3 Body and Mind in “Shell-Shock”
War and Change within Psychological Medicine

As the war went on, doctors reflected on the status of knowledge about “shell-shock”, and constructed narratives about the progress of medical understanding of the disorder. These narratives were articulated in the neutral language of science, and presented as fact rather than interpretation. In July 1918, the anthropologist-neurologist-psychologist W.H.R. Rivers put forward his view:

In the early days of the war the medical profession, in accordance with the materialistic outlook it had inherited from the latter part of the nineteenth century, was inclined to emphasise the physical aspect of the antecedents of a war neurosis. As the war has progressed the physical conception has given way before one which regards the shell explosion or other catastrophe of warfare as, in the vast majority of cases, merely the spark which has released long pent up forces of a psychical kind.¹

In this simple and authoritative statement, Rivers presented “what happened” as established fact, as uncontroversial as the acknowledgement that Britain declared war on Germany on 4 August 1914. This kind of deceptively “objective” statement hides the subject position of the author and implicitly refuses the possibility of disagreement. Rivers’ own stance on the war neuroses, the elaboration of a modified psychoanalytic theory and therapy, was both highly individual and related to the “analytic” school associated with Maghull Military Hospital.² The account which opens this chapter is taken from his preface to the Canadian psychologist John T. MacCurdy’s War Neuroses (1918), the most directly Freudian explanation of “shell-shock” published in wartime. Rivers’ interpretation of wartime developments does not represent majority medical opinion.

In fact, there was no medical consensus on the physical or psychological origins of “shell-shock”: not at the outset of the war, not in 1918,

² The “analytic” school is discussed in depth in Chapter 5.
and not for some decades afterwards. Narratives of linear transition from physical to psychological understandings of the war neuroses are not supported by the evidence of wartime medical discourse on “shell-shock”, despite the central place of this claim in most histories of the disorder, and in arguments that the war caused a fundamental reorientation of medical approaches to mental illness. This chapter explores physical theories of causation in medical explanations of “shell-shock” and assesses the extent of transition to psychological modes of understanding during the war. Undoubtedly, the experience of “shell-shock” complicated medical views of psychological processes, mind–body relations, and the interaction of heredity and environment in nervous and mental disorders. However, physical theories of causation did not dominate early medical approaches to “shell-shock”. Initial interpretations emphasized the diversity of potential physical and psychological causes of the disorder, as well as the interaction of body and mind in the production, maintenance and treatment of symptoms. When we remember that many “shell-shock” doctors were not specialists in mind, nerves, and brain, this lack of clearly formulated preliminary causal explanations is unsurprising. Although the war did cause an important shift in medical opinion, this was not the transition from physical to psychological modes of understanding. Rather, it was the emergence of distinctly articulated forms of physical and psychological explanations out of the useful chaos of the diagnostic strategies of pre-war psychological medicine.

The crucial effect of the war was to make manifest the latent potential for fully psychological modes of understanding within categories such as functional disorder. One order of conceptualization did not replace another. The coherent articulation of physical and psychological modes of understanding developed out of older, more equivocal approaches and bore the hallmarks of this tradition, not least in the continued importance of heredity (as individual or racial inheritance) across the spectrum of medical opinion. Newer explanations coexisted with older forms of understanding. As demonstrated by the most popular methods of treatment for “shell-shock”, there was no binary division between physical and psychological modes of explanation in wartime psychological medicine. Therapeutic conservatism remained common, and even treatments which directly targeted the mind usually demonstrated naïve conceptions of psychology. The absence of physical explanations of “shell-shock” did not mean the presence of sophisticated forms of psychological thought.

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3 See my earlier discussion on historiographical constructions of the war as a catalyst for the adoption of psychodynamic approaches in Loughran, ‘Shell-Shock and Psychological Medicine’.
Indeed, the publication of more complex psychological theories by a handful of doctors sparked a minor backlash against psychodynamic approaches. This demonstrates the practical benefits, even as it reveals the limitations, of the ambiguous accommodations common within pre-war psychological medicine. Furthermore, the differentiation of physical and psychological modes of explanation heralded another important shift, which at least partially countered tendencies towards greater understanding of psychological pain: the displacement of responsibility for “shell-shock” from the war onto the individual soldier. When doctors emphasized the importance of hereditary weakness or earlier psychological maladaptation in the production of “shell-shock”, they implicitly denied that breakdown was most often a legitimate and understandable response to the war itself.

**Early Medical Responses to the Nervous and Mental Disorders of War, 1914–1916**

In November 1914 the earliest reports of cases of ‘nervous and mental shock’ among soldiers appeared in the British medical press. These reports did not mention the physical effects of bursting shells but explained soldiers’ symptoms as the result of ‘exposure and the severe strain and tension of the fighting line’ or ‘the depressing effect of the horrible sights and sounds of modern battlefields’. The authors also described some cases as ‘traumatic hysteria’. Over the next few months, doctors noted similarities between the symptoms of war shock and those found in victims of industrial and railway accidents. The nervous and mental disorders of war were immediately assimilated into the diagnostic categories of pre-war psychological medicine. At the same time, doctors struggled to understand how the war environment contributed to the production of symptoms in soldiers. In the first eighteen months of the war, the interplay of pre-war modes of explanation with attempts to comprehend the effects of battle on soldiers shaped medical responses to “shell-shock”. This approach militated against the ascription of purely physical aetiologies to the disorder. The pre-war diagnostic categories

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employed to understand similar symptoms were too ambiguous to allow uniform implementation of physical explanations, while the essential novelty of industrial warfare compelled doctors to explore factors beyond the effects of shell explosions.

Aetiological ambiguity is conspicuous in early medical reports on the nervous and mental disorders of war. Authors deliberately avoided moncausal theories. Instead, they resorted to elaborate descriptive categories: ‘men who came back from the front with nerves shattered’; ‘the dumb and the deaf, the paralysed, and the insane from shell explosions and shock’; and ‘military cases of hysteria, hystero-traumatism, traumatic neurosis, and nervous troubles due to suggestion’. A bill proposed in the House of Commons in April 1915 to facilitate the early treatment of mental disorders replicated this deliberate inclusiveness, referring to those ‘suffering from mental disorder of recent origin arising from wounds, shock, disease, stress, exhaustion, or any other cause’. The desire for precision without commitment to definite causes tied some authors in knots. One account discussed ‘cases labelled more or less definitely as “nervous breakdown,” “collapse,” “shell shock,” “shell concussion,” “traumatic hysteria,” “traumatic neurasthenia,” where the symptoms are insomnia, battle dreams, disturbances of the special senses, “functional” palsies and anaesthesias, emotional overreaction, defects of mental synthesis, mental instability or disequilibrium, even paramnesia and hallucinations’. Another medical commentator gave up in despair, concluding that no existing label adequately described diverse cases of ‘nervous shock under a single heading’. It is easy to see the appeal of “shell-shock” as a term which attributed miscellaneous symptoms to war conditions but refused further efforts at diagnostic precision.

Many medical commentators were reluctant to ascribe first causes to “shell-shock” because they lacked knowledge, or found it difficult to think beyond the ambivalence of familiar modes of explanation. But it is also crucial to appreciate that in the early months of the war, the appearance of symptoms in soldiers was more important than other

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aspects of their manifestation. It is partly because men serving their country suffered these symptoms that doctors resisted reducing war syndromes to their exact pre-war counterparts but instead portrayed such conditions as the outcome of immersion in war, which incorporated the totality of embodied experience.\textsuperscript{11} Any number of factors might lead soldiers to break down: anxiety, fatigue, lack of food, ‘the horrors of the battlefield’, concussion, strain and tension, or ‘the sight of blood, of suffering, and of death’.\textsuperscript{12} Doctors saw war as the supreme causative agent of “shell-shock”, and therefore explored the emotional, “psychic” and physical pressures of warfare. Although they realized that therapeutic efficacy would depend on more precise knowledge, at this early stage of hostilities doctors also emphasized the shared origin of these conditions above their different manifestations. What really mattered was not whether symptoms resulted from ‘psychical or physical traumata’, but that they were ‘the product of modern warfare under modern conditions’\textsuperscript{13}.

Of course, rigid distinctions between physical and psychological disorders had little place in the workable ambiguities of pre-war psychological medicine. The theory of psycho-physical parallelism allowed for psychological or somatic explanations, as well as considerable latitude in assigning the ultimate causes of mental disorder. This flexible approach was reflected in the diagnostic categories and language used to describe soldiers’ nervous and mental illnesses in the early months of the war, which had shifting connotations in pre-war medical discourse and were all open to interpretation. In describing symptoms as “traumatic”, doctors referred soldiers’ conditions to a diagnostic category with acknowledged physical and “psychic” elements, but no accepted theory of causation.\textsuperscript{14} They also spoke of “nerves”, another concept occupying the shadowy hinterland between brain and mind, psyche and soma.\textsuperscript{15} The same ambiguity is evident in extensive references to “shock”, another concept which skirted the ground between the “psychic” and

\textsuperscript{11} See, for example, A. Feiling, ‘Loss of Personality from “Shell Shock”’, \textit{Lancet}, 10 July 1915, 63; Anon., ‘Mental and Nervous Shock among the Wounded’, 802.
\textsuperscript{13} Anon., ‘Lord Knutsford’s Special Hospitals for Officers’, \textit{Lancet}, 27 November 1915, 1201.
\textsuperscript{14} See Chapter 4 for an extended discussion of the traumatic neuroses.
the physiological, manifested in many different forms (‘surgical shock, psychical shock, apoplectic shock, commotio cerebri, diaschisis’), and had uncertain origins.  

Above all, in the early months of the war, the default diagnosis for these conditions was functional disorder. Indeed, at this stage in the war, on the rare occasions when doctors did propose physical theories of causation they assumed widespread acceptance of the functional nature of most cases. Before 1916, physiologist Thomas Elliott (1877–1961) and ophthalmologist John Evans (1871–1941) put forward the two most detailed expositions of physical theories. Both physicians adopted the same rhetorical strategy, arguing that the majority of cases were undoubtedly functional, but it was nevertheless possible that some resulted from actual organic lesions. They explicitly aimed to highlight alternative physical explanations for the nervous and mental disorders of war and to provide aids for differential diagnosis. At this point, it seems that doctors considered the potential organic origin of symptoms only after functional disorder had been ruled out, or after therapeutic methods based on this diagnosis had failed. Throughout the war, the belief persisted that some doctors too readily assumed the functional nature of these conditions, although others pointed out the dangers of misdiagnosing “psychic” conditions as organic injuries. Most doctors also accepted the coexistence of functional and organic injuries, including wounds.


18 A. Hertz [Hurst], ‘Paresis and Involuntary Movements Following Concussion Caused by a High Explosive Shell’, Neurological Section, PRSM, 8:2 (1914–15), 84.


As in pre-war psychological medicine, diagnosis of functional disorder did not necessarily mean that doctors viewed conditions as psychological. A report on ‘the pathology of shell concussion’ from August 1915 argued that rapid and dramatic changes in atmospheric conditions could cause instantaneous death and pondered whether ‘acute neurasthenia’ resulted from similar but less extensive damage to the nervous system sustained in shell explosions.\(^{21}\) In theories of “shell-shock”, doctors continued to exploit the conceptual fissures inherited from pre-war modes of explanation, as when “psychological” explanations were coupled with nominal allegiance to the existence of an underlying physical pathology. For example, John Herbert Parsons, ophthalmic consultant to the home troops, described cases of traumatic amblyopia (blurry vision) as ‘wounds of consciousness’ because he could find ‘no demonstrable organic lesion’ but cautiously added that ‘this does not imply that there is no neural lesion to account for the psychological disorder, but merely that it has hitherto escaped observation’.\(^{22}\) This was not mere rhetoric designed to appease thoroughgoing materialists. The entire mode of medical thought tended to break down distinctions between physical and psychological damage and to stress interchange between body and mind in functional disorders. Some doctors held that functional disturbance might eventually become ‘structural and permanent’; others maintained that when physical damage healed, purely functional symptoms might remain; still others argued that hysterical symptoms, such as transient paraplegia, might be grafted on to organic disorders.\(^{23}\) Most doctors believed it was impossible to draw hard-and-fast lines between “psychic” and somatic damage in “shell-shock”.

When doctors debated the possible physical causes of wartime functional disorders, their discussions extended beyond the effects of shell explosions. At meetings of the laryngological section of the Royal Society of Medicine held in 1915 and 1916, doctors considered military cases of functional aphonia (inability to produce voice): some diagnosed ‘pure’ functional disorder, some argued that functional elements coexisted with anatomical irregularities, and others suggested incipient or developed


tubercular disease as the cause.\textsuperscript{24} Of course, physicians did linger on the possible effects of continual exposure to shell explosions, the most novel and dramatic feature of modern warfare – but they saw these effects as extending beyond damage to the nervous system. Even at a very early stage in the war, doctors conjectured that often, shell explosions did no more than tip exhausted and emotional men over the edge into definite breakdown.\textsuperscript{25} Some speculated that prolonged shelling caused sensory overload which inhibited the function of the special senses, leading to loss of sight, hearing, or smell.\textsuperscript{26} One report compared functional deafness in soldiers to auditory problems in ‘boilermakers, riveters, blacksmiths, and people working on railways’.\textsuperscript{27} The battlefield could be configured as a gross extension of the pathologial modern industrial environment.

In the first years of the war, physical theories of causation did not dominate medical discourse on “shell-shock”. Instead, physical theories of causation sat alongside other forms of explanation which emphasized the interaction and coexistence of physical and “psychic” elements.\textsuperscript{28} Even doctors who believed in the physical origins of some cases of “shell-shock” noted that sometimes symptoms were caused by terrifying ‘psychical experiences’ and anxiety over the performance of duty.\textsuperscript{29} Neurologists did not rush to insist on physical aetiologies; the neurological journal \textit{Brain} published no articles on “shell-shock” until 1919. On the other hand, some doctors put forward relatively complex psychological theories in the initial stages of the war. In March 1915, the


\textsuperscript{27} Anon., ‘Shell Explosions and the Special Senses’, 663.


\textsuperscript{29} Turner, ‘Remarks on Cases of Nervous and Mental Shock’, 833 and 835.
neurological section of the Royal Society of Medicine discussed traumatic amblyopia. No participants referred to concussion or commotion (the theory that dynamic force exerted by explosions caused decompression within the organism). One claimed the disturbance was ‘purely mental and belonged to the region of ideas’; another referred to a case in which this ‘mental condition’ had been caused by the man’s anxiety over the welfare of his wife and children; the final respondent, Hugh Crichton-Miller (1877–1959) talked about ‘defence’ and ‘anxiety’ mechanisms produced by intolerable mental conflict. A few months later the gastroenterologist Adolphe Abrahams explained a patient’s hysterical paraplegia as an ‘anxiety-neurosis’ originating in the soldier’s fear that he would be permanently crippled and become a burden to his family. Although this kind of familiarity with sophisticated psychological language was unusual in this period, realization of the emotional strain of warfare was not. The more elaborate psychological theories formulated in the later years of the war evolved out of these moments of simple recognition.

1916: Differentiation, Opposition, and Displacement

In 1916, debates on the war neuroses moved up a gear, with nearly treble the number of articles published on “shell-shock” in the medical press as in the previous year. When the sections of neurology and psychiatry of the Royal Society of Medicine held a special combined meeting on ‘shell-shock without visible signs of injury’ in January 1916, there was a new seriousness to the discussions and clear commitment to grappling with “shell-shock” as a scientific problem. Doctors now had considerable experience in diagnosing and treating “shell-shock”, and consequently could develop more sustained arguments and conclusions. Moreover, it was now evident that Britain was in the war for the long haul. As the numbers of “shell-shocked” men increased and the rate of volunteers for the army slowed, the “shell-shock” epidemic could not be viewed apart from the looming manpower crisis. Renewed medical engagement with the nervous and mental disorders of war reflected urgent fears about the mental health of the army and the potential consequences of psychiatric failure for the fighting strength of the nation.


This more serious approach manifested in increased criticism of “shell-shock” as a viable diagnostic label. Although the initial appeal of “shell-shock” lay in its aetiological ambiguity, it rapidly became apparent that this vagueness could also limit its usefulness as a diagnostic category. Doctors needed to return patients to military service or productive civilian work as quickly as possible and to obtain replicable results. The deferred aetiological judgements and hit-and-miss therapeutic measures of pre-war psychological medicine did not serve these purposes. Less than a year after the first appearance of “shell-shock” in print, neurologist Henry Head impatiently complained that ‘heterogeneous … nervous affects from concussion to sheer funk, which have merely this much in common that nervous control has at last given way’, should not be bracketed together. Dealing with all these conditions under one label, Head claimed, was ‘to sweep up the various fruits which fall from the trees in a strong wind and then to discuss them without first stating that some fell from an apple and some from a pear tree’.33 This rejection of “shell-shock”, a term which accorded primacy to the origins of suffering in war rather than more specific causes or particular symptoms, was necessary to doctors’ more vigorous attempts to discriminate between different mental and nervous disorders of war.34

These efforts resulted in increased differentiation between physical and psychological theories of causation. The exploratory ethos of the first half of the war, when doctors attempted to blend physical and “psychic” causes and symptoms, did not entirely vanish: it survived in individual accounts, and in the trend for physiological theories of emotion.35 However, from 1916 inclusiveness ceased to be the dominant approach to “shell-shock”. In the second half of the war, some doctors began to elaborate complex theories of physical causation for the first time, while others formulated intricate and explicitly psychological theories.36 These developments were two sides of the same coin: the

35 Physiological theories of “shell-shock” are discussed in Chapter 6.
methodical exposition of physical theories provoked similarly detailed articulation of psychological theories in response, and vice versa. Alongside this differentiation, another movement occurred in both forms of theorization: displacement of responsibility for mental breakdown from the war itself onto the individual soldier, the material it worked upon. The war could be exculpated in two ways. Some psychological theorists located the origins of breakdown in the patient’s unique mental make-up and life history, rather than in the distressing experiences of war alone. War could cause even the strongest individual to break down, but often simply set the spark to flammable material in the patient’s own psyche.³⁷ Other doctors emphasized that breakdown usually occurred in men with inherently weak and unstable nervous systems.³⁸ These forms of explanation often merged: most physicians maintained that heredity and life experience were both important factors in the production of neurosis, but in their own theories focused on one over the other.³⁹ Theories of “shell-shock” that were radically different in almost all other respects shared this tendency to absolve the war of ultimate responsibility for breakdown.⁴⁰

This was not an intentional move, but emerged from attempts to resolve the question of why some men broke down while others did not. The war alone ceased to be sufficient explanation for “shell-shock”

⁴⁰ Simon Wessely argues that the most novel aspect of the construct of post-traumatic stress disorder when introduced into the psychiatric canon in 1980 was the view that the ‘insanity of war’ alone, rather than genetic predisposition or upbringing, could cause protracted and severe psychiatric breakdown. S. Wessely, ‘Twentieth-Century Theories on Combat Motivation and Breakdown’, Journal of Contemporary History, 41:2 (2006), 281–2.
and instead became seen as a contributory factor in breakdown: more severe than most, perhaps, with more direct influence on some cases than others, but nevertheless an agent which worked on the latent susceptibilities of the individual rather than a horrific event which alone accounted for these men’s disorders. In 1916 conscription was introduced: this was the year of the Somme, the year in which the crisis visibly deepened and the unity of the war effort became ever more important. In this context, doctors across the spectrum of medical opinion reframed “shell-shock” as a pathological individual reaction rather than an unavoidable response to the environment of war.

This shift in medical discourse is all the more striking because in the early months of the war, doctors rarely even hinted that soldiers might break down due to existing nervous instability. The temporary retreat from heredity as a viable explanation for (war-related) nervous and mental disorders was the most surprising aspect of medical discussions in 1914 and 1915, especially as the experience of war did not dent hereditary beliefs elsewhere in Europe. However, in Britain doctors initially judged the conditions of industrial warfare sufficient explanation for most breakdowns, partly because they optimistically believed that selection procedures prevented unstable individuals from joining up. Medical men emphasized that the ‘terrible stresses’ of trench warfare made “shell-shock” an entirely different order of experience to civilian nervous disorders. Broken soldiers should ‘be regarded and spoken of as mentally war wounded’. This position arose out of the strong voluntary tradition in Britain. In the earliest days of the war, soldier heroes were almost always represented as willing volunteers. Having proved their moral worth through the act of joining up, such men were less vulnerable to medical suspicions of hereditary taint. It is notable that the resurgence of hereditary explanations occurred after the Military Service Act 1916, although the legacy of voluntarism continued to shape public portrayals of masculine courage and doctors rarely mentioned conscription in their wartime publications.

This retreat from hereditary explanations for breakdown constituted a complete revolution from the dominant position of pre-war psychological medicine, but was short-lived. In the later years of the war,

44 Voluntarism is discussed further in Chapter 5.
medical authors frequently commented on the prevalence of ‘neuropathic or psychopathic disposition’ or ‘hereditary taint’ among soldiers suffering from mental or nervous disorders. As with physical and psychological theories of causation, elaborate investigations into the role of heredity in “shell-shock” were a product of the second half of the war and afterwards. Some doctors compiled statistics demonstrating the prevalence of personal and family histories of nervous and mental instability among “shell-shocked” soldiers; when results showed little direct correlation between heredity and war-related breakdown, they argued that the methods of investigation must have been unreliable, and the actual incidence of predisposition was undoubtedly higher. Alex Watson suggests that the realization that psychiatric disorders affected only a small minority of the men exposed to similar stressing factors spurred doctors to investigate hereditary predisposition. This explains the impulse to research heredity but not the results of these investigations. If some doctors believed the war had shown that any man could break down, for others the “shell-shock” epidemic had revealed ‘the large number of neuropathic persons there are who “carry on” in civilian occupations, battling with their feelings of self-insufficiency as best they may, and the still more numerous others in whom these


conditions are latent’.\textsuperscript{49} The tendency to fall back on hereditarian explanations reflects doctors’ pre-existing prejudices and underscores how remarkable it was that doctors neglected heredity in the early years of the war.

The later emphasis on heredity was not universal. Neurologist Howard Tooth (1856–1925) pointed out that given the horrendous strain of warfare, it spoke ‘well for the mental stability of the British soldier that there are not five times as many neurasthenics as there are’.\textsuperscript{50} Other doctors believed that hereditary predisposition increased the likelihood of breakdown, and might even be an operative factor in most cases, but nevertheless maintained that the experience of trench warfare might ‘shatter’ even ‘the strongest nervous system’.\textsuperscript{51} Millais Culpin (1874–1952) believed that ‘given enough of the strain of modern warfare, any man whatsoever will eventually break down’, but also claimed to have discovered increased incidence of predisposition (not necessarily hereditary) among patients as the war went on. He concluded that ‘the number of patients whose symptoms are due entirely to war experiences acting upon a mentally sound organism is likely to be small’.\textsuperscript{52} On the other hand, for Frederick Dillon (1887?–1965) the war showed that mental disorder did not necessarily result from ‘inborn predisposition’. Instead, ‘We are all of us potentially or latently susceptible to neurotic manifestations’.\textsuperscript{53}

The doctrine of hereditary predisposition was undermined to some extent by the experience of war, but there were limits to this process. The conclusions of the Report of the Committee of Enquiry into “Shell-Shock” (1922), based on the expert testimony of both military and medical witnesses, provide a useful guide to dominant opinion at the end of the war. The Report stated that ‘pre-disposition plays an immense part in the incidence of shell shock’ but also listed several other factors which increased the likelihood of breakdown, including environment, training, and education in childhood.\textsuperscript{54} This widened the definition of

\textsuperscript{49} C.H. Bond, ‘The Position of Psychological Medicine in Medical and Allied Services’, JMS, 67:279 (October 1921), 431.
\textsuperscript{54} Summary of findings, RWOCESS, p. 148.
‘predisposition’ in accordance with the latest psychological thinking but did not discount the importance of heredity in breakdown. The eugenicist Alfred Tredgold (1870–1952) claimed that although ‘mental stress’ played some part in “shell-shock”, ‘in most of the sufferers a definite predisposition to this breakdown was present’, as some ‘were never near to the firing line, nor had they seen or heard an exploding shell’. As late as 1940, Charles Myers echoed these conclusions, explaining that often “shell-shock” was dependent ‘on a previous psycho-neurotic history and inherited predisposition, on inadequate examination and selection ... and on the lack of proper discipline and esprit de corps’. To the end of the war and beyond, medical belief in hereditary weakness as a predisposing factor in the production of “shell-shock” remained widespread.

**Concussion and Commotion: Frederick Mott and Physical Theories of Causation**

One doctor whose view on the importance of heredity in nervous and mental disorders was not changed at all by the war was the neurologist and pathologist Frederick Mott. Mott is best known as the most influential British proponent of physical theories of causation for “shell-shock”. Although he did not publish directly on “shell-shock” until 1916, by the end of the war Mott had produced more articles on the topic than any other physician. He conducted lengthy investigations into the potential commotional origins of “shell-shock” and insisted until his death that some cases had a purely physical basis. Mott’s interventions decisively shaped medical debates on “shell-shock”. Although physical theories of causation were tentatively touted from the early months of the war, from 1916 many more doctors confidently asserted the organic basis of at least some cases of “shell-shock”, almost always citing Mott’s research in support of this position. At around the same time, other

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55 Anon., ‘Mental Disorder in Relation to Eugenics’, *BMJ*, 26 February 1927, 386. See also W. Salisbury Sharpe’s comments in Anon., ‘Traumatic Neurasthenia and the “Litigation Neurosis”’, *BMJ*, 17 December 1927, 1145: ‘The worse case of so-called shell shock he had seen was that of a man who had been for nearly ten years wholly incapacitated by a purely functional paralysis, and yet who had been at no time nearer the war than Plymouth’.

56 Myers, *Shell Shock in France*, p. ix; see also A.F. Hurst, *Medical Diseases of War*, 4th edn (London: Edward Arnold, 1944), pp. 1, 3. This emphasis on heredity contrasted with Hurst’s claim in the immediate post-war period that the majority of war hysterics had ‘no personal or family history of neuroses’; ‘The War Neuroses and the Neuroses of Civil Life’, *Guy’s Hospital Reports*, 70 (1922), 142.


58 For arguments by other authors published in 1916 in support of the theory of commotion, see Campbell, ‘War Neuroses’; Turner, ‘Arrangements for the Care of
physicians started to firmly refute physical theories of ‘shell-shock’. Mott’s elaboration of physical theories provided a clear statement for other doctors to support or argue against, and so boosted the differentiation of physical and psychological modes of explanation from 1916 onwards. However, even Mott never argued that all cases of ‘shell-shock’ resulted from organic damage to the nervous system. Indeed, his earliest discussion of the nervous and mental disorders of war concentrated on ‘psychic’ conditions. This should warn us not to assume the existence of neat divisions between physical and psychological theories.

Mott put forward his most sustained exposition of physical theories of causation in the Lettsomian lectures delivered in February and March 1916. He set out three classes of injury to the central nervous system caused by high explosives: immediate fatality, including death without visible injury; non-fatal wounds and injuries of the body which did not exhibit functional disturbances; and injury to the central nervous system without visible effects, including ‘functional neuroses and psychoses’. Mott acknowledged that some war-related functional disorders were not caused by the effects of shell explosions but justified the inclusion of functional disorders in this discussion because any ‘psychic’ disturbance must have a physical counterpart, even it was undiscoverable. By mid-1917, Mott believed he had clearly identified a class of ‘true’ or ‘real’ ‘shell-shock’ caused by concussion, commotion, or gas inhalation, which should be separated from purely functional cases. However, he also insisted that there was no fixed division between these two classes, and that ‘emotional’ and ‘commontional’ factors could play a part in the same case; for example, he diagnosed one soldier as a case of ‘shell shock and psychic trauma from witnessing death of comrades; psychic trauma maintained by terrifying experiences and dreams;

Cases of Nervous and Mental Shock’, 1073; Anon., ‘The War: Nervous and Mental Shock’, BMJ, 10 June 1916, 830–2; Clarke, ‘Some Neuroses of the War’, 49–50; Garton, ‘Shell Shock and Its Treatment by Cerebro-Spinal Galvanism’.
nervous predisposition’. Mott, the staunchest supporter of physical theories of causation, believed mind and body were both implicated in the production of many cases of war-related nervous and mental disorder.

A similar line of argument was pursued in other detailed researches on “shell-shock”. In 1919, Alfred Carver (d. 1950), an RAMC captain who served at Maghull Military Hospital, published the results of experiments into commotional shock. Carver observed the effects of high explosives on fish, rats and mice, and humans. He aimed to correct ‘the present tendency to regard the neuroses of war as of exclusively emotional origin’, and to gain ‘a more general recognition for the underlying physical basis demonstrable in a considerable proportion of them’. Carver concluded that ‘physical or “commotional” factors’ were present in many cases, but emphasized that ‘under the conditions of modern warfare the soldier is continually subjected both to physical and emotional causes of shock, and that the two factors operate in conjunction’. Crucially, although physical or emotional causes might initially dominate in any given case, ‘the individual, once sensitized by either, remains for a long time, perhaps always, hypersensitive to both forms of stimulation, and a vicious circle is thus established’. Carver was not a crank: he presented papers to the neurological section of the Royal Society of Medicine, and published in Brain, the British Journal of Psychology, and the Lancet. Nor did he stubbornly cling to physical theories: in the post-war period his research extended in more clearly psychological directions. Rather, he explored different approaches to “shell-shock”, and placed physical theories on a wider spectrum of potential explanations. Carver’s experimental methods were unusual, but his arguments were consonant with broader trends in wartime medical debates.

Accounts which insisted on the interdependence of physical and “psychic” factors fitted with pre-war approaches to nervous and mental disorders. Continuity in modes of explanation is also evident in Mott’s work. Mott’s research into “shell-shock” extended his existing interest in


64 A. Carver and A. Dinsley, ‘Some Biological Effects due to High Explosives’, Section of Neurology, PRSM, 12 (Parts 1 and 2) (1918–1919), 51.
the causes of insanity, which incorporated active campaigning for research into the early treatment of mental disorders.67 These efforts were driven by his conviction that the apparent increase in insanity was one of the most pressing social issues of the day and formed part of his wider concern with the social aspects of health and illness.68 Mott’s research on alcohol and syphilis emphasized the interaction of physical, environmental, temperamental, and “psychic” factors in the production of addiction, illness, and disease.69 His publications on “shell-shock” furthered these explorations and fit seamlessly with his longer-established concerns and research methods. Likewise, the manner of Mott’s engagement with psychological theorists illustrates the persistence of older approaches. Mott was not a sophisticated psychological thinker. In his efforts to understand the human mind and behaviour he drew on diverse sources, from classical texts to Jung and Freud, without acknowledging the contradictions between apparently opposed theories of mind.70 This eclecticism was typical of pre-war British medicine and only began to seem outdated after the war.

Mott’s war experience did cause him to modify his views about the prevalence of commotional “shell-shock”. At the outset of the war, he believed that a substantial number of cases had suffered organic damage to the central nervous system, although he did not state a precise figure at this time.71 In 1918 he estimated the ratio of emotional to commotional cases as 10:1, and in 1922 he revised this upwards to 5:1, following the conclusions of the Report of the Committee of Enquiry into “Shell-Shock”.72 This reassessment of the level of commotional “shell-shock”


71 Mott, *War Neuroses and Shell Shock*, p. 35.

followed the general trend of medical opinion. After 1917, most articles on “shell-shock” focused on emotional and psychological theories, even if they did not deny the existence of commotinal shock. Although the concept of invisible injury to the central nervous system continued to merit some attention in articles, books, correspondence and reports of public lectures and meetings of medical societies, discussions usually concluded that ‘true’ “shell-shock” constituted only a small proportion of cases. This remained the position of most post-war medical literature. The official medical history of the war published in 1923 stated that approximately 2.5 per cent of cases ‘showed evidence of a possible lesion of the nervous system’.

Even in the 1940s, some former “shell-shock” doctors still insisted that ‘men of stout heart’ had broken down through ‘the blast of a shell which damaged their brains’, and that ‘when a man is hit he deserves more consideration than when he is frightened’. Arguably, such theories have never completely disappeared: there are definite similarities between the diagnostic categories of commotional shock and

73 Anon., ‘The Treatment of War Psycho-Neuroses’, *BMJ*, 7 December 1918, 634.
mild traumatic brain injury (MTBI), claimed to be the signature injury of recent conflicts in Iraq and Afghanistan.80

Of course, it does matter that interest in physical theories peaked at the mid-point of the war and that the promotion of these theories continued after the war’s end: this demonstrates there was no linear or absolute transition from physical to psychological modes of understanding. Likewise, Mott’s physical theories of causation are important because they spurred the articulation of explicitly psychological theories and so helped to draw out the latent “psychological” potential in pre-war modes of explanation. But we should not use physical theories of causation as the litmus test of change within psychological medicine. Apart from a brief flare of excitement in 1916–17, these theories formed a minor part of medical discourse on “shell-shock” from the outset of the war until decades after its end. Physical theories were put forward in response to a novel feature of industrialized warfare, the use of massive quantities of high explosives. It is not really surprising that there was a short-lived vogue for these forms of explanation, or that most doctors preferred to develop other theoretical frameworks which emphasized “psychic”, psychological, or emotional factors, or that some doctors refused to discount physical theories of causation some decades after the war. It makes more sense to ask how doctors employed, adapted, or rejected older forms of explanation for nervous and mental disorders. Here we must return to the role of heredity in theories of “shell-shock”.

Mott’s views on the prevalence of commotional shock changed over the course of the war. His belief in heredity as the most important predisposing factor in mental disorders did not.81 In his 1916 lectures, Mott argued that the material and emotional conditions of trench warfare could ‘exhaust and eventually even shatter the strongest nervous system’.82 This acknowledgement seemed to mark a retreat from his pre-war insistence on heredity as the single most reliable determinant of mental disorder.83 However, Mott continually undermined this apparently radical conclusion by insisting that ‘neuropathic’ individuals were more likely than the ‘neuro-potentially sound’ to break down in response to shell fire or other aspects of trench warfare.84 In 1918 he instigated an investigation into the family and personal history of patients at the

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Maudsley Hospital, which purported to discover ‘a family history of neurotic or psychopathic stigmata’ in 74 per cent of ‘psycho-neurotic cases’. Overall, hereditary predisposition played a more important part in Mott’s theories of “shell-shock” than organic damage to the nervous system. He believed that it contributed to breakdown in both emotional and commotional cases of “shell-shock”: ‘neuropathic’ individuals would collapse under physical or emotional strain more quickly and severely than healthy men. Doctors sceptical of physical theories of causation put forward similar arguments. Again, the absence of a physical explanation does not guarantee the presence of psychological approaches.

Although Mott reassessed his views on the pervasiveness of commotional shock, he never evolved a more sophisticated psychological position. His pre-war research on alcoholism and syphilis acknowledged the part of “psychic” factors in the production of disease as did his first publications on “shell-shock”, but his attempts at psychological understanding were always naïve. Right up until his death, heredity remained the central pillar of his arguments about the causation of mental disorder. It is even possible that the experience of treating “shell-shock” strengthened Mott’s belief in the importance of heredity. In wartime, Mott displayed brisk sympathy for soldier patients, but his post-war work dissected the inadequacies of the conscript army. When the patriotic fervour surrounding “shell-shock” had faded, Mott publicly stated that the war had ‘shown that a very considerable percentage of the male population are potential neuropaths, and it only required the necessary stress of fear and exhausting nervous strain to reveal the same’. He lamented the sad consequences of treating these ‘neuropaths’: the

87 At least one obituarist identified Mott’s finding that the war neuroses usually occurred in those of a ‘constitutionally neuropathic disposition’ as the most important aspect of his wartime research, and did not even mention his support for commotional theories. Anon., ‘Obituary: Sir Frederick Mott’, 1229.
88 Wiltshire, ‘Contribution to the Etiology of Shell Shock’, 1209–10 explicitly argues against theories of concussion and commotion, but identifies ‘neuropathic predisposition’ or ‘taint’ as one of the most important factors in the production of war neurosis.
89 F.W. Mott, ‘Heredity in Relation to Mental Disease and Mental Deficiency’, BMJ, 19 June 1926, 1023–6.
government now struggled with a crippling pensions bill, and inferior men had not been ‘killed off to anything like the degree that the A1 physically and mentally sound men were’. War no longer stimulated ‘the purifying effect that it had in ancient times when in the struggle for existence the mentally and physically strong alone could survive’. Audiences listened to this crude and repugnant social Darwinism without protest. In Mott’s case, the war did not foster greater psychological understanding. It hardened existing prejudices, and convinced him that civilization was in the throes of decline.

**Suggestion, Hypnosis, and Therapeutic Conservatism**

The uneven and complex effects of the war on British psychological medicine are perhaps most evident in the therapies deployed, created, revived, and adapted to manage and cure “shell-shock”. From one perspective, medical treatment of “shell-shock” looks deeply conservative. Peter Leese has shown that the most common home front treatments for “shell-shock” consisted of conventional measures such as rest, massage, diet, and drugs. Versions of Weir Mitchell’s rest cure were still popular, especially for cases of neurasthenia and nervous exhaustion. Doctors removed the gross symptoms of hysteria using suggestion and hypnosis, but remained committed to rest and diet as measures to foster long-term improvement. Treatments based on mental and physical relaxation aimed to repair “nerves” by helping bodies to recover from exhaustion and providing a soothing atmosphere for minds troubled by war. As in pre-war psychological medicine, diagnosis of the “psychic” origins of a disorder coexisted with conservative therapies which targeted the body. Mainstream therapeutic practice shows up the limitations of psychological knowledge.

The picture is quite different if we examine public discussion of therapies, which represented a different form of knowledge about “shell-shock” and often served different purposes. Conservative treatments did not attract much attention in the medical press. Archival records tell us about

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93 Anon., ‘British Medical Association Special Clinical Meeting’, 711; Hewat, ‘Clinical Cases from Medical Division, Royal Victoria Hospital, Netley’, 211–3; Hurst, ‘War Neuroses and the Neuroses of Civil Life’; W. Harris, ‘The Value of Sleep’, *Practitioner*, 122:1 (January 1929), 19; Dillon, ‘Neuroses among Combatant Troops’, 66; Humphries and Kurchinski, ‘Rest, Relax and Get Well’.
practice on the ground, but do not capture important differences between pre-war and wartime medical discourse on treatments for nervous and mental disorders, or how this discourse may have helped to change therapeutic practice. At the public level, the focus was on therapeutic experimentation, albeit usually within established bounds. The impetus for this experimentation was the need to return “shell-shocked” soldiers to productive roles within or outside the military. The results of these experiments were disseminated through the medical press, causing some doctors to adapt their approaches, and exposing many more to new ideas. This kind of influence cannot be precisely calculated.

For the most part, experimental treatments followed lines familiar within pre-war psychological medicine, and therefore remained within certain boundaries. The absence of physical theories and rejection of conservative therapies rarely led to adoption of sophisticated psychological theories and treatments. Most doctors readily accepted that “shell-shock” often constituted a “psychic” or emotional response to war experience. However, this acceptance was compatible with simplistic models of “psychic” functioning. In this view, war was terrifying; it scared and horrified men; fear and horror were expressed as hysterical or “nervous” symptoms, especially among those predisposed to neurotic illness; the doctor should remove symptoms, reassure the man that he was not “really” ill, and return him to productive service. As with physical, “psychic”, and psychological theories, the important division is not between treatments focused on the body and those aimed at the mind. The relevant distinction is between treatments employing simplistic models of mental functioning and crude methods such as suggestion to remove hysterical manifestations, and those employing complex and fully articulated models of psychological functioning to tackle problems at the level of psychological process rather than that of the symptom. Most often, those wartime treatments which were not exclusively concerned with building up nervous strength aimed only to remove symptoms, most often through suggestion.

Applications of suggestion usually adhered to principles established within pre-war psychological medicine. This approach was used from the early months of the war, although over time suggestion attracted greater publicity and was employed more widely. Physicians often mixed methods of suggestion depending on symptom type or perceptions of likely responsiveness to particular procedures.94 In the most basic form of this treatment, doctors made direct suggestions to the patient, often

supported by the creation of an ‘atmosphere of cure’ (by banning crutches and other visible signs of disability or showing patients other men previously cured by the same methods).95 Another technique involved forcing the lost function into action, thereby demonstrating to the patient that there was nothing physically wrong with him. To this end, doctors stimulated the muscles of paralysed men using electricity, and put mute patients under anaesthesia in the hope that they would drift into speech.96 In contrast to direct methods, some forms of suggestion were fundamentally dishonest, and tricked the patient into believing that a particular medical procedure had cured his somatic illness. William Reynell (1885–1948), neurological specialist to a Ministry of Pensions clinic, told patients suffering from hysterical vomiting that the insertion of a stomach tube before meals prevented stomach contractions after eating.97 Although all suggestive techniques aimed only to remove symptoms, different methods incorporated quite different views of the doctor–patient relationship and the ethical responsibility of the physician to his patient.

The most notable champion of suggestion for “shell-shock” was Arthur Hurst (1879–1944), who served as consultant to the British forces in Salonika, neurologist to the Royal Victoria Hospital, Netley, and then as commanding officer of the Seale Hayne Military Hospital at Newton Abbot. Hurst initially employed eclectic methods including hypnotic suggestion and deception (he pretended to perform operations on soldiers suffering from hysterical deafness in order to convince them that he had dealt with a physical problem and thereby restored their hearing).98

96 Hewat, ‘Clinical Cases from Medical Division, Royal Victoria Hospital, Netley’, 211–12; Fraser, ‘War Injuries of the Ear’, 118-19; Stopford, ‘So-Called Functional Symptoms in Organic Nerve Injuries’, 796; Herringham, A Physician in France, p. 136. A form of “treatment” based on similar principles was jolting the patient out of his symptom through ‘some novel and unexpected emotional or physical shock’, although it seems that this was more often observed as an accidental effect of surprise than pursued as deliberate medical policy. See for example Leonard Guthrie in ‘Special Discussion on Shell Shock’, xli.
By the end of the war, Hurst and his co-workers had concluded that most patients could be cured through persuasion and re-education alone. But before this, Hurst gained a short-lived reputation for “miracle” cures, partly based on the propaganda film War Neuroses (1917) which used re-enactments and judicious editing to showcase his successes. Hurst and his medical officers were disappointed if they had not removed hysterical symptoms ‘within twenty-four hours of admission’, and boasted that one aphonic patient had been dispatched in ‘thirty seconds’. Although few could match this speed, supporters of suggestion often emphasized its swiftness. Opponents argued that removal of symptoms did not deal with their underlying causes, whether nervous exhaustion or severe emotional disturbance, and therefore suggestion did not achieve lasting cures. Charles Myers likened the use of suggestion to the practice of ‘a surgeon who might attempt to get rid of an abscess by opening it where it pointed, neglecting to follow up the pus to the original source from which it had tracked’. Similar objections were raised against hypnosis, but here the opposition was much more virulent. Hypnosis struck at the ideals of

99 In Hurst’s version of persuasion and re-education, the doctor appealed to the patient’s reason to establish recovery and then taught him to perform the lost function again. Symns, ‘Hysteria as Seen at a Base Hospital’, 96; Hurst, Medical Diseases of the War [1918], p. 33; Shephard, War of Nerves, pp. 78–80.


105 For accounts of hypnotic treatment, see A.W. Ormond, “The Treatment of “Concussion Blindness””, Journal of the RAMC, 26:1 (January 1916), 44; J.B.
rationality, autonomy, and self-control – indeed, at the very heart of manly character. Alongside Freudian psychoanalysis, hypnosis was the most controversial form of treatment for “shell-shock”.106 The disreputable heritage of hypnosis – the charlatanism of Mesmer, the predatory powers of Svengali and, most recently, the menace of Freudianism – was never far from the minds of medical critics.107 Use of hypnosis in cases of “shell-shock” often prompted outrage, although some doctors defended its employment in the exceptional circumstances of wartime.108 Antagonists argued that hypnosis deepened tendencies towards suggestibility and dissociation, and warned against suppressing the subject’s capacity for willed action.109 Hypnosis involved no effort from the patient, and so tended ‘towards deterioration and weakness’ rather than ‘development and strengthening of the character’.110 This analysis of medical power could be extended to all forms of suggestion. As Paul Lerner notes, all such techniques ‘sought to restore the patient’s control over his own body, but paradoxically, in doing so ... demanded that the doctor wield full control and authority over the patient’s mind and body’.111

Wartime doctors were aware of these power dynamics. Even proponents of suggestion agreed that the method worked through ‘the dominance of a strong mind over a weak one’, and boiled down to ‘essentially a contest between the physician’s personality and that of the hysterical patient’.112 Most freely acknowledged that suggestion was an unsophisticated method. At best, deliberate use of suggestion was depicted as heightening the element of suggestive hope present in all forms of

Tombleson, ‘An Account of Twenty Cases Treated by Hypnotic Suggestion’, Journal of the RAMC, 29:3 (September 1917), 340–6; Myers, ‘Contributions to the Study of Shell Shock (II)’.


108 See correspondence under the heading ‘Hypnosis in Hysteria’, Lancet, 21 September 1918, 404–5; 28 September 1918, 433; and 5 October 1918, 471; under the heading ‘Hypnotism’, Times, 22, 23 and 25 April 1919; and under the heading ‘Hypnotism, Suggestion, and Dissociation’, BMJ, 12 May 1919, 561; 19 May 1919, 592–3; 17 May 1919, 624–5; and 31 May 1919, 693.

109 Shaw, ‘Considerations on the Occult’, 1474.


111 Lerner, Hysterical Men, p. 122.

medical treatment. At worst, it was portrayed as a “primitive” art form. Rivers concluded a lecture series on ‘Medicine, Magic and Religion’ by stating that from ‘the psychological point of view the difference between the rude arts I have described in these lectures and much of our own medicine is not one of kind, but only of degree’. Although suggestion worked on the mind, it did not constitute a properly psychological form of treatment. However, practical familiarity with suggestion encouraged some doctors to ask further questions about the operation of the mind, and so fostered greater engagement with the psychological. In itself, suggestion was not radical, but its practice set some doctors on the road to radical conclusions. Suggestion demonstrated the manipulability of the mind, and encouraged doctors to try to replicate or extend its results using methods not open to the same objections. It therefore inspired exploration of psychological processes. As doctors conceded that suggestion did not tackle the ultimate cause of neurosis and therefore could not prevent relapse, they sought forms of explanation and modes of treatment which might achieve what suggestion could not.

**Psychodynamic and Psychoanalytic Approaches**

Doctors unsatisfied with physical remedies or suggestive techniques often explored psychodynamic approaches, most notably psychoanalysis. Many historians now argue that the experience of “shell-shock” did not, as was once thought, overturn the dominant explanatory frameworks of British psychological medicine by encouraging mass conversions to Freudianism. Certainly, psychoanalysis “proper” did not enter the medical mainstream in wartime, and even the most committed British doctors significantly modified Freudian theories in their own approaches to “shell-shock”. The reviewer who described Charles Myers as advancing ‘a point of view that approximates towards that of psychoanalysis’ nicely captured the tentative nature of British explorations of

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114 R.R. Marett, ‘The Primitive Medicine-Man’, Section of the History of Medicine, *PRSM*, 11 (Parts 1 and 2) (1917–18), 49; Anon., ‘Some Methods of Treatment Exercised by the Ancient Australian Medicine Men’, *King’s College Hospital Gazette*, 3 (October 1924), 508–11.
Freudianism. Wartime revisions of psychoanalytic theory and practice demonstrate the continuing influence of pre-war modes of thought and the limitations of medical engagement with Freud. However, the war did cause an upsurge of critical interest in psychodynamic approaches to mind which built on the conceptual assimilations of the pre-war period and steadily ripened in the decades after the armistice. This process of change was multidirectional, complex, and accommodated many apparent contradictions.

A case in point is British modifications to Freudian theory, especially the radical rejection of an exclusively sexual aetiology for war-related neurosis. Even Ernest Jones (1879–1958), Freud’s most active British disciple, claimed at times that the instinct of self-preservation was more important than the sexual instinct in the development of “shell-shock”. Although British objections to Freud did not focus exclusively on the sexual elements of his theory, these definitely provoked more extreme hostility than other aspects of psychoanalysis. When the physician David Forsyth (1877–1941) postulated a psychoanalytic interpretation of “shell-shock”, diagnosing one patient as ‘a case of unconscious homosexuality with well-marked anal eroticism’ and another as ‘anxiety hysteria, together with a strong Oedipus complex’, he prompted a four-month-long debate in the correspondence columns of the Lancet. The most antagonistic comments centred on the corruption of innocent patients by psychoanalytic ‘filth’. The vituperative response to Forsyth’s article was at odds with the accommodation of psychodynamic theories in pre-war medical

discourse. Venomous refutations of Forsyth’s analysis further demonstrate the process of differentiation between approaches to “shell-shock”: full articulation of a psychoanalytical interpretation of war neurosis prompted the elaboration of opposing views. However, this furore was also prompted by the application of a fairly straightforward Freudian interpretation to soldiers. The rejection of sexual aetiologies, especially in W.H.R. Rivers’ thoughtful and extended discussions, was applauded by those unsympathetic towards Freud, and probably convinced some members of the medical community to engage more closely with other aspects of psychoanalytic theory. But in point of fact, most psychoanalytically oriented doctors did not reject the sexual aetiology of neurosis lock, stock, and barrel. Rather, they argued that the sexual origins of neurosis might be important in civilian cases, even if Freud had concentrated too exclusively on this aspect, but that the shock and strain of warfare was sufficient to explain breakdown in otherwise “normal” men.

This emphasis on war as a stressor of abnormal severity helps to explain an apparently paradoxical fact about the potential role of “shell-shock” as a catalyst for change within British psychological medicine: although as a consequence of the war many doctors read Freud more closely and started to formulate psychodynamic theories of mind, this did not lead to the adoption of complex psychotherapeutic methods. Of course, war conditions were not conducive to full-blown psychoanalysis. Doctors had little time and even fewer resources, and needed to treat or discharge men as quickly as possible. But more important was the belief that breakdown in soldiers had been triggered, if not caused, by recent war experience, and so treatment did not need to unearth ‘hidden psychical trauma and its buried complexes’. Even David Eder, one of the founder members of the London Psycho-Analytical Society, accepted this view and treated only five patients from a series of one hundred cases by psychoanalysis. Mass breakdown in apparently

122 Burton-Fanning, ‘Neurasthenia in Soldiers’, 911; Hurst, Medical Diseases of the War [1918], pp. 73–5.
125 Eder, ‘Address on the Psycho-Pathology of the War Neuroses’, 268.
healthy young men encouraged doctors to explore unfamiliar approaches to mind, but the existence of war as the factor decisively tipping men into psychiatric illness discouraged the full application of psychoanalytic therapies. Ultimately, most doctors believed that war itself precipitated the development of “shell-shock” – sooner in the physically or mentally unstable, later in the physically and mentally sound, but eventually it would weaken all men. The therapeutic rationale of psychoanalysis was undermined by this combination of wartime constraints on practice and the belief that latent weakness had risen to the surface only through the extreme stress of war. The war simultaneously provoked, limited, and contained the potentially radical effects on psychological medicine of intellectual engagement with psychoanalytic theory.

The incomplete application of analytic therapies to “shell-shock” also extended the characteristic conceptual and practical strategies of pre-war psychological medicine. As shown in Chapter 2, popular therapies for functional disorders reflected views of mind and body as indissolubly linked and sought to strengthen body, mind, and character. This approach to treatment assumed no strict correlation between the dominant causative factor in illness – partly because this was ultimately unknown – and specific therapeutic measures. The pragmatism of pre-war British psychological medicine left doctors open to engagement with psychological theorization, but limited their embrace of it. The same process is seen in wartime flirtations with psychoanalysis.126 Walter Duncanson Chambers (1886?–1958), an asylum psychiatrist who served with the RAMC in France, diagnosed an ‘oedipus-complex’ in one young officer; his treatment extended no further than sending the man back to his unit ‘to look for his manhood once more’.127 Paul Bousfield, physician to the Lancaster Clinic of Psychotherapy, introduced examples of ‘an abnormal erotic condition’, ‘infantile fixations’, and ‘a strong “father complex”’ into his discussion of treatment of the war neuroses through lowering blood pressure (he did not claim this was the only possible method of treatment).128 The “translations”, accommodations, and partial assimilations of pre-war approaches to psychological theories carried over into wartime.

This is illustrated by responses to W.H.R. Rivers’ theory of the role of repression in war neurosis. Rivers argued that the most severe symptoms

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126 Fearnsides, ‘Essentials of Treatment’, 47.
of war neurosis were caused by attempts to banish distressing memories from consciousness, and that the recovery and reintegration of these memories into a coherent personal narrative of war experience could significantly relieve symptoms. In 1919, Millais Culpin, a surgical specialist who retrained in psychology as a result of his war experience, concluded that the therapeutic value of the revival of repressed memories was ‘the most important lesson taught us by the war’. But Culpin also complained that this topic was not even mentioned by other participants at a recent meeting on the war neuroses. As this suggests, some physicians either did not understand Rivers’ argument or denied its validity. When Rivers first delivered his paper on the repression of war experience to the psychiatric section of the Royal Society of Medicine, one respondent suggested that talking about war experiences perpetrated symptoms, and recommended trout-fishing as a way to dispel memories of warfare. Acknowledgement of the emotional origins of war neurosis easily coexisted with recommendations for doctors ‘to induce “self-forgetfulness”’ and teach patients not to think about their war experiences. However, doctors who did agree with Rivers also “translated” his argument that expression of emotion relieved symptoms. Laughton Scott (1887–1953), another physician to the Lancaster Clinic of Psychotherapy, spoke quite simply of the benefits of ‘confession’. This selective appropriation of elements of Rivers’ theory, as well as the specific language of assimilation, echoes pre-war approaches to Freudian psychoanalysis.

130 M. Culpin, ‘Correspondence: The Discussion on War Neuroses’, *BMJ*, 19 April 1919, 501. Culpin admitted that when he had been unable to find a cause for patients’ mental conflicts, he too had fallen back on the advice to repress their troubles; Culpin, *Psychoneuroses of Peace and War*, p. 121. For further controversy over the value of the theory of repression, see A. Carver, ‘Forgetting: Psychological Repression’, *BMJ*, 10 January 1920, 46–7, and subsequent correspondence under the heading ‘Forgetting: Psychological Repression’, *BMJ*, 17 January–21 February 1920.
Assimilation and “translation” characterized wartime encounters with psychoanalysis. Although the word ‘psychoanalysis’ appeared in the medical press frequently from 1918, this usually indicated little more than lip service to the talking cure. Quite often, when doctors referred to ‘psychoanalysis’ in their own practice, they meant only that the physician should have a long conversation with the patient about his war experiences, and continued to stress their distance from Freud’s theories and techniques.134 This stratagem was noted by other doctors, who saw it as evidence that despite all the chatter about novel “psychic” theories, new names only cloaked older approaches and explanations.135 Accommodation without fundamental revision – described previously as welding rather than assimilation – is also evident. The second edition of R.H. Cole’s textbook of nervous and mental disorders, published in 1919, was scattered with new references to Freud. But these involved no more than a sentence or two inserted into the existing text. Cole took account of the surge of interest in Freudian and other psychological theories, but did not alter his general framework of explanation as a result of exposure to these ideas.136

Because so few “shell-shock” doctors fully endorsed psychoanalysis, the qualified and tentative characterization “analytic” best describes those who engaged with psychoanalytic ideas. “Analytic” is not a synonym for “psychoanalytic”. Military doctors did not employ psychoanalysis “proper” as a treatment for “shell-shock”. “Analytic” is used here as an umbrella label for doctors who displayed keen interest in the psychodynamic theories of Continental physicians, and sought to understand how their therapeutic techniques might be modified to provide effective care in wartime conditions. These “analytic” doctors also drew on modes of conceptual assimilation familiar from pre-war psychological medicine, and employed an eclectic mix of therapeutic methods which did not neatly match up to particular theories of mind.


136 Cole, Mental Diseases: A Text-Book of Psychiatry for Medical Students and Practitioners [1913], pp. 28, 216, 221; 2nd edn [1919], pp. 31, 220, 225.
“Analytic” doctors worked with a sophisticated model of psychological functioning which incorporated understanding of unconscious processes and the complex interaction of previous events in the patient’s life history with the effects of more recent war experience in the formation of neurosis. They employed psychological analysis, including techniques derived from psychoanalysis, for diagnostic purposes. Most tried to elicit patients’ lost memories and to prevent the repression of emotion associated with distressing incidents, but also treated patients with non-analytic therapies such as suggestion, persuasion, and re-education. Apart from Rivers, few “analytic” doctors provided elaborate theorizations of mental processes. They drew lightly on the technical vocabulary of psychology, instead using plain language such as ‘interview’ and ‘heart-to-heart discussion’ to describe therapeutic encounters. It was common to underplay the specialist skills necessary for analysis, and to claim that drawing out a patient’s war experience demanded no ‘expert knowledge, but simply common sense, discreet sympathy, and tact’. Finally, these doctors made sense of psychological theories and therapies through analogies to other scientific and medical activities such as chemical analysis, anatomical dissection, diagnosis of physical ailments, and surgical operations. Such comparisons tamed and normalized psycho-dynamic theories.

These modes of presentation might be viewed as mere rhetorical strategies designed to soften the public reception of controversial material. The psychologist T.H. Pear (1886–1972), co-author of *Shell-Shock and Its Lessons* (1917), one of the major wartime publications in the “analytic” mould, claimed as much in his unpublished reminiscences. Wartime outbreaks of hostility towards psychoanalysis led some sympathizers to dissociate themselves from Freudianism. For example, Millais Culpin displayed thoughtful fascination with Freudian dream interpretation in his publications, but felt compelled to disavow descriptions of his methods as ‘psycho-analytical’.

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141 M. Culpin, ‘Dreams and Their Value in Treatment’, *Practitioner*, 102:3 (March 1919), 162; Culpin, ‘Correspondence: The Discussion on War Neuroses’, 501. Grafton Elliot
diagnostic theory and therapeutic practice in the work of “analytic” doctors cannot be simply written off as a tactical posture. There is evidence of genuine scepticism towards certain elements of psychoanalysis, as when Grafton Elliot Smith (1871–1937) uncompromisingly described Freudian dream interpretation as a mass of ‘repulsive excrescences’. But most importantly, there is no fundamental contradiction between the view that “analytic” doctors pursued certain rhetorical strategies in their presentation of psychodynamic theories, and the view that these modes of presentation demonstrate continuities with the conceptual approaches of pre-war psychological medicine. The witting and unwitting choice of particular rhetorical strategies reveals the existence in British medical culture of shared ways of thinking and approaching problems. For example, “analytic” doctors were not the only physicians to compare psychotherapy to surgical operations: the same comparison was made by psychoanalysts defending their claim to scientific expertise, and by medical men warning their colleagues about the dangers of amateur investigations into the unconscious. In war as in peace, British doctors integrated psychological modes of explanation with existing approaches to mind and its disorders.

Conclusion

In 1919, Robert Armstrong-Jones attempted to elucidate some of the newer theories of mind for a general medical audience. He explained that ‘the simile has been advanced that the Mind is a constant running stream of consciousness, like a mighty river’. To help his readers understand what this comparison meant, Armstrong-Jones proposed an act of imagination:

If we could picture for one moment the river Thames as frozen solid from its source to its outlet, and we were to divide it across, say, at Blackfriars Bridge, then if we could turn up each divided end and look at it, we should get a view of our own consciousness at a particular time and place; but if we were to contemplate the whole course of the river, then we should have the whole human mind during any one life-time.

Smith and Thomas Pear also denied they were psychoanalysts: G.E. Smith, ‘Correspondence: Functional Nervous Disease’, Lancet, 6 May 1916, 971; Smith and Pear, ‘Letters to the Editor’, 64.


If the stream of consciousness is the paradigmatic metaphor of psychodynamic psychology, then freezing the stream and chopping it up into separate components represents equally well the characteristic response of mainstream British psychological medicine to the challenges posed by new forms of psychological thought and practice.145 For the most part, British doctors struggled to assimilate psychodynamic approaches to mind, and employed the same conceptual strategies for handling psychological theories already in use before 1914.

At the same time, the effects of the “shell-shock” epidemic on British psychological medicine were more complex than sometimes assumed. At the beginning of the war, doctors did not adopt exclusively and uncomromisingly organicist positions on the likely origins of “shell-shock”. Elaborate physical theories of causation emerged alongside “psychological” explanations of the war neuroses. Although psychological modes of understanding became more prominent in the later years of the war, they did not displace physical theories of causation. Older forms of explanation emphasizing the interplay of “psychic” and somatic elements in nervous and mental disorders remained commonplace throughout the war. Theorists who concentrated on physical factors in the development of “shell-shock” did not exclude emotional and psychological elements from their accounts, and those who focused on “psychological” explanations did not deny the potential role of physical factors in at least some cases.146 Moreover, after a temporary suspension of (public) belief in heredity as a significant aetiological factor in war-related breakdown, many doctors reverted to their pre-war positions on the importance of inherited predisposition. The differentiation of physical and psychological modes of understanding proved crucial in the long-term development of British psychological medicine, but there was not steady progress towards psychological thought. The processes of change were uneven, multidirectional, and never complete.147

145 Armstrong-Jones approached the study of the stream of consciousness in the manner of an anatomist or pathologist. John Herbert Parsons explained why this method was not appropriate to psychology: ‘In dealing in this manner with a living moving stream, such as the stream of human consciousness, the anatomical method fails through freezing everything into a static condition. The anatomist’s dry bones can be made to live only by the physiologist’s study of the parts in motion – the play of the muscles, the circulation of the blood, the telegraphic impulses along the nerves, and so on. So the psychologist, though he is forced to study mental processes by a method of analysis, must correct the distortions which he thus artificially produces by constant reference to the everlasting and continuous flow of consciousness’. Parsons, Mind and the Nation, pp. 60–1.


147 See Mathew Thomson’s excellent short discussion of some of these issues: Psychological Subjects, pp. 182–6.
What really matters is not whether a psychological revolution occurred within the span of four years, but what those four years meant for British psychological medicine over the longer period. The war exposed doctors who had not previously specialized in nervous and mental disorders to the frailties of the human mind and demanded that they do everything possible to patch up broken men. As a result, doctors engaged with new theories of mind and rejected prejudices against older forms of treatment such as suggestion. The effects of “shell-shock” on British psychological medicine cannot be reduced to what happened in the moment of war. This is partly because the war simultaneously provoked and constrained radical reassessments. It forced doctors to reconsider the causes of breakdown, but provided a ready-made and exceptional explanation for “shell-shock”. It demanded they find methods of treatment, but allowed them no time to explore more elaborate psychotherapeutic measures. It made them realize that any man could break down, but provided no answers as to why not every man did. The effects of war on psychological thought cannot be neatly wrapped up, quantified, and confined to a discrete period of time. War familiarized doctors with new ways of thinking about psychological problems, but these innovatory approaches coexisted with older therapeutic measures and modes of understanding. The experience of 1914–18 stretched rather than broke the explanatory frameworks of pre-war psychological medicine. But stretched far enough, any shape will eventually become unrecognizable.