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**Out of Sight, Out of Mind: Reflections from the Covid Era on Social Knowledge
and Medical Thinking in Adolf Lukas Vischer's 'Barbed Wire Disease'***

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Abstract

This article explores the relationship between the camp experience and the production of medical knowledge through the phenomenon of 'barbed wire disease'. This was a term used by First World War POWs and internees themselves to describe symptoms of depression and related neurological disorders. The Swiss surgeon Adolf Lukas Vischer borrowed it for the title of a book he wrote in 1918 suggesting that the spatial and temporal peculiarities of camp life made prolonged captivity in such an environment inhumane and a threat to future societal stability. The article argues that Vischer's findings should be seen through the lens of historical time. His observations led him to draw attention to the contemporaneous plight of previously highly mobile and self-reliant migrants across the world now living for an unknown duration within the confines of the barbed wire. Yet equally, the article makes the case for thinking in a transhistorical way about the (often under-appreciated) mutual interdependence of social knowledge and medical thinking, especially in times of large-scale displacement. The shadow of the past, it will be suggested, continues to shape approaches to the mental health problems faced by people living in atypical temporal and spatial settings today, including those experiencing the symptoms of Long Covid and those held in immigration detention.

Key Words Adolf Lukas Vischer; immigration detention; First World War; Long Covid; prisoners of war

Word Count 14,856

In the autumn and early winter months of 1917 we were again plagued by the question of the ending of the War and of peace. Not that we had ever been able to free ourselves from such thoughts during our whole imprisonment. Our fate was so dependent on the War that forgetfulness of it could only be... momentary... No one stood by us; and everything, the dark, underground dwellings, the wretchedness of our companions, our mauled letters and pilfered parcels, every smallest sign emphasised that haunting horror which forced its way into our most secret parts, stole into our dreams, and against which we had to ceaselessly struggle.¹

These words feature at the start of the twentieth chapter of the Hungarian-Transylvanian writer Aladár Kuncz's memoir *Black Monastery* (*Fekete kolostor*), which first appeared in Hungarian in May 1931, shortly before his death, and subsequently in English and French translations. The publication is an account of Kuncz's five years as a civilian internee following his arrest as an enemy alien in France in August 1914, where he was staying as a tourist. He spent most of the war in two camps on islands just off the French North Atlantic coast: from October 1914 to July 1916 at Noirmoutier and from July 1916 to April 1919 at the citadel on the Ile d'Yeu. His claim that the last months of 1917 were the point at which long-term prisoners reached 'the edge of the abyss' as far as their mental health was concerned is interesting because it tallies with observations made by the Swiss surgeon and medical inspector Adolf Lukas Vischer at the British-run camp at Knockaloe on the Isle of Man, which he visited on three separate occasions during that year.² Both men agreed that rumours of imminent exchanges of particular categories of older prisoner—and even the removal of some of those selected to transit camps—was partly responsible for the spread of 'barbed wire disease'. Known as *Stacheldrahtkrankheit* in German, this was a term invented by prisoners to describe a variety of psychological and neurological problems they observed in themselves and each other. According to Kuncz:

The number of serious nerve cases increased in that fourth winter. Two Germans went raving mad. They were taken to a French lunatic asylum, and there they died. The other cases were only wrecks, but apparently there was enough life in them to prevent them being sent home... one who seemed a hopeless case... was seized by such persecution-mania that he refused to eat... [and] had to be fed forcibly, or... induced... to take the food of his own accord.³

This article seeks to understand how knowledge of 'barbed wire disease' spread across the military and civilian POW camps of Switzerland, France, Germany and Britain in the years 1916-19 and to

relate this social knowledge to campaigns by the International Committee of the Red Cross (ICRC) and other humanitarian bodies to expand exchange schemes and get more prisoners home.⁴ While taking care not to draw direct parallels, especially when it comes to modelling causes and rates of 'infection', the article also explores similarities between the 'barbed wire disease' endured by prisoners of war and civilian internees in the twentieth century and the experiences of Long Covid sufferers, the often forgotten illness of the post-Covid 19 era. Such similarities, I will show, lie in downstream neurological or psychological symptoms, including 'brain fog' or memory loss; attention problems; anxiety and depression; and insomnia. They also appear in the communicative realm of historical experience and expectation, as seen in difficulties in transitioning from one stage of the condition to another; uncertainty as to its duration, scale and potential financial costs; and paranoia or resentment among patients who feel that they are disbelieved or not taken seriously by members of the medical profession, employers, welfare officials and/or other figures of authority.

Some of the symptoms of today's Long Covid, such as joint pain, breathlessness or loss of smell and taste were admittedly not present in prisoners suffering from 'barbed wire disease'.⁵ Furthermore, to use concepts developed by the German cultural theorist Reinhart Koselleck, the two conditions emerged in historically very different temporal and spatial worlds.⁶ Focusing on similarities, then, should come with a stiff health warning against drawing false equivalences that are medically illiterate and historically inaccurate (or both). And yet, as I shall argue, it should not be imagined that investigating the spread of social knowledge about medical conditions across historical boundaries is a redundant exercise; in fact, it has and can benefit current clinical practice, including in the spheres of psychology and neurology, not least, as Mark Honigsbaum has recently argued, because it forces us to recognise that 'infectious diseases nearly always have wider environmental and social causes' and consequences.⁷ Equally we can learn a lot about the effects and after-effects of captivity by investigating how societies and particular groups have tried to come to terms with the social impact of pandemics and their aftermaths. Methodologically speaking, this might also mean following British historian David Vincent's call to 'explore the tension between the evidential record and the imaginative challenge of describing the intensity of human suffering'.⁸

Towards the end of the article, I will come back to the question whether 'barbed wire disease' really was, as Vischer claimed, 'infectious', and if so, in what sense. I will also make the case for seeing captivity as a metaphor for the social experience of Long Covid sufferers, and suggest that

heuristically, this is a better approach to follow than drawing direct parallels with ‘barbed wire disease’ as an illness. In other words, I will argue that Long Covid should be seen as the transhistorical equivalent not of ‘barbed wire disease’ itself, but of the captor state and its medical experts. However, first it will be necessary to look in more detail at how the latter was represented in scientific literature, and the shadow such writings throw over the treatment of Long Covid and other post-viral illnesses today. This will be followed by a short biographical section on Vischer, a section on the social and historical context of knowledge transfer of prisoners’ experiences with ‘barbed wire disease’, and a section considering how ‘barbed wire disease’ was entangled with contemporaneous knowledge of camps as exceptional spaces governed by exceptional temporalities.⁹

‘Barbed Wire Disease’ and the Past and Present Influence of ‘False Ideation’ Models

Historically, ‘barbed wire disease’ was a term used by internees and prisoners themselves to describe feelings of depression and related neurological disorders, such as memory loss and inability to concentrate, whilst in captivity. It was also coopted as the title for a book by Vischer written in 1918.¹⁰ According to the latter, ‘barbed wire disease’ was used interchangeably by POWs with other terms such as *le cafard* (by the French), *grauer Vogel* (by the Germans) and ‘nerves’ (by the British).¹¹ Prisoners suffered from it at ‘many degrees, varying from the very excited to the introspective, apathetic condition’. However, very few ‘who have been over six months in the camp are quite free from it’.¹² Judging by his own observations, Vischer estimated that ‘severer cases’ amounted to about one in ten.¹³ Furthermore,

the treatment of prisoners has but little influence on their mental condition. Brutal treatment does not produce the disease, neither does good treatment prevent it... Even a beautifully situated camp is no preventive... The disease is not cured by mere release from imprisonment.¹⁴

Long Covid can be described clinically as a ‘long-term consequence of SARS-CoV-2 infection, lasting beyond the initial “acute” phase of infection, affecting multiple bodily organs and systems, causing a huge variety of symptoms of varying severity and duration, and potentially relapsing and remitting over time’.¹⁵ For the purpose of this article, we will be interested in the neurological and mental health aspects only, while recognising that it is a ‘biological illness... not psychological in origin’, and that its symptoms are not ‘a consequence of pre-existing anxiety or depression’. Currently about one in five

sufferers are estimated to be in the category 'severe' when it comes to the psychological impacts of Long Covid.¹⁶ This is important because, as the authors Gez Medinger and Danny Altmann have recently argued, 'the emotional assault delivered by Long Covid can be just as intense as the physical one'.¹⁷

In a recent article in the British *Guardian* newspaper, Devi Sridhar, Professor of Public Health at the University of Edinburgh, also notes that 'Clinicians... have made less progress on helping [patients] with Long Covid' and compares this with the considerable advances made in understanding the variants and sub-variants of the Sars-CoV-2 virus itself. However, she concedes that 'research to understand the underlying biology [of Long Covid] and how to develop treatments... is under way'.¹⁸ Much less progress has been made towards an understanding of the social experience of Long Covid and its impact on mental health. However, to quote David Vincent again, we can find here a 'practical function' for social history, namely to 'educat[e] [medical experts], politicians and administrators about the societies they find themselves in when [epidemiological and other] disaster[s] occur'.¹⁹ In particular, conceptualising medical experts as historical beings can help us to appreciate more keenly that scientific advances, while extremely important, do not take place in a timeless and spaceless bubble. The past and present societies which continuously reproduce the material and cultural conditions that shape the spread of infectious diseases, generate new medical knowledge about relief, prevention and cures, and frame patients' experiences and expectations of illness, remission and recovery, are all structured within particular spatiotemporal settings. Understanding this is vital to the broader social project of patient advocacy and promotion of patients' rights. Or to put it more concretely, whilst in Vincent's words the 'initial effect of the [Covid-19] crisis' was to 'concentrate effort and expenditure on hospital-based physiological medicine' and, at least in the UK, to heighten 'the underfunding of mental health and related social services... throughout the previous decade', this is still open to social and political challenge going forward, including through consciousness-raising about the past.²⁰

Interestingly, both 'barbed wire disease' and Long Covid, while very different in respect to causes, have a history rooted in assumptions by doctors that patients were experiencing 'false ideation about having an organic illness'.²¹ For Long Covid, this can be traced back to theories developed in the 1980s and early 1990s about the causes of ME (Myalgic Encephalomyelitis or Chronic Fatigue Syndrome). Regarding 'barbed wire disease', the thesis of 'false ideation' can be

linked to observations by members of medical commissions during the early prisoner exchange programmes (before 'barbed wire disease' itself was recognised as one of the illnesses which might qualify a prisoner for transfer to Switzerland or another neutral country). The French-Swiss doctor Charles Julliard even published a case study in July 1917 of an Austrian civilian internee he had treated in a military hospital in France in 1916. His symptoms were 'unexplained', but included vague pains, headaches and insomnia. Julliard argued that he was suffering from a mental condition analogous to the 'pension neurosis' or *Rentenkampfnervose* which pre-war doctors had observed among workers who had tried to make claims against accident insurance schemes.²² The closer they got to receiving compensation, the worse their symptoms became. Likewise, the nearer a prisoner came to persuading a medical commission to grant them repatriation, the more they seemed to suffer from unexplained ailments. Julliard gave this form of 'compensation sickness' a new name, 'La Captivitose', and recommended that the only possible cure was to tell the patient in clear-cut terms that they would not be repatriated. Once they had accepted this, the symptoms would disappear.²³

The 'false ideation' theory has been, and continues to be, very influential in medical circles. Julliard and other Swiss doctors working on military commissions after 1916 even portrayed it as a more humane diagnosis than straightforward 'malingering', because it acknowledged that the patient's symptoms were not being faked but were the result of unconscious processes. The harsher alternative was to be found all over war-torn Europe, including, for instance, in Austria-Hungary, where members of the psychiatric section of the common Ministry of War's *Militär-Sanitäts-Komitee* believed that 'there was practically no difference between a malingerer and a neurotic'.²⁴ Yet even here, as Maciej Górny has shown, 'the year 1917 marked both a climax and a serious crisis in... war psychiatry', encouraging specialists at the periphery of the crumbling empire to develop alternative discourses about 'healthy nerves' among the Dual Monarchy's subject nationalities in contrast to the alleged decadence of the imperial administration in Vienna.²⁵

In fact, the question of which nationalities had the most robust mental constitutions became an important political as well as medical issue in 1917 as both sides in the war showed signs of wavering in their commitment to fight on to outright victory. As Laurina Stryker has demonstrated in the case of British attitudes towards shellshock, citing involuntary or *unconscious* causes of 'hysterical' symptoms such as blindness, paralysis or mutism, served a hidden nation-building purpose, namely to demonstrate the existence of a 'potent underlying commitment to ideals of

courage and duty' which was merely being blocked by something beyond the patient's control.²⁶ In Germany too, according to Benjamin Ziemann, the 'changing representation of politics' during the war was grounded in a 'dramatized narrative centered around the notions of sacrifice and fate'. This meant that explanations of nervous disorder linked to unconscious obstacles to accepting the necessity of sacrifice and the unavailability of fate were popular because they shored up a mythologised notion of organic unity through a strong people's community (*Volksgemeinschaft*).²⁷ And failing that, emphasis on 'healthy nerves' and 'undefeated warriors' at least helped to overcome what Brian Feltman has referred to as the 'stigma of surrender', both in relation to POWs and in relation to the German nation as a whole.²⁸

Yet as this article will demonstrate, beyond these often-recycled myths, 'barbed wire disease', like shellshock, was a 'disability that affected real lives and caused lasting damage' with symptoms enduring 'long after the end of the war'.²⁹ Furthermore it will establish that the 'false ideation' explanation, just like the label 'malingerer', was resisted by internees and prisoners as well as by sympathetic physicians like Vischer. The latter developed what today we would call a more 'patient-centred' approach, one that involved listening to prisoners' *conscious* explanations of their symptoms and related experiences of camp life and reading their self-published journals. His work also challenged many of the cultural representations of captivity being constructed outside the camps. In so far as it was aimed at psychologists and neurological experts, its purpose was to bring about a shift in social awareness and disposition towards patients rather than to influence clinical practice directly. However, so long as we acknowledge the contemporaneous political motives behind it, Vischer's approach to 'barbed wire disease' can also help to inform new ways of conceptualising Long Covid today as a societal as well as medical phenomenon.

Adolf Lukas Vischer³⁰

Adolf Lukas Vischer was born in Basel, Switzerland, in 1884 and in the opening years of the twentieth century trained as a surgeon in his hometown as well as in Munich and London. In November 1912 he conducted his debut mission abroad with the ICRC. His destination was Macedonia, where he undertook field surgery on the Serb side during the First Balkan War, including at the Battle of Monastir; this was followed by a trip to inspect camps for Turkish and Indian POWs in Mesopotamia in 1916. In the same year he became a visiting doctor to military internees held in neutral Switzerland

under bilateral agreements between the western belligerents, and, together with clinical neurologist Robert Bing, conducted a study of British, French and Belgian patients at the *Etablissement sanitaire des Armées pour internés* in Fribourg.³¹

In 1917-18 he was seconded to the Swiss legation in London, where he carried out inspections of various military camps, hospitals and asylums on the British mainland and at Oldcastle in Co. Meath, Ireland. Vischer's most important journeys, however, were to visit the German, Austro-Hungarian, Bulgarian and Turkish civilian prisoners held in camps at Douglas and Knockaloe on the Isle of Man. He travelled there no less than three times, and on the third trip, in November 1917, stayed for five days inside the Knockaloe camp, then home to 18,441 internees, observing aspects of their mental well-being. This was to be one of the key sources for his book on 'barbed wire disease'.

The study was published in German in late 1918 and then in English translation in early 1919, with an introduction by the British-American clinical neurologist Samuel Alexander Kinnier Wilson (see figures 1 and 2). Reviewed rather blandly in the *British Medical Journal* (BMJ) in July 1919,³² it is occasionally cited in medical literature and, more often, in historical accounts, but usually in very general and sometimes inaccurate terms. The army medical officer and exchanged POW Philip Newman, for instance, wrote at the beginning of an article published in the BMJ in 1944:

Vischer's small book... deals briefly with the factors producing ['barbed wire disease']... and with the prisoner's reaction to his environment during prison life. Dr Vischer was a visiting doctor in German prisoner-of-war camps during the last war; he drew his conclusions not as a prisoner of war but as a psychologist studying a series of patients. His experience was vast, and his conclusions were drawn from an immense amount of data.³³

In fact, as Vischer strongly emphasised in the book, he was not a psychologist but a surgeon. He had 'no claim to an exceptional knowledge of mental disease'.³⁴ His perspective was that of a camp visitor, not a specialist.³⁵ He made no systematic collection of data but relied largely on conversations with prisoners and his own observations. Psychologists and neurologists were generally sceptical of his claims that 'barbed wire disease' was the norm for (almost) all civilian and military prisoners who had spent over six months in captivity. Quakers and other humanitarian groups were also affronted by his above-cited claim that 'acts of kindness', such as gifts of books, board games, sports equipment and materials for craft making, did not help to alleviate symptoms.³⁶ Once back in Basel, Vischer published one more study, on the psychology of transitional moments from captivity to freedom,³⁷ but

then made a major career switch in the 1920s, from surgery to gerontology. His many works on the ageing process were again originally published in German but often translated into English. He died in Basel in 1974.

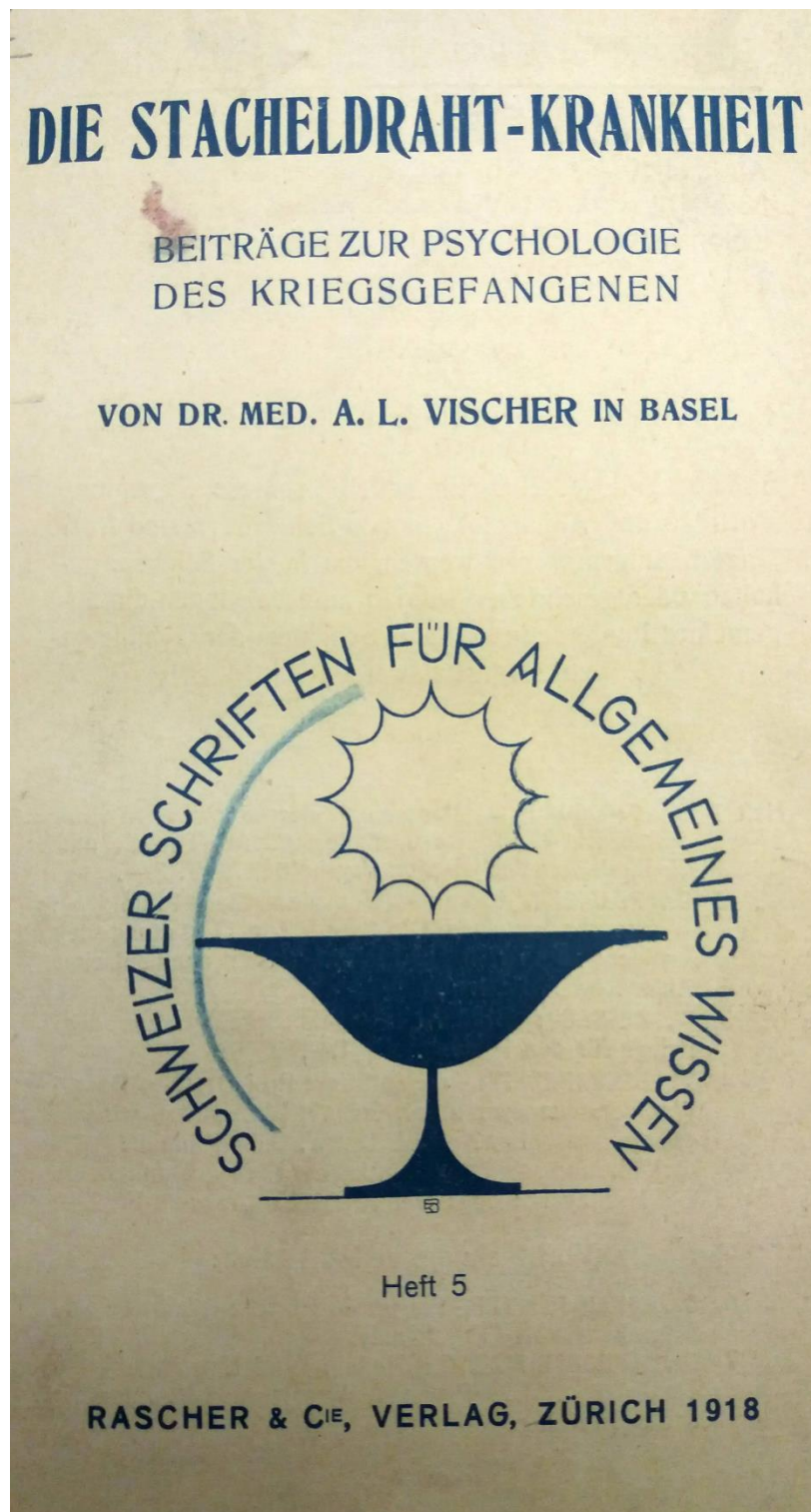


Figure 1: Front cover of the original German-language edition of Vischer's book (1918)

BARBED WIRE DISEASE :

A Psychological Study
of the Prisoner of War

BY

A. L. VISCHER,
M.D. Basle, M.R.C.S. Eng.

Translated from the German, with Additions by the Author

With an Introductory Chapter by
S. A. KINNIER WILSON,
M.A., B.Sc., M.D. Ed., F.R.C.P. Lond.

And a Frontispiece by
Miss E. FORTESCUE-BRICKDALE



LONDON :
JOHN BALE, SONS & DANIELSSON, LTD.
Oxford House
89-91, GREAT TITCHFIELD STREET, W. 1
1919

Figure 2: Title page of the English-language edition of Vischer's book (1919)

Knowledge Transfer in Historical and Social Context

The prevalence of mental illness among civilian internees and military POWs during the First World War began to receive attention from psychologists and neurologists from 1916 onwards, but not enough to ensure that bespoke measures were put in place to reintegrate them into society as a group. The usual assumption among military officials was that captivity cured neurosis by taking soldiers away from the chief cause of their 'nerves', namely proximity to artillery fire.³⁸ They did not think about civilian prisoners at all, because they believed that neurosis in men could only be related to battlefield experience or trauma due to physical accidents. Meanwhile in hospitals on the home fronts, where civilian and military doctors both worked, identification of the long-term special medical needs of all acutely unwell veterans and non-combatants was based on what Fiona Reid calls the 'iconic wounds' of the 1914-18 period—gas, shellshock and facial injuries.³⁹ This has also filtered through into the historiography, so that a considerable number of the most well-received books on the history of war and trauma in the 1914-18 period have little or nothing to say about POWs.⁴⁰ This is in spite of the strong evidence of mental health problems relating specifically to captivity that can be found in war pension files, and pay-outs made to individuals affected, albeit on a case-by-case basis and not to POWs as a category. As the medical historians Edgar Jones and Simon Wessely explain:

After the Armistice, large numbers of British veterans who had been POWs were granted financial compensation and their medical records revealed the existence of psychological symptoms. Indeed, doctors examining repatriated veterans at post-war boards often diagnosed them as suffering from neurasthenia or disordered action of the heart (DAH), illnesses which ran counter to the hypothesis that captivity protected against neurosis.⁴¹

Scientists differed from military officials. But even when they did turn their attention to POWs, their findings were often influenced by domestic political pressures too. For instance, a congress held by the German Neurological Society in Munich in September 1916 concluded that British and French POWs were largely free of the kind of 'hysteria' that produced shellshock. However, the participants went on to use this finding to boost their main contention that 'the majority of [German] war neurotics were fakers', an argument whose double-edged meaning for German nationhood remained unmentioned. Instead, the apparent contentment of British and French prisoners in German captivity was emphasised, leading to the conclusion that exposure to shell fire, particularly in short bursts of service at the front, did no permanent damage to nerves. Even so, the conference participants could

not agree on whether shellshock should be regarded as a deliberate form of malingering warranting disciplinary action, or as an unconscious 'flight into illness' which was best cured by active medical treatment.⁴²

Similar controversies took place among psychologists and neurologists in Britain with views shifting away from the 'malingering' thesis by 1917, according to Joanna Bourke.⁴³ It was largely in Switzerland, however, that medical experts came to consider captivity as a subject that mattered in its own right, not because of the existence of a broader set of questions about how cases of 'nervous exhaustion' should be interpreted in the context of ongoing war. Vischer and Julliard, for instance, differed greatly in their assessment of the causes of mental ill-health among soldiers and civilians in British, French and Swiss captivity, and even in their choice of terminology, with Vischer rejecting Julliard's reading of *La Captivité* as a straightforward variant of neurasthenia. Where they both agreed, however, and where they differed from their Munich colleagues, was in their common belief that the 'mentality of the prisoner is based on social and historical conditions'—not on mere physical removal from active combat.⁴⁴ In other words, they both followed the methods, if not the findings, of the American neurologist George Beard, who argued in 1869 that neurasthenia—a label invented by the latter to describe a new form of 'nervous exhaustion' among American businessmen—could only take root 'due to the unprecedented demands on the nervous system imposed by modern living'.⁴⁵

Beard's influence on the series of debates about neurasthenia that took place in Germany between the 1870s and 1900s was profound, leading Joachim Radkau to speak of 'the nervous age'.⁴⁶ And an intellectual inheritance such as this—rejecting as it did the older 'premise of a [natural or unchanging] psycho-biological continuum'⁴⁷—raises an important set of questions about how medical experts like Julliard and Vischer conceptualised the relationship between modernity and First World War captivity. Did they, in fact, link cases of war neurosis, like Franz Kafka, then employed by the Prague-based Bohemian Workers' Accident Insurance Institute, did in two public letters in 1916, to 'modernity's mechanization, speed, and industrial violence'?⁴⁸ The answer is yes, albeit with the important qualification that they located the causes in some of the ostensibly benign aspects of contemporary liberal internationalism and humanitarianism too.

One point that both Vischer and Julliard made was that (military) POWs from 'civilised' countries had formal protections under international law, and furthermore, that awareness of these rights was widespread in the belligerent armies, thanks partly to the efforts of the Swiss government

and the ICRC. Under the Geneva conventions of 1864 and 1906, all military captives were granted the same standards of food, clothing and medical attention as provided to soldiers of the captor state. Those of officer rank could not be required to work, so that boredom and monotony might become a problem. And for all ranks, including officers, captivity was rendered provisional in a temporal sense, as belligerents had a binding obligation to repatriate prisoners at the end of hostilities.⁴⁹

Of course, there were numerous cases during the war when these rules were not adhered to. One example among many would be the forced work battalions operating behind the lines on the western front, as Heather Jones has shown.⁵⁰ Cases of deliberate prisoner killing immediately after surrender, although less frequent than sometimes imagined, have also been documented.⁵¹ Sometimes belligerent powers deliberately took reprisals against military and civilian prisoners after receiving reports of brutal treatment of their own nationals in enemy hands.⁵² However, in the kind of home front camps and military hospitals visited by Julliard and Vischer in France and Britain, such reprisals were rare. In general, the prisoners were treated in accordance with international conventions. This applied even more to those held in neutral Swiss captivity.⁵³

Alongside these formal provisions, there were also informal protections for both military POWs and civilian internees. With some exceptions, most belligerents allowed the ICRC and protecting powers to undertake inspections of civilian as well as military camps on the home fronts. In line with the Geneva conventions, a great deal of interest was shown by visitors in nutritional standards and hospital facilities.⁵⁴ By early 1917 at the latest, as a report on the welfare of European and Indian prisoners in Turkish camps written for the ICRC by Vischer and another Swiss physician, Alfred Boissier, indicates, prisoners' mental health was also being raised as a matter of humanitarian concern as well as scientific interest in medicalised understandings of captivity.⁵⁵ Alongside this, prisoners belonging to larger and undefeated countries enjoyed the benefits of the *Gegenseitigkeitsprinzip* or reciprocity principle. In other words, they were protected against abuses by dint of the enemy's fear that this might lead to reprisals against their own nationals.⁵⁶ And finally, sick and ill prisoners might benefit from bilateral exchange agreements between belligerents, with the ICRC, although always denied a direct role in diplomatic negotiations, nonetheless being able to exert some form of 'soft power' influence on outcomes through its acknowledged expertise about conditions in captivity. Reciprocal accords between enemy states for the release of *grands blessés* or severely wounded were already signed in 1915 and involved direct repatriation to the prisoner's country of

origin, on the understanding that they were permanently unfit for military service. By 1916 several countries had also negotiated agreements for the transfer of certain categories of *petits blessés* into neutral captivity. If after three months there were no improvements in their health, they could apply for full repatriation; in case their health did improve, they would have to sit out the war in Switzerland. And under the Anglo-German agreement signed at The Hague on 2 July 1917, 'barbed wire disease' itself was cited as the only mental health condition, alongside several physical illnesses, that would qualify a military or civilian prisoner for transfer into internment in Switzerland or another neutral country.⁵⁷

For Julliard, the rights afforded to POWs, especially when it came to exchanges, raised the same kind of 'problems' as the rights afforded to workers under pre-war accident insurance schemes in Switzerland and Germany. The concept of 'pension neurosis' (*Rentenkampfneurose* or literally, fight-for-compensation neurosis) was already well known to many doctors (and insurance companies) before 1914.⁵⁸ Julliard's study of the Austrian patient in a French military hospital thus took up a pre-war theme. As Fiona Reid suggests, class was a key factor here, as doctors working for insurance schemes typically associated 'feckless[ness]', whether in the workplace or on the battlefield, with 'ineffectual working-class males'.⁵⁹ This in turn was linked to broader debates about the racial 'fitness' of the urban poor emerging from the eugenics movement, and in Britain from fears generated by the ill-health of army recruits at the time of the second Anglo-Boer War (1899-1902).⁶⁰

For Vischer, on the other hand, formal and informal protections for POWs and civilian internees had more nuanced implications. On the positive side, most prisoners, or at least those in home front camps, would survive captivity. With some exceptions, they would receive post and therefore news and extra food and other comforts from families and charities at home, a source of both conditional enjoyment and endless worry for prisoners. They could not be punished collectively for offences committed by individuals, and they were entitled to have their religious and educational needs respected. In other words, Vischer would not have recognised the Italian philosopher Giorgio Agamben's claim that First World War camps were a modern laboratory for the production of 'bare life'—life that was neither worth saving nor worth ending.⁶¹ Nor could he have imagined the existence, or to use a less essentialising term, the Europe-wide invention of the so-called *Muselmänner*, those concentration camp inmates of the Second World War era, who, suffering from physical exhaustion,

starvation, regular beatings and lack of any news from loved ones, were resigned to death but had not yet died or been killed.⁶²

On the other hand, Vischer saw that rights could also present new burdens for prisoners of war, especially for those who had previously been in good health. It demonstrated that long periods of captivity were very much survivable in a physical sense. Yet it also meant that prisoners knew that their ordeal, however long it lasted, was still restricted in temporal terms. The fighting, and thus their time in captivity, would end one day. As Kuncz observed in the quote at the beginning of this article, military POWs and civilian internees were highly dependent on the outcome of the war. Yet they felt powerless, in their current situation, to do anything to influence that outcome. For those who had imbibed the message that the war ‘threaten[ed] every citizen and the integrity of the nation itself’—a historically contingent way of viewing war going back to the beginnings of the modern democratic age in the early years of the French Revolution and rearing its head again in many countries in 1914—this was especially hard to bear.⁶³ ‘Every citizen’ also meant every family member. And the war would not wait until their release. Battles needed to be won now, whether on the home fronts or the fighting fronts. Families had to be fed and clothed immediately, not just when the prisoners came home. As Vischer noted about the receipt of correspondence from home, this was indeed a right but also a torment:

A considerable part of the prisoner’s mind is occupied in waiting for home news, for letters and parcels that mostly appear at irregular intervals. The restrictions on his usual habits continually obtrude themselves on his consciousness in all possible ways, and finally occupy his whole mental life.⁶⁴

The notion of fully or relatively healthy prisoners being forced to wait out the war in inactivity also explains why the second half of 1917 was particularly important in the development of knowledge of ‘barbed wire disease’. The events that immediately preceded the coming of the fourth winter of the war—the Reichstag Peace Resolution in Germany, the Papal Peace Note, the Bolshevik revolution in Russia, the Italian defeat at Caporetto, the publication of former War and Foreign Minister Lord Landsdowne’s letter in the *Daily Telegraph* openly questioning whether victory was worth it at any cost—all suggested that a negotiated end to the war might be near. The same applied to prisoner exchanges which were beginning to be implemented on a larger scale in the second half of 1917. In

his book, probably drawing on a specific observation he had made at Knockaloe in November 1917, Vischer wrote:

In one civilian camp th[e] rumour [of an imminent exchange] was so persistently asserted that many of the prisoners started to pack their trunks for fear of being late; others bade each other farewell, even in the middle of the night. This is an instance, not only of talk in common, but of emotion in common, at work.⁶⁵

A second aspect of the cross-over between 'modern life' and First World War POW and internment camps that both Julliard and Vischer picked up on was the sheer diversity of camp populations. People of all nationalities, cultures, languages, classes, ethnicities and skin colours could end up in wartime captivity, an observation that applies especially to civilian internment.⁶⁶ For Julliard, this diversity simply made it statistically more likely that one or two individuals of 'abnormal' personality would find themselves in captivity. The prospect of mitigating certain aspects of their ordeal, or even getting a 'free pass' home, would trigger their unconscious into producing physical symptoms that mirrored their neurotic makeup. What mattered, in other words, was the individual's predisposition towards 'nerves' prior to captivity, not the temporal and spatial peculiarities of captivity itself.

As the above quote indicates, Vischer may have felt sympathy for the plight of individual prisoners but was chiefly interested in how the camp, as a historically contingent institution, produced 'emotion in common' from what, at the beginning of their incarceration, was an extremely diverse group of people. Transmission-wise this was analogous to, but of course biologically not the same as, viral infection. For him, one of the modern features of First World War internment was that it was rooted as much in movement of peoples as it was in their institutionalisation. Civilian camps contained many recently arrived immigrants whose country of origin was now at war with their country of residence and who were especially 'unprepared for camp life'. This was the case in particular

... among... individuals with self-reliant independent characters, such as are so often met with among civilian prisoners. These are often people who have emigrated in order to strike out a new career and develop unrestricted their own individuality. To such people, restraint comes very much harder than to officers and men who by their barrack life are prepared to some extent for a cramped and herded existence. Here the levelling influence of the uniform with its exclusion of individuality stands its bearer in good stead.⁶⁷

Historical context is crucial here. Indeed, as Konrad H. Jarausch notes in the introduction to his history of the twentieth century, 'the growing restlessness of Europeans' in the period 1900-14 was an 'important psychological motivation for their dynamism'. In particular it led them to seek ever 'greater opportunity' for travel abroad and other means of 'better[ing] themselves'.⁶⁸ Incarceration behind barbed wire presented significant physical and psychological barriers to the continued pursuit of this enterprising spirit, without offering any 'cure' for the heightened levels of nervous energy that was said to be the primary cause of the post-1890s inability to rest. Some military men, conscripts or volunteers, may also have seen life in the army itself as a chance for self-improvement and travel, leading them to find it equally hard as civilians to adjust to the temporal and spatial restrictions of the camp environment. Tellingly, one German lieutenant confided in his diary in 1917, a year or so after his capture by the British, that what he and his fellow officers found especially difficult about indefinite captivity was that when the 'barbed wire madness' hit them, 'no amount of energy can help—everything slowly but fatally leads to the same delirium'.⁶⁹

However, Vischer was not only interested in how internment impacted on those whose former—and relatively privileged—life situation had been built upon individual aspiration and personal choice. The less well off, including many immigrants, who, prior to wartime captivity as soldiers or 'enemy aliens' had worked in the de-personalised and de-personalising industrial economy, were equally likely to be affected. This was because factory life 'proceeds so joylessly and monotonously' and, like the prison camps, involved 'herded existence with chance acquaintances'. Furthermore, and again like internment, it was inimical to rest, which was what returning POWs and internees most needed.⁷⁰ Citing the pre-war work of the German psychologist Willy Hellpach (who became Minister-President of the state of Baden in the 1920s), he noted that Marxism grew out of the negative spiritual conditions engendered by 'certain conditions of life' experienced by the modern worker. But he elaborated on this by also arguing that 'barbed wire disease' constituted a distinct type of modern illness that resulted directly from the hardships of captivity:

In no class of life are the conditions so monotonous as the proletariat. For that reason, the spiritual life is always the same and the psychical life remains unchanged. This phenomenon, which affects the proletariat so generally and which among them is not so easy to recognise, takes a transparent form among prisoners of war. For they are all subjected to the same conditions of life, giving rise to the same factors transforming their mental existence.⁷¹

Vischer's horror at Russian Bolshevism—which may have been magnified by the *Landesstreik* (national strike) in Switzerland in November 1918—is likely to have influenced him here. However, he also had a genuine concern for how the transition from war to peace, and from military mobilisation to peacetime work patterns, might make the problem of class inequalities worse. The presence of around 3,000 'unwanted' Russian soldiers—often deserters or escaped POWs—among the released military internees in Switzerland in 1918-19 perhaps impacted on his thinking too.⁷²

The third link between First World War camps and modernity was the ever-lasting uncertainty contained in prisoners not knowing how long they would be detained for. This was one of the big differences with criminal prisons, Vischer argued (another being that long-term convicts, by definition, must have had psychopathic personalities before committing the violent crimes that got them sent to jail). But 'uncertainty' needs some nuance here. It went hand in hand with the common knowledge among prisoners of war that they would almost certainly be released one day, a prospect that began to take up more emotional space in the second half of 1917. Kuncz explained the unsettling features of this dual presence of uncertainty and certainty in the following, somewhat surreal, passage, in which the word 'Nature' acts as a substitute for 'release' (and culture, by implication, is understood as the set of rules governing the socially and legally produced, mutually inter-dependent relationship between the prisoners and the captor state):

I think Nature had never been so near to me [as in those end months of 1917], and I have never fled from it in such panic fear as then. I did not dare look back at the clouds and the temptation of the sky; I did not dare listen to the pounding of the waves. I only looked at the mud in the yard and the black, gleaming pools of water. For hours on end I ran up and down... deadly tired, to hammer into my consciousness the fact of imprisonment, to cling to the noisome present, the horror of reality which, like the wretched fragment of a splendid ship, alone could bring my life safe to a certain shore.⁷³

For Kuncz, then, if time had stood still whilst he was in captivity,⁷⁴ it was not in any absolute sense, but only in nightmarish relation to how time was simultaneously passing him by in the modern, war-torn, temporally off-beat and 'high energy' world beyond the barbed wire. As with Covid-19, 'coping [mentally] with' the experience of internment 'involved inheritance and improvisation', including in relation to the subjective views of time that humans—as historical beings—develop. Methodologically speaking this is an important observation, as it underlines Vincent's argument that 'social history is

founded on an engagement with time'.⁷⁵ Yet ultimately for Kuncz, the real political as opposed to cultural meaning of internment was not to be found in the inner temporal conflict he experienced between innocence and (self-) knowledge, inheritance and improvisation or nature and culture, but rather the external, question of who the internment experience and its temporal meanings actually belonged to. And like Vischer, his answer was that it was the 'property' of the prisoners.

Camps as exceptional spaces

One of the issues that both Vischer and Kuncz were more ambivalent about was whether POW and internment camps were truly *exceptional* spaces or a part of modernity in general. 'Exceptional' here should not be understood as relating to the Schmittian idea that when sovereign rulers resort to use of emergency powers, they are necessarily creating 'states of exception' by exerting a theologically-rooted detachment from all secular rules and norms.⁷⁶ Rather, as we have seen, Vischer interpreted liberal norms, including international conventions, exchange agreements and comparable worldly humanitarian interventions, as being core features of the camp system in its totality. For him, what was 'exceptional' was the extraordinary psychological impact on the 'healthy' human mind of indefinite wartime captivity. 'More than anything else', he wrote, 'the barbed wire winds like a red thread through [the prisoner's] mental processes. With hypnotic gaze his mind's eye is fixed on this obstacle'.⁷⁷ Earlier in the book he argued that 'barbed wire disease' was a 'subject of great social importance' because four to five million captives might 'return to their home with a damaged mentality' after the war.⁷⁸ This would have a momentous 'influence on the collective psychology of the community' and possibly weaken European societies' defensive mechanisms against 'Nihilism and Bolshevism'. Former prisoners, he concluded, would have to be diverted from the 'dangerous state of mind' represented by these new ideologies.⁷⁹

Thus Vischer used the term 'barbed wire disease' more as a straightforward descriptive marker and less as a metaphorical devise. Just as the term 'Long Covid' directly reproduces the relationship between the virus and its extended biological after-effects, so the concept of 'barbed wire disease' suggests the spatial and temporal connection between the physical wire and mental health or neurological disorders. This was captured vividly in an illustration created by the British artist Eleanor Fortescue-Brickdale as a frontispiece for the English-language edition of Vischer's book (see figure 3).



Figure 3: Frontispiece illustration by British artist Eleanor Fortescue-Brickdale for the English-language edition of Vischer's book, published by John Bale, Sons and Danielsson Ltd., London, 1919.

Yet 'barbed wire disease' in the sense that Vischer used it had argumentative content as well as descriptive form. His emphasis on the scale and urgency of the 'problem' of Bolshevism, not visible in Fortescue-Brickdale's artwork, kept bringing him back to the second half of 1917 as a significant social and historical reference point. And here mental illness in once healthy individuals and groups certainly did function as a metaphor for what he saw as a new, impromptu, mass-produced chaos in human affairs caused by modernity and accelerated by the new cultural and political uncertainties thrown up by the First World War. 'It has been known for a while', he wrote in his 1919 brochure *On the Psychology of Times of Transition*, 'that in periods of historical upheaval, the number of mentally ill people increases while the number of suicides decreases. This turned out to be the case in this war too'.⁸⁰

In 1918-19, plenty of other medical experts linked 'nervousness' in the population more generally to the new-found appetite for strikes, riots and even revolution. Especially in Germany, where different variants of the 'stab-in-the-back legend' were being invented and circulated, individuals of 'abnormal' psychology were held responsible by anti-Bolshevists for exploiting the people's general weakened state and subverting the will to fight on to victory.⁸¹ Vischer himself had no intention of supporting this line of argument—indeed, if anything, he was a liberal anti-militarist who was more 'in tune with global concerns' than with inward-looking European nationalisms.⁸² Moreover, the most positive reviews of his work in German-speaking Central Europe tended to come from progressive newspapers, including the left-liberal *Berliner Tageblatt* in Germany and the socialist *Arbeiter-Zeitung* in Vienna.⁸³ Nonetheless, the historical context in which he talked about threats to neurological defences against societal collapse, and his strong support for the family as a bulwark against 'unhealthy' political mentalities did possibly lend support to more right-wing and alarmist ways of thinking too.⁸⁴ Transcending these political markers, Vischer saw indefinite incarceration of prisoners and civilians as providing a historically and socially created space in which to experiment with or (in his case) to express profound anxiety about the creation of new forms of 'improvised disorder'.⁸⁵ The very intensity of the camp as a modern, artificial and ultimately destructive 'space of communication and shared experience' is what most concerned him.⁸⁶ Only an ordered system of repatriation, he argued, including active medical treatment for those former POWs and civilian internees suffering from 'barbed wire disease', would prevent disordered nerves from leading to unsettled communities and radicalised politics.

Once the dust had settled on the immediate post-war process of repatriation of prisoners, however, the main tendency of military commissions looking into lessons to be learned from the POW experience was to challenge Vischer's findings in relation to the uniqueness and scale of the 'barbed wire disease' phenomenon. Most medical experts also refused to accept the paradox that he had identified, namely that to move on from the consequences of the war, it was necessary for the state openly to own and confront those implications. Instead, they adopted the assumption that Bing and Vischer warned against in an article in the *Lancet* a few months after the war's end: *cessante causa, cessat effectus*.⁸⁷ Kinnier Wilson, who wrote the introduction to the English edition of Vischer's book, already paved the way for this in early 1919. Vischer had produced no 'reliable statistics', he noted. He had ignored the possibility that food, or lack of it, rather than 'barbed wire disease', may have been responsible for at least some of the symptoms. More importantly, he had failed to consider the hypothesis that hereditary factors or 'predisposition of some sort, however one might choose to express it' were responsible for most cases. And above all, he had overlooked the stronger nerves of 'races' like the British:

I am bound to say that my experience of returned prisoners does not coincide with the opinion expressed... [by Vischer]; those with 'damaged mentality' have been few and far between.

With a return to normal environment the mists of 'barbed wire disease' have disappeared with gratifying rapidity; improvement of the physical condition of the prisoners has resulted in speedy re-integration of the psychological malfunctionings, such as they have been.⁸⁸

This, indeed, was the common view at the end of the First World War. At any rate, I have only been able to find three specialists who were willing, at least in part, to concur with Vischer's warnings about scale. In a leading Swiss neuro-science journal in 1919, the Zurich-based Hans Christoffel, who had had experience working with 200 'psychotics and neurotics' at the psychiatric department of one of Hamburg's main reserve military hospitals during the First World War, reassured readers that 'instances of nervous exhaustion among active combatants' were 'relatively uncommon'. In his view, 'a one-off short-term trauma is not enough for this; what is needed is a more or less lasting cause, as we see, for instance, in recurring, obstinate, systemic diseases and in the affective pressure of an uninterrupted period of wartime captivity'. Only on grounds of the total dissimilarity of confinement to the very different type of trauma that occurred on the battlefield was Christoffel willing to concede Vischer's point that '[T]he endless tension, the constant stress [and] the compulsion to change all

personal habits of life' in internment camps could 'lead to a state of collapse'.⁸⁹ Meanwhile the German psychologist Hellpach, writing again in 1919 and in the same journal, albeit in relation to 'war neurasthenia' in general, argued that the treatment of such cases constituted 'the greatest social problem which will stand before us as mind doctors after the war'.⁹⁰

A similar point was made in 1919 by the Luzern-based Swiss military doctor J. Waldispühl in an article in *Heimkehrer*, a German newssheet which was aimed not at medical experts but at returning prisoners themselves.⁹¹ Waldispühl's wider publicity work, alongside the more academic writings of Vischer, Christoffel and Hellpach, may explain why some ex-POWs were granted military pensions in Germany and Britain as individuals, albeit in France (where interestingly Vischer's book failed to appear in print) they were only offered occasional 'allowances' on a collective basis to get them through times of economic austerity.⁹² In the French case, the view of long-term ex-POWs as non-combatants was stronger. Even Charles de Gaulle, captured at Verdun and held in German captivity until 1918, made known his contempt for those of his fellow officers who did not try to escape.⁹³ In Germany, ex-POWs were theoretically acknowledged as combatants but were 'spurned by other veterans and unwelcome in the ranks of the "really war disabled"'.⁹⁴ Fragmented war memory also prevented them from organising jointly for better recognition and financial compensation.⁹⁵ As for former civilian internees, they were of course not entitled to military pensions in any country and struggled to gain acknowledgement as war victims. In Britain, for instance, Kinnier Wilson claimed to be impressed by the 'adaptability' of most individuals who found themselves in civilian captivity:

... this adjustment to his surroundings and to the general situation, this philosophical outlook on the hard facts of internment, must have been the means of saving the clutches of the neurosis that was officially recognized in The Hague conference in 1917. 'Make the best of it', was the philosophical motto of all who won through successfully in spite of the physical sufferings and mental torments.⁹⁶

Meanwhile, little was done in the international arena either to recognise 'nervous exhaustion' among former POWs and civilian prisoners of war, with the ICRC losing its case for having the latter treated equally to the former when it came to legal protections. True, in 1929 the revised version of the Geneva convention conceded that some military prisoners might develop long-term mental health conditions that could justify internment in a neutral country, as had happened via the bilateral

agreements between belligerents discussed above. But studies by Clare Makepeace, Bob Moore and the medical historians Jones and Wessely all concur that the tendency during the Second World War was to downplay numbers of sufferers and the urgency of treatment, even if there had been some initial concerns in 1940.⁹⁷ According to Makepeace, 'a significant minority of [British Second World War] prisoners [in Europe] suffered from psychological disturbances, but, without any sort of diagnosis, little clarity and much ambiguity surrounded the form these disturbances took'.⁹⁸ While British captives themselves referred to 'going "round the bend"', medical officers used terms like 'nervous troubles' or, drawing on the language of the 1929 Geneva convention, 'psychasthenia', but were reluctant to revive Vischer's notion of a 'barbed wire disease'.⁹⁹

Scientific literature in the 1940s was equally opaque and just as reluctant to suggest that long periods in camps could significantly alter the mental balance of a previously healthy prisoner. After reading a piece on experiences of captivity (his own and others) by returned medical officer Philip Newman, published in the BMJ in January 1944, Millais Culpin wrote the following letter to the editor:

Major Newman, perhaps because of the surgical outlook that persistently regards nerves as corporeal structures, avoids that thought-stifling witch word neurosis, though he falls down once on neurotic. This makes more surprising his view that individual psychological treatment for any returned prisoner of war is 'debatable' because 'it may carry with it a public acknowledgment of mental abnormality, which must at all costs be avoided'. This reminds us of, 'He's not mental, doctor; it's his nerves', and is a poor reason for depriving the men of treatment... I can assure Major Newman that the difficulty he pictures is quite familiar, and the solution is to remove the stigma from 'mental'.¹⁰⁰

Culpin, a medical practitioner with experiences of his own working with 'war neurotics' at the London Hospital during the First World War,¹⁰¹ also made the more ironic point that stories told in the press and broadcast media about the heroic attempts by some men to escape from German captivity in both world wars were themselves an unintended 'acknowledgement of mentality abnormality':

I believe it is technically the duty of every prisoner of war to try to escape, but when I listened to a radio account of a man who succeeded after four attempts, though the victim of savage punishment and the witness of the shooting of a fellow venturer, I recognize his state as probably identical with that of other men whose repeated efforts to escape depended upon a

pathological compulsion that persisted in other form, a tendency to fugues, for example, after return to civil life.¹⁰²

At least Newman, in his BMJ article, mentioned Vischer, although, as we have seen above, he misrepresented him as a ‘psychologist studying a series of patients’ rather than a surgeon and camp inspector.¹⁰³ In Germany, meanwhile, it is difficult to find any reference to Vischer or to ‘barbed wire disease’ in published form after 1933, and certainly after 1939. When it was mentioned, it was usually associated with private memoirs or heroic studies of ‘extreme’ forms of captivity in First World War Russia and especially Siberia, as seen, for instance, in Edwin Erich Dwinger’s *Die Armee hinter Stacheldraht* (1929) and Hermann Pörzgen’s *Theater ohne Frau* (1933)—both written by men who later joined the NSDAP.¹⁰⁴ In Austria, by contrast, extracts from the medical studies by Vischer and Waldispühl were printed alongside personal accounts published by prisoners of all nationalities in the two-volume compendium edited by the military historians and war archivists Hans Weiland and Leopold Kern, *In Feindeshand* (1931).¹⁰⁵

The next appearance of the phrase ‘barbed wire disease’ or ‘Stacheldrahtkrankheit’ in a German-language publication came in January 1949 in an article published by a former prisoner in British captivity, Walter Hemsing, in the Hamburg-based liberal weekly *Die Zeit*. Hemsing was less prone than some writers in the context of the Cold War to dwell on the particular horrors of Soviet POW camps—where, he claimed, more than 300,000 German prisoners still languished—or on the extreme forms of hunger-induced mental and physical collapse that led to what was often now known in West Germany as *Heimkehrerkrankheit* (returnees’ disease).¹⁰⁶ However, he did concede that some (although by no means all) of his fellow prisoners succumbed to psychological disorders. ‘Science’, he noted without mentioning Vischer by name, ‘has been dealing with these mental disturbances since the First World War and initially summarised them under the heading “barbed wire disease”’. Where he differed from Vischer was his recourse to older views—including those reinforced by the National Socialists and readapted for the purposes of ‘racial hygiene’—on the importance of genetic inheritance. For this reason, he rejected the existence of a ‘barbed wire disease as such’. Captivity, in other words, was still for Hemsing merely a trigger. The real cause was a ‘predisposition to pathological disease’.¹⁰⁷

Even so, he drew attention to the paradox—as Kuncz had in *Black Monastery*—that despite their desperate longing for release, ‘when the time comes, a strange fear grips the prisoners’, including the healthier ones:

On the one hand, they are afraid of the responsibility, of the initiative that they have to take, of the courage for freedom that is now required of them again—on the other hand, they have dreamed in the camp of a home so full of kindness and love that... they are already dimly aware of just how much reality will disappoint them.¹⁰⁸

For Hemsing, individual personality traits, linked to genetic inheritance, were what mattered in determining how long these nervous symptoms would last. Neurotics were people ‘who repeatedly evade or must evade certain pressures’ and who therefore react in negative ways in any given situation, including captivity. Once again, the notion of malingering and/or ‘flight into illness’ was playing a role in how the psychological and neurological effects of captivity were being modelled.¹⁰⁹ As Svenja Goltermann has shown, even in the sphere of financial restitution (*Wiedergutmachung*) for German victims of Nazi persecution, as opposed to returnees from the Soviet Union, these older concepts were often used in medical judgements about the causes and likely duration of ‘psychological suffering’. Thus, the pressure to distinguish clearly between ‘fakers’ and ‘genuine’ victims led doctors, legal advisors and welfare officials to emphasise the physical nature of the latter’s ailments, especially in cases where the effects of severe hunger, torture or forced labour could be cited as ancillary components. Alternative and socially more attuned discourses about a spatially and temporally specific ‘dislocation depression’ (*Entwurzelungsdepression*) among former Nazi concentration and work camp inmates were firmly rejected by mainstream physicians in 1950s West Germany and by many of their colleagues in neighbouring western European countries as well. ‘Emotional cases’, meanwhile, were still linked to ‘pension neurosis’ and ‘false ideation’. All in all, until the 1960s there was little medical support for the notion of an ‘experience-related change in personality’ requiring bespoke treatment and societal recognition.¹¹⁰

In Britain too in the early post-1945 period, the assumption was that ‘previous personality traits’ were the most important factor in predicting whether a POW or internee would succumb to mental disorders, with hunger, torture or other physical hardships behind the barbed wire considered as secondary causes. This followed a study conducted between January and May 1944 at the Hollymoor Military Psychiatric Hospital at Northfield, Birmingham, which covered the treatment of 100

POWs who were in-patients there. The finding was that '50 per cent of cases had a "neurotic family history", 60 per cent had shown "pronounced neurotic traits in childhood" and 25 per cent had suffered an earlier breakdown'.¹¹¹ The Austrian neurologist and Holocaust survivor Viktor Frankl, on the other hand, claimed in a 1961 handbook that Nazi concentration camps as historically-specific spaces—in spite of all the undoubted mass killings, starvation and other utterly criminal horrors that took place inside them—not only failed to produce neurotic symptoms 'in the narrow sense' in previously unaffected prisoners, but even led to the 'recovery' of those who came in showing signs of the condition.¹¹²

Only in the 1970s and 1980s, in the aftermath of the Korean and Vietnam wars, as Jones and Wessely discovered in their research, was there a shift in western medical literature from emphasising 'resilience' to recognising the 'psychological vulnerability' of the majority of (formerly 'healthy' as well as 'unhealthy') prisoners of war and civilian internees. And in their view, this sudden 'finding' brought with it the dangers of over-correction, especially when projected backwards from Korea and Vietnam to earlier conflicts. Cases of 'resilience' in the First and Second World Wars were now 'understated' when it came to medical research, they concluded.¹¹³ Yet interestingly, historical scholarship published since their study appeared in 2010 does tend to emphasise the mental toughness and creative energy as well as the psychological vulnerability of those who spent time as POWs in both conflicts.¹¹⁴

Vischer too never denied the resilience of the military prisoners and civilian internees he encountered, although this was not his actual focus. Rather he was drawn to explore the existential meanings of prolonged wartime captivity as a psychological mass phenomenon with unknown consequences. 'The question of their legal status concerns the internees to no small degree', he wrote in 1919. 'They are looking for clarification of their identity. Are they still prisoners of war?'.¹¹⁵ In fact, legally and internationally, First World War captivity was more or less wound up by 1920, but in post-war European societies, as Vischer predicted, it continued to occupy a lot more mental space, not least in the minds of the men who experienced it and the female and male relatives who also faced the same question in the context of their own lives: is he still a prisoner of war? The answer, in many cases, was a painful yes.

Conclusion

What, then, was 'barbed wire disease'? And what did it contribute to the overall historical complexion of internment as a source of knowledge, both medical and social? Jones and Wessly may be right to say that it was (and is) a little understood mental health condition that could only really be talked about in language that we would recognise today—in other words as a form of post-traumatic stress disorder—from the late 1970s onwards.¹¹⁶ It was also highly contagious, even though 'infection' was the result of specific historical and social conditions, not viral transmission. As a significant, but declining, numbers of First World War POWs and civilian internees were still alive in that decade, it was possible for historians to record some of their subjective memories. Especially Peter Liddle, who conducted oral history interviews with about sixty former British civilian internees from the First World War prison camp at Ruhleben near Berlin, found several who were willing to discuss mental health problems in more open ways than might have been the case in previous decades. The most extensive discussion came with ex-internee H. Richard Lorenz in 1977:

Lorenz: Oh, it took me about four years to get normal again.

Liddle: How do you mean?

Lorenz: Well, I remember being in a medical barrack and being examined and the doctor set me apart and said, this is a case of nervous disease.

Liddle: So you got nervous troubles?

Lorenz: Yes, well, of course everybody did. I don't think you could say anybody was normal in there.

Liddle: In what way did you become slightly abnormal though?

Lorenz: Well, we didn't know it in the camp. I mean we were amongst our own, but when I came out you know I can still remember if... I had something to eat, say in a Lyons shop. I couldn't sit at a table there with anybody opposite me. That sort of thing... I mean our language was simply awful... I still use bad language when I am on my own... I mean it's just a relief you know.¹¹⁷

We learn from this that 'barbed wire disease' was a real medical phenomenon. But equally we learn that it was a social experience that could affect former prisoners' lives, and those of their families, for long periods of time. This historically situated social impact cannot be analysed solely in terms of presences and absences in pension files, and references or non-references to it in scientific literature.

It had multi-layered subjective meanings, both for former prisoners themselves and for medical practitioners. 'Memory matters', as Paul Lerner puts it in relation to other kinds of war trauma.¹¹⁸ Indeed, it is as important to medicine as it is to history.

The knowledge produced by internment was therefore primarily social. And as social knowledge it was and still is part of a temporally and spatially bound history of experience. 'Barbed wire disease' was already a highly contested issue in 1917, before Vischer wrote his book, as seen in comparisons made with *Rentenkampfneurose* on the one hand and demands from the ICRC for larger scale releases on the other. It became more of a political problem in 1918-20, with the repatriation of millions of prisoners, few of whom were offered specific or bespoke treatment for neurological or mental health problems. And for different but no less important reasons, largely related to immigration detention but also to the legacy of indeterminate sentences passed by UK courts, Covid-19 lockdowns across the world, or home learning for children, it remains a live issue today.¹¹⁹ For instance, an independent report on abuses at the Brook House Immigration Removal Centre near the UK's Gatwick Airport, published in September 2023, recommended that the Westminster Parliament pass new legislation to reduce administrative forms of immigration detention to a maximum of twenty-eight days. Not only was the report concerned about specific evidence of 'inhuman' and 'degrading treatment'. The first point in the executive summary made a formal case against the current indefinite time limit, using the kind of social knowledge and medical reasoning that Vischer did:

Out of sight, out of mind: places of detention are the hidden spaces in our society. Most people will have no experience of being incarcerated and few will have worked in such environments. They are places where communication is restricted, rights and freedoms are curtailed, where isolation from loved ones is a fact of life, and where the toll of detention can have an impact on people's mental and physical wellbeing. For anyone who has been detained by the State, it is a profoundly life-altering experience.¹²⁰

Without wishing to draw false equivalences or suggest direct parallels between military and civilian internment during the First World War and the Covid-19 lockdowns in peacetime from 2020 to 2022, and without wishing to claim that citizens required to stay at home for their own and others protection from a highly infectious killer disease are somehow 'prisoners' of a captor state, a sudden and involuntary subjugation to atypical temporal and spatial settings is also what most children, the elderly

and other vulnerable people subjectively experienced during the recent pandemic. Statistical data can give some indication of the scale and urgency of the problem. An article in *The Guardian* on 5 September 2023, for instance, noted the severe impact of lockdown on the mental health of some of the pupils who began secondary school in the academic year 2020-1, and warned of repeat consequences should a new bout of prolonged home learning begin, this time caused by a 'nationwide safety alert' over crumbling concrete in schools. The alarm had to be raised, the piece continued, because of what had been learned during Covid: 'Government data from February and March 2021 shows that rates of probable mental disorder in children and young people increased between 2017 and 2021 from 12% to 17% among those aged six to 16 and from 10% to 17% among those aged 17-19'.¹²¹ In relation to the population as a whole, the UK charity Mind already published the results of a statistical survey involving over 16,000 respondents in June 2020. The inquiry demonstrated not only that the first lockdown had been 'devastating for mental health' but that 'the worst could be yet to come':

Overall, 65% of adult participants with a pre-existing mental health problem said it had become worse during lockdown, while the figure was higher, at 75%, among people aged 13-24 with pre-existing mental health problems. What's more, 22% of participants above the age of 13 without prior experience of mental health problems said that their mental health during lockdown was poor or very poor.¹²²

Yet when it comes to what historians can do, it is probably best to recognise that statistical evidence will never suffice alone to create conclusive knowledge of health conditions, and that similarities drawn between illnesses in different periods of historical time will always be contested, especially when one condition ('barbed wire disease') is caused by temporal and spatial factors and the other (Long Covid) by biological ones. It may well be better to embrace Stryker's assertion that 'historians, no less than psychologists' should own up to their subjectivity, or in other words, 'should be responsible for making overt the political importance of their interpretations', as opposed to hiding behind unrealistic claims to objectivity.¹²³ We also need to bear in mind the German phrase 'genesen heißt nicht gesund'—'recovery [from primary illness] does not mean being restored to health'—a saying whose power to capture imaginatively the sheer individual and collective misery of Long Covid sufferers can only fully be grasped when linked to specific historical conditions that militate against optimal treatment and/or appropriate financial mitigations.

Indeed, just as in Vischer's day there was no way of establishing a watertight connection between captivity and the symptoms of 'barbed wire disease', so today there are no studies that provide a cast iron link between the SARS-CoV-2 infection and Long Covid. The fact that the causes of Long Covid, while known to be biological, have still not been identified in detail, presents us with the further problem that patient diagnoses, mitigations and potential cures are still based on the methodological uncertainties of trial and error, and not much more. One less than satisfactory answer to this dilemma is to assume that nothing is real in human affairs except chance, meaning that we might as well wait patiently until the experts happen upon a scientific breakthrough in respect to this illness. A more creative solution—following David Vincent's call for combining imaginative and evidential approaches to studying the social impact of infectious diseases while also engaging with the subjective dimensions of time and space—would be to make use of the literary device of metaphorical personification. In an unvarnished sense, of course, Long Covid does not have any agency of its own. It does not make impromptu decisions in the way that politicians and other actors from the real worlds of finance, medicine and administration do. And to push the point further, unlike humans, who are historical beings, it has no concept of time and space. However, by combining personification with transhistorical thinking Long Covid can nonetheless be cast as a phenomenon that has all the capriciousness of a modern (and liberal) captor state, offering humanity and relief when the mood suits it and demanding tough new security measures, an imagined redrawing of the barbed-wired perimeters, when its prisoners try to push up against its boundaries or seek short cuts to early 'release'. It does not kill but it exhausts, mentally as well as physically; it has an unknown time-limit, but it cannot last for ever; and it may come to an end through individual reprieve or through the conclusion of hostilities (which in Long Covid terms means the discovery of new drugs that can effectively treat it). If this is a case of knowledge transcending historical as well as national boundaries, then it is important to recognise it as social knowledge about captivity itself as a manifestation of the (liberal) state's power to intern and release, a power situated in particular spatiotemporal settings, and not knowledge of the specific causes of 'barbed wire disease', which, in spite of Vischer's best efforts, was and remained a contested field of inquiry among medical experts.

The very fact that there are uncertainties and ambiguities, particularly when it comes to assessing the likely origins, duration, scale and societal impact of an illness linked to 'brain fog' and other neurological complaints, also indicates the benefits that may come to science through the

transformative practice of humility. Here again the humanities have a role to play. This is specifically the message of a recent book on Long Covid by the senior German physician Jördis Frommhold. For her, humility is ‘a state of mind’ [*eine Geisteshaltung*] in which ‘the humble [medical specialist] recognises their own strengths and weaknesses, shows appreciation for the work of others, is always willing and open to learn, and accepts that we are all just a small part of a greater whole’.¹²⁴ This is a political as much as a scientific message, and one which Vischer—a physician who worked at a time when internecine arguments between overly self-important neurologists, military officers and psychologists prevented any broader understanding of the relationship between war, social conditions and mental illness¹²⁵—would easily have recognised. To quote Frommhold again:

If we hope to work with our Long Covid patients to persuade them to accept their illness and learn to deal with it appropriately, this will only be successful if those affected realise that the existence of their condition is also accepted by doctors, tax-payers and... generally speaking—society... [We] cannot sit back and wait until the exact causal links between what we see and experience [as medical practitioners] every day are finally unravelled in research institutes.¹²⁶

When it comes to understanding First World War internment as a source of knowledge about medicine and its entanglements with social history, humility might also mean accepting that rights and abuses, time standing still and time going into over-drive, or intense boredom and frightening levels of over-stimulation could co-exist within the same institution, the camp, the same set of temporal and spatial restrictions, marked by the barbed wire, and the same set of national and international practices, including policies designed to combine security and humanity.¹²⁷ Given that prison camps continue to exist as institutions beyond the end of the twentieth century, and given that particularly in the West, immigration concerns are often at their heart, we need a similar level of humility when describing and understanding their function and their health impacts today. Patient-centred writings on Long Covid and its historical forebears are one place where we might usefully start.

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Notes

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¹ Kuncz, *Black Monastery*, 330.

² Stibbe, *Civilian Internment*, 216.

³ Kuncz, *Black Monastery*, 339-40.

⁴ On these campaigns, see Stibbe, *Civilian Internment*, 197-203,

⁵ On symptoms, see Medinger and Altmann, *The Long Covid Handbook*, esp. 10.

⁶ Koselleck, *Vergangene Zukunft*.

⁷ Honigsbaum, *The Pandemic Century*, xv.

⁸ Vincent, *The Fatal Breath*, 17.

⁹ Scholars today are also beginning to study the camp as an institution existing within specific spatial and temporal frameworks. For the latest research see Bochmann and Fischer von Weikersthal,

Institution Lager. However, in this article the focus will be on knowledge that developed synchronously as well as diachronically.

¹⁰ Vischer, *Barbed Wire Disease*.

¹¹ *Ibid.*, 51-2.

¹² *Ibid.*, 53.

¹³ *Ibid.*, 53-4. See also Bale and Vischer, "Some Remarks." 696.

¹⁴ Vischer, *Barbed Wire Disease*, 57.

¹⁵ Medinger and Altmann, *The Long Covid Handbook*, 7.

¹⁶ *Ibid.*, 124-5.

¹⁷ *Ibid.*, 143.

¹⁸ Devi Sridhar, "Covid Rates are Rising: Should we be Worried?" *The Guardian*, 19 August 2023.

¹⁹ Vincent, *The Fatal Breath*, 24.

²⁰ *Ibid.*, 65.

²¹ Medinger and Altmann, *The Long Covid Handbook*, 125.

²² On 'pension neurosis', which was also sometimes known as 'pension psychosis' or 'pension hysteria', reflecting different approach, or perhaps straightforward confusion, among medical specialists, see Zilcosky, "Kafka's Poetics."; Lerner, *Hysterical Men*, 32-3; Radkau, *Das Zeitalter der Nervosität*, 339-53; Perry, *Recycling*, 125, 129; and Goltermann, 'Psychisches Leid', 435.

²³ Julliard, "La Captivité."

²⁴ Górný, "The 'Healthy Nerves.'" 130.

²⁵ *Ibid.*, 125.

²⁶ Stryker, "Mental Cases." 163.

²⁷ Ziemann, "Total War." 381-2.

²⁸ Feltman, *The Stigma of Surrender*, esp. 165-6.

²⁹ Stryker, "Mental Cases." 167.

³⁰ The information in this section is a summary of material in Bing and Vischer, "Some Remarks."; Ohry and Solomon, "Dr Adolf Lukas Vischer."; and Stibbe, *Civilian Internment*, 215-18.

³¹ On the hospital in Fribourg, see also Barton, *Internment in Switzerland*, 61-2.

³² Anon., "Barbed Wire Disease."

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- ³³ Newman, "The Prisoner-of-War Mentality." 8.
- ³⁴ Vischer, *Barbed Wire Disease*, 24-5.
- ³⁵ As acknowledged by an anonymous reviewer of Vischer's book in the BMJ in 1919. See Anon., "Barbed Wire Disease."
- ³⁶ Stibbe, *Civilian Internment*, 220.
- ³⁷ Vischer, *Zur Psychologie der Übergangszeit*.
- ³⁸ Feltman, *The Stigma of Surrender*, 75.
- ³⁹ Reid, *Medicine*, 71-112.
- ⁴⁰ See, for example, Bourke, *Dismembering*; Crouthamel and Leese, *Psychological Trauma*; Lerner, *Hysterical Men*; Perry, *Recycling*; Reid, *Medicine*.
- ⁴¹ Jones and Wessely, "British Prisoners." 166.
- ⁴² Zilcosky, "Kafka's Poetics." 346. On the 1916 Munich congress see also Lerner, *Hysterical Men*, 74-85; Górný, "The 'Healthy Nerves.'" 126-7; and Jones and Wessely, "British Prisoners." 166.
- ⁴³ Bourke, *Dismembering*, 108-23.
- ⁴⁴ Vischer, *Barbed Wire Disease*, 58.
- ⁴⁵ Cooter, "Medicine and Modernity." 102-3. See also Flaskerud, "Neurasthenia." 657.
- ⁴⁶ See Radkau, *Das Zeitalter der Nervosität*, esp. 49-73; and more generally, Ullrich, *Die nervöse Großmacht*, esp. 374-5, 581.
- ⁴⁷ Biess, 'Men of Reconstruction', ?
- ⁴⁸ Zilcosky, "Kafka's Poetics." 346.
- ⁴⁹ Feltman, *The Stigma of Surrender*, 50, 52-3, 138.
- ⁵⁰ Jones, *Violence*, esp. 127-251.
- ⁵¹ Kramer, *Dynamic*, 63-4.
- ⁵² See Jones, *Violence*; Stibbe, *Civilian Internment*.
- ⁵³ On Swiss captivity, see Barton, *Internment in Switzerland*.
- ⁵⁴ Vischer, *Barbed Wire Disease*, 23.
- ⁵⁵ Stibbe, *Civilian Internment*, 215.

⁵⁶ On the *Gegenseitigkeitsprinzip*, see Bauerkämper, *Sicherheit und Humanität*, Vol. 1, 122. Of course, in some contexts this principle back-fired, exposing prisoners to repeated cycles of reprisals and counter-reprisals.

⁵⁷ Stibbe, *Civilian Internment*, 204-7, 214.

⁵⁸ Zilcosky, "Kafka's Poetics."

⁵⁹ Reid, *Medicine*, 85, 87.

⁶⁰ See Bonzom, "Human Derelicts".

⁶¹ Agamben, *Homo sacer*.

⁶² Langbein, *Menschen in Auschwitz*, 138-61. In reality, of course, *Muselmänner* were themselves never a homogenous, unchanging or entirely voiceless group in the camp societies of Nazi-occupied Europe, but, in so far as they were labelled as such by others, they formed a constitutive part of those societies and shaped the way that they were constructed and experienced in spatial and temporal terms. For a detailed discussion, see Becker and Bock, *Re-Thinking the Muselmann*. The more straightforward point I am making here, however, is that the very concept of the 'Muselmann' would have been unimaginable to Vischer in 1917-18 and played no part in his construction of 'barbed wire disease'.

⁶³ Lazar, *States of Emergency*, 101.

⁶⁴ Vischer, *Barbed Wire Disease*, 31.

⁶⁵ *Ibid.*, 45.

⁶⁶ Stibbe, *Civilian Internment*.

⁶⁷ Vischer, *Barbed Wire Disease*, 55.

⁶⁸ Jaraus, *Out of Ashes*, 8.

⁶⁹ Gustav Bernhard Hofheinz, diary entry, 14 July 1917. Cited in Lübbers, 'Lesen als Form der Bewältigung', 333.

⁷⁰ Vischer, *Barbed Wire Disease*, 84

⁷¹ *Ibid.*, 58.

⁷² See Bürgisser, "Unerwünschte Gäste", esp. 74-7.

⁷³ Kuncz, *Black Monastery*, 337.

⁷⁴ The reference here is to Cohen-Portheim, *Time Stood Still*.

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- ⁷⁵ Vincent, *The Fatal Breath*, 19.
- ⁷⁶ Lazar, *States of Emergency*, 2-3.
- ⁷⁷ Vischer, *Barbed Wire Disease*, 31.
- ⁷⁸ *Ibid.*, 25.
- ⁷⁹ *Ibid.*, 25, 83.
- ⁸⁰ Vischer, *Zur Psychologie*, 157.
- ⁸¹ See Lerner, *Hysterical Men*, 214-22; Stibbe, *Debates*, 38-45. The 'stab-in-the-back legend' suggested that the German army was not defeated in the field in 1918 but was knifed from behind by traitors and mentally deranged revolutionaries on the home front.
- ⁸² Reznick, *War and Peace*, 152.
- ⁸³ "Die Stacheldraht-Krankheit." *Berliner Tageblatt*, 21 October 1918; "Die Stacheldrahtkrankheit." *Arbeiter-Zeitung*, 8 September 1918.
- ⁸⁴ Vischer, *Barbed Wire Disease*, 84.
- ⁸⁵ Becker, "Captive Civilians." 281.
- ⁸⁶ Jaraus, *Out of Ashes*, 12.
- ⁸⁷ Bing and Vischer, "Some Remarks." 696.
- ⁸⁸ Kinnier-Wilson's foreword to Vischer, *Barbed Wire Disease*, 16.
- ⁸⁹ Christoffel, "Depression." 263.
- ⁹⁰ Lerner, *Hysterical Men*, 219
- ⁹¹ Waldspühl, "Die Stacheldraht-Krankheit."
- ⁹² Abbal, "Die französische Gesellschaft." 301-3.
- ⁹³ *Ibid.*, 297.
- ⁹⁴ Lerner, *Hysterical Men*, 230.
- ⁹⁵ Pöppinghege, "Kriegsteilnehmer zweiter Klasse?"
- ⁹⁶ Kinnier-Wilson's foreword to Vischer, *Barbed Wire Disease*, 21.
- ⁹⁷ Makepeace, *Captives*, 157-8; Moore, *Prisoners*, 402-3; Jones and Wessely, "British Prisoners." 172-3.
- ⁹⁸ Makepeace, *Captives*, 155.
- ⁹⁹ *Ibid.*, 157.

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- ¹⁰⁰ Culpin, "Prisoners of War." 159.
- ¹⁰¹ Bourke, *Dismembering*, 112.
- ¹⁰² Culpin, "Prisoners of War." 158.
- ¹⁰³ Newman, "The Prisoner-of-War Mentality." 8.
- ¹⁰⁴ See Wurzer, "Die Erfahrung der Extreme." esp. 117-19.
- ¹⁰⁵ Vischer, *Zur Psychologie*; Waldspühl, "Die Stacheldraht-Krankheit."
- ¹⁰⁶ On *Heimkehrerkrankheit*, see Biess, 'Men of Reconstruction', esp. 338-9. For the broader socio-political context, see also Schwelling, *Heimkehr-Erinnerung-Integration*, esp. 112-16.
- ¹⁰⁷ Walter Hemsing, "'Stacheldrahtkrankheit' der Kriegsgefangenen." *Die Zeit*, 20 January 1949.
- ¹⁰⁸ Ibid.
- ¹⁰⁹ Ibid. See also the discussion in Goltermann, *Die Gesellschaft der Überlebenden*, 367-70.
- ¹¹⁰ Goltermann, "Kausalitätsfragen."
- ¹¹¹ Jones and Wessley, "British Prisoners." 176.
- ¹¹² Goltermann, "Kausalitätsfragen." 434.
- ¹¹³ Jones and Wessley, "British Prisoners.", 183.
- ¹¹⁴ For the First World War, see, for example, Feldman, *The Stigma of Surrender*; Wilkinson, *British Prisoners*; and Reznick, *War and Peace*. For the Second World War, see Makepeace, *Captivity*.
- ¹¹⁵ Vischer, *Zur Psychologie*, 159.
- ¹¹⁶ Jones and Wessley, "British Prisoners." 179-81.
- ¹¹⁷ University of Leeds Special Collections, Liddle Collection, RUH 31, H. Richard Lorenz.
- ¹¹⁸ Lerner, *Hysterical Men*, 237-44.
- ¹¹⁹ On immigration detention and mental health, see the various materials on the website of the UK charity Medical Justice, esp. the document "Mental Health in Immigration Detention Action Group: Initial Report" (2013), available at <https://medicaljustice.org.uk/research/mental-health-in-immigration-detention/>. On indefinite sentences, introduced in the UK in 2006 and abolished in 2012, but not retrospectively, see "Recall of Offenders Given Indefinite Sentences Soars." *The Guardian*, 4 September 2023.
- ¹²⁰ Eves et al., *The Brook House Inquiry Report*, Vol. 1, 1.

¹²¹ “Schools concrete crisis is risk to pupils’ mental health, headteacher warns.” *The Guardian*, 5 September 2023.

¹²² “UK’s mental health has deteriorated during lockdown, says Mind,” *The Guardian*, 20 June 2020.

See also Vincent, *The Fatal Breath*, 65, 267.

¹²³ Stryker, “Mental Cases.” 167.

¹²⁴ Frommhold, *Long Covid*, 11.

¹²⁵ Bourke, *Dismembering*, 123.

¹²⁶ Frommhold, *Long Covid*, 10.

¹²⁷ Bauerkämper, *Sicherheit und Humanität*.