[106] The problem for the historian is that anecdotes can be found to support any hypothesis and without representative population studies it is impossible to know how widespread demoralisation was or whether it was sufficiently deep to impact on mental and physical health. That the government funded schemes designed to lift the morale of the nation (such as the 1948 Olympic Games and the 1951 Festival of Britain), at a time when these were scarcely affordable, suggests that the mood of the people was generally downbeat after the euphoria of victory had passed. As contemporaries believed, pervasive low mood in time of austerity may have increased the likelihood of psychosomatic illnesses and their report to NHS doctors.

Conclusion

During the 1940s and 1950s there were two parallel phenomena relating to the stomach. First, there was an epidemic of duodenal ulcer confirmed by post-mortem studies, which to this day has not been explained by gastroenterologists. Hypotheses have ranged from a high salt diet, increased levels of smoking through to the natural evolution of a disease process. Complementing this, and in cultural terms inextricably intertwined, was an epidemic

of indigestion and abdominal pain. In most cases this did not reflect an underlying disease. Increasingly this symptom was interpreted as caused by stress. The pressure of modern living, in particular industrial and commercial routines in large cities, was identified as a primary cause.

Hacking stated that an illness movement 'will take only if there is a larger social setting that will receive it'.[107] In order for an illness to gain legitimacy it must resonate with a larger cultural framework, which makes it intelligible. Illness representations spread throughout a population: a sort of 'epidemiology of representations,' the circulation and contagion of ideas and anxieties.[108] Psychosomatic illness occupied an increasingly prominent place on the health agenda of post-war Britain. Not only were its manifestations common, but symptoms also proved difficult to treat not least because there was little agreement about causation and appropriate management. Because cases often mimicked severe or life-threatening diseases, doctors spent much time investigating and monitoring such cases in an attempt to find reliable diagnostic tools. Patients often exhibited distress and many followed a trajectory into chronic invalidity. At a time when psychiatric diagnoses attracted well-established stigma, it was not surprising that patients were reluctant to trouble doctors with overt anxiety or depression but tended to present physical symptoms that required less justification of the clinician's time. It was far easier to present with a suspected duodenal ulcer than with worries about work or relationships. The peptic ulcer episode, which today is ascribed to bacterial infection (*helicobacter pylori*) quite unrelated to personality, diet or nature of employment, demonstrated the power of culture to influence causal explanations, treatment and the provision of benefits. Uncertainty and unreliable diagnostic techniques lay at the root of the peptic ulcer phenomenon allowing multiple explanations and encouraging caution in management techniques.

Notes

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