

## Phantom suffering?

Joanna Bourke looks into physical and emotional wounding after the First World War

The First World War did not end in 1918. The suffering inflicted during the war continued for decades after the ceasefire. Millions of men returned home with distressing psychological and physical wounds. Their lives were ruled by pain, despair, and conflict with pension authorities and medical personnel. The war-afflicted body-in-pain was a life sentence.

I was reminded of this fact when opening two bulky files in the National Archives in Kew (London) a few months ago. It was the pensions file for Lieutenant Francis

(‘Frank’) Hopkinson, who died on 17 December 1974 at the age of 85. He had lived for over half a century in severe pain as a result of having been wounded during the Third Battle of Ypres on 12 August 1917. Hopkinson had undergone numerous surgical operations, including having his left leg amputated three times. He had also been hospitalised with shell shock. From those terrifying months in 1917 and 1918 until his death in 1974, Hopkinson endured profound physical and mental anguish due to an agonisingly tender stump and phantom limb pain. An exploration of

Hopkinson’s life sheds light on the treatment of men wounded during the First World War.

Who was Frank Hopkinson? He was born in 1889. He was the second son of Canon Charles Girdlestone Hopkinson, rector of Whitburn (in Sunderland), and was educated at Marlborough. When war was declared, this strapping, six-foot tall, young man who enjoyed riding horses eagerly joined the 11th Durham Battalion. The recruitment officer judged him to be ‘not particularly nervy’, with ‘normal

health. (His files can be found in the National Archives WO 339/12060 (P1030322) and PIN 26/21799.)

This all changed on 12 August 1917 when a bomb smashed his left leg into fragments. His leg became infected with gas gangrene and was amputated three times. Hopkinson was distraught. He was to spend his life on crutches and never experienced prolonged periods of employment again.

Hopkinson also suffered from shell shock. While being evacuated to hospital, Hopkinson ‘had to wait some hours under



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Railway arches during Air Raid’. The strain was too much: he ‘developed confusion of thought with suspicions and hostility’. On 1 October 1917, he was sent for treatment to Palace Green Hospital in London for shell-shocked officers. He was described as having an ‘anxious expression... He is confused and suspicious of his surroundings, doubtful as to dates and times. Afraid...’. It took nearly five months for his doctors to report ‘Mental condition now clear’.

Nervousness, insomnia and impaired memory would plague him his entire life.

Medical attention, however, initially focused on his phantom limb. The phenomenon was first described in 1551 by the great French military surgeon, Ambroise Paré. In Paré’s words,

A most clear and manifest argument of this false and deceitfull [*sic*] sense appears after the amputation of the member; a long while after they will complain of the part which is cut away. Verily it is a thing wondrous strange and prodigious, and which will scarce be credited, unless by such as have seen with their eyes, and heard with their ears the Patients who have many months after the cutting away of the Leg, grievously complained that they yet felt exceeding great pain of that leg so cut off. (Ambrose Paré, quoted in Thomas Johnson, *The Workes of that Famous Chirurgion, Ambrose Parey* [*sic*], London: Author, 1649)

Most famously, though, post-amputation sensations were brought to public attention during the American Civil War when neurologist Silas Weir Mitchell coined the term ‘phantom limb’ and went on to provide the first modern clinical description of ‘these hallucinations... so vivid so strange’. He observed that

Nearly every man who loses a limb carried about with him a constant or inconstant phantom of the missing member, a sensory ghost of that much of himself, and sometimes a most inconvenient presence, faintly felt at times, but ready to be called up to his perception by a blow, a touch, or a change of wind. (*Injuries of Nerves and Their Consequences*, 1872, p.348)

Hopkinson described the pain more evocatively: it felt as if ‘the foot was being crushed but... at stump level only’ and ‘like electric shocks’ that made him ‘shout out’.

During and immediately after the war, Hopkinson’s anguish attracted sympathy. But as the years passed, he had difficulty persuading his doctors that his suffering was ‘real’. It did not help that his ‘shell shock’ had not been a direct consequence of combat but had begun when he was exposed to an air raid in England. This showed a lack of soldierly self-control and was interpreted as further evidence that he had a pre-existing mental weakness. From the 1930s, medical reports increasingly reiterated the view that Hopkinson was of a ‘marked neurasthenic type’ and exhibited a ‘hypochondriac type

of personality – rather an “old womanish” type’. In the words of the Medical Board in January 1936, Hopkinson was a ‘man of sensitive temperament, not a good type’, perhaps an allusion to his homosexuality.

At the very least, pension officials concluded, Hopkinson’s psychoneurosis was ‘constitutional’ and therefore not eligible for financial compensation. When Hopkinson complained about agonisingly painful hands (after spending decades using crutches, his hands looked like ‘discoloured raw beef’), the Medical Officer concluded that the root cause of his disorder was Hopkinson’s ‘general nervous disposition’. For Hopkinson, it must have seemed like he was caught in an impossible bind: his suffering either pre-existed the war or was constitutional. It was as if the war never happened.

The chief problem for Hopkinson was that he was confronting deeply embedded clinical beliefs about stump and phantom pains. From the late-1930s onwards, it was widely assumed that these pains were neurotic in nature. At the hospital where Hopkinson received most of his treatment – Queen Mary’s Hospital at Roehampton – R.D. Langdale Kelham concluded that the typical phantom limb patient was

more often than not a person with an unsatisfactory personality. It may be he is an anxious, introspective, dissatisfied, ineffective [*sic*] who, becoming obsessed by his symptoms, and brooding upon them and his disability, tends to dramatise their degree, using undoubted exaggerations in his description of his sufferings. (*Artificial Limbs in the Rehabilitation of the Disabled*, London: HMSO, 1957, pp.131–139)

Kelham’s assessment dominated the field. Only rarely did physicians suggest the opposite causality – in other words, that chronic pain might *lead* to psychological distress, rather than being *caused* by it.

Hopkinson ended up being treated by physicians on both sides of a major divide in the treatment of chronic pain – in shorthand, this was the difference between those who focused on the brain’s reaction to painful stimuli (‘centralists’ or cerebralists) and those who were peripheralists (the painful sensations originated from ‘excitation of nerve ends’ in the scar or stump).

Cerebral theorists placed their bets on the efficacy of neurosurgery. In 1943 Geoffrey Jefferson, the doyen of neurosurgeons, examined Hopkinson.

He offered Hopkinson a radical treatment: chordotomy (also spelt cordotomy). This involved dividing the pain pathways in the spinal cord, thus ‘interrupting the pathways of the painful impulses in order to abolish or modify their effects on the sensorium, either before they reach it or in the brain itself’ (Lambert Rogers, ‘Refresher course for general practitioners: The surgical relief of pain’, *British Medical Journal*, 16 August 1952, p.383). Many neurosurgeons believed it could reduce or even eliminate intractable pain.

A particularly eloquent defence of chordotomy was mounted by Murray A. Falconer, the director of Guy’s-Maudsley Neurosurgical Unit. For Falconer, the effectiveness of the treatment was itself proof that phantom limb pain was not ‘a psychological disturbance’. When it

“their inability to solve his crises eventually led each of them to turn away”

was suggested that performing a major operation might itself be curative for *psychological* reasons, Falconer was dismissive: ‘I find it difficult to believe’, he scoffed, ‘that in my hands antero-lateral chordotomy acted as a psycho-therapeutic procedure, when previous operative procedures on the stump had failed to give relief’ (*British Medical Journal*, 7 February 1953, p.301).

When told of the operation’s distressing side-effects, including weakened sphincter control, Hopkinson decided to try physical, or ‘peripheralist’, forms of treatment for his phantom pains. In the 1930s and 1940s, therefore, he tried anodal galvanism or electricity treatment. In the 1950s, he opted for percussion therapy, that is, thumping his painful stump with a mallet and wooden peg. In the words of the neurologist W. Ritchie Russell, of the United Oxford Hospitals, with percussion therapy a patient would learn to ‘knock away his phantom pain whenever it was troublesome’ (*British Medical Journal*, 11 June 1949, pp.1024–1026.)

The failure of all these treatments led both Russell and Leon Gillis, the author of the highly influential 1954 book *Amputations*, to reconsider Hopkinson’s case. Gillis believed that treatment needed to encompass ‘psychological as well as physiological factors’ (p.339). He noted that Hopkinson’s stump and phantom pain worsened when he was upset or when he heard people singing hymns.

Russell went even further. He argued that it made ‘no sense saying that one pain is functional and one organic’ because ‘all pains are both physiologically determined and functionally graded

according to a wide variety of personal factors’. Even when the pain was largely the result of emotional factors, physical treatments might work. This was why he was willing to endorse ‘old methods of treating pain with electricity’ since, at the very least, it would provide ‘a physiological distraction’ that might actually reduce suffering. Russell believed that ‘the successful therapist for intractable pain treats the problem like a game in which he endeavours to outmanoeuvre the tricks played by the C.N.S. [central nervous system] of his patient’. He had no scruples in encouraging therapists to use ‘the deception of the poker player and the confidence of the quack’. To those critics who believed that he was ‘too optimistic’ about curing chronic pain, his response was simple: ‘I think it important to be over-confident in treating pain, so I make no apology’ (*Proceedings of the Royal Society of Medicine*, 52 (1959), pp.984–987).

Unfortunately, Hopkinson was too disillusioned and too disenchanted to believe in any positive outcome. He died on 17 December 1974.

Hopkinson’s war lasted 57 years. Although his symptoms changed relatively little throughout his life, his sufferings cannot be summarised under any single headings. His pain was acute, chronic, physiological, psychological, and emotional; it gripped him within hospital wards and when he was ‘sitting alone in my Bedroom’. On the surface, Hopkinson should have been able to elicit sympathy: he was a white male who had been born into a privileged family and had served as an officer in war. In fact, his class-status was a further cause for agony: as one doctor reported,

The officer is a man of sensitive temperament and a loss of his leg affects him more than one of coarser fibre. He... hates people looking at him and sympathizing with him.

Those physicians who witnessed his pain often attempted to sympathise and provide succour but their inability to solve his crises eventually led each of them to turn away – sometimes in despair; other times, in annoyance. The invisibility of his wound – his stump seemed to be ‘normal’ and the limb that burned like fire did not exist – trumped all scientific theorising. But his suffering was anything but ‘phantom’.

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