

## **Shell-shock in First World War Britain: an intellectual and medical history, c.1860-c.1920**

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**Shell-shock in First World War Britain:  
an intellectual and medical history, c.1860-c.1920.**

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[ 2006 ]



## Abstract

Historians have identified shell-shock, a contemporary umbrella term for the range of nervous and mental afflictions suffered by soldiers in the First World War, as a key episode in the transition to modern psychological approaches to mental disorder in Britain. This thesis argues that wartime theories of shell-shock display considerable continuity with central tenets of pre-war psychological medicine. An approach to the history of shell-shock which emphasises continuity opens new perspectives on the significance of the episode for British psychiatry and society in the early twentieth century. This thesis shows that theories of shell-shock were formulated within an evolutionary framework of understanding, and breaks down the conventional historiographical division between ‘organic’ and ‘psychological’ explanations of the war neuroses. It argues that in the debates on shell-shock, doctors explored questions about the constituents of human identity which had been given fresh urgency by the Darwinian revolution. They attempted to understand the relative roles of mind and body in the causation of mental disorder, but also invoked other conceptual pairings: the relations between animal and human behaviour, the balance of emotion and will in ideal conduct, the influence of heredity and environment in shaping action, and the interaction of individual and social psychologies. Wartime psychological medicine thus drew on and extended existing debates within and outside medicine, including those on the traumatic neuroses, crowd psychology and democracy, and the relative rights and responsibilities of citizen and state. The thesis argues that the importance of shell-shock therefore extended beyond its putative effect on British psychology. Theories of the war neuroses were a microcosm of debates on the nature of modernity, its nebulous effects on the individual, and its consequences for society.

### **Statement of originality**

I certify that this thesis, and the research to which it refers, are the product of my own work, and that any ideas or quotations from the work of other people, published or otherwise, are fully acknowledged in accordance with the standard referencing practices of the discipline. I acknowledge the helpful guidance and support of my supervisors, Professors Daniel Pick and Michèle Barrett.

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## Acknowledgements

It is difficult to know where to begin and to end a list of the debts incurred during the writing of this thesis. The administrative staff at the History department of Queen Mary, University of London, particularly Kathryn Mallen, Miriam Lakin, and Jenny Ruder, all helped to make life run more smoothly in numerous ways. The staff of the British Library and the Wellcome Library for the History of Medicine also deserve thanks for their friendly assistance. The research could not have been undertaken without funding received from the Arts and Humanities Research Council, and a stipendiary fellowship funded by the Scouloudi Foundation and administered by the Institute of Historical Research. The members of various seminars held at Queen Mary and the Institute of Historical Research offered extremely helpful comments on papers based on this research. The remarks Professor Morag Shiach made on early drafts of two chapters were a useful guide at subsequent stages of writing. Dr. Dan Todman kindly read a full draft of the thesis. His perceptive criticisms were much appreciated, and undoubtedly helped to make the final argument more coherent. My supervisors, Professors Daniel Pick and Michèle Barrett patiently put up with broken deadlines and endless prevarication, and never failed to provide encouragement, inspiration and criticism at the right times and in the right places. For this, and too much else to list here, I thank them. Matthew Grant has lived with this thesis for nearly as long as I have. Throughout its writing, he alternately cajoled, questioned, suggested, criticised, cheered, proof-read, but most importantly always listened and supported. It is not a fair exchange, but in return I dedicate the finished article to him with love and gratitude.

## Abbreviations<sup>1</sup>

<i>ANP</i>	<i>Archives of Neurology and Psychiatry</i>
<i>BMJ</i>	<i>British Medical Journal</i>
<i>DPM1</i>	D.H. Tuke (ed.), <i>A dictionary of psychological medicine, volume 1</i>
<i>DPM2</i>	D.H. Tuke (ed.), <i>A dictionary of psychological medicine, volume 2</i>
<i>EMJ</i>	<i>Edinburgh Medical Journal</i>
<i>JAP</i>	<i>Journal of Abnormal Psychology</i>
<i>JMS</i>	<i>Journal of Mental Science</i>
<i>MR4</i>	G.H. Brown (compiler), <i>Munk's Roll, volume 4</i>
<i>MR5</i>	R.R. Trail (ed.), <i>Munk's Roll, volume 5</i>
<i>MR6</i>	G. Wolstenholme (ed.), <i>Munk's Roll, volume 6</i>
<i>MR7</i>	G. Wolstenholme (ed.), <i>Munk's Roll, volume 7</i>
<i>ODNB</i>	<i>Oxford Dictionary of National Biography (2004)</i>
<i>RWOCESS</i>	<i>Report of the War Office Committee of Enquiry into "Shell-Shock"</i>
<i>TMW</i>	<i>The Medical World</i>

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<sup>1</sup> Full details for the books listed here are given in the bibliography.

### Note on the text

Some clarification is called for concerning the form of name used for certain doctors throughout the thesis. Several of the doctors published under a combination of a middle and family name: for example, the name given at the heading of articles by John Samuel Risien Russell was J.S. Risien Russell, or for Samuel Alexander Kinnier Wilson, S.A. Kinnier Wilson. In the main text, footnotes, and bibliography, individuals who followed this practice have been referred to by family name only. This follows the practice in *Munk's Roll* and in the *Medical Directory*. Special mention should be made of Grafton Elliot Smith, whose family name was 'Smith', but is frequently (although not consistently) referred to as 'Elliot Smith' in secondary works. Here he is always 'Smith' in footnotes and bibliography. Some of the doctors referred to later hyphenated their names, usually after being awarded honours of some kind. James Purves Stewart became Purves-Stewart, Walter Langdon Brown became Langdon-Brown, and Edward Schäfer became Edward Sharpey-Schafer. The publications used by these authors here pre-dated hyphenation, and so all are referred to by family name in footnotes and bibliography. Two individuals changed their name over the period covered by this thesis. In 1915, Robert Jones became Robert Armstrong-Jones, and in 1916 Arthur Hertz changed his name to Hurst. The names under which particular articles were published are clearly indicated at relevant points in the text. For ease of reference all articles published by these authors are grouped in the same place in the bibliography, although the name under which they were published is also indicated.

Some comment on the dates for journal references in the footnotes and bibliography is also necessary. The *British Medical Journal* and the *Lancet* were published fortnightly, and *The Medical World* weekly, but standard practice is to reference the numbers of half-yearly bound volumes. This practice has been followed in footnotes. The interested reader might find the exact date of publication useful, however, so in the bibliography the week of publication is also given in square brackets following the standard reference. A similar practice has been followed regarding the *Proceedings of the Royal Medical Society*, which was published annually. In the footnotes, standard references are given: in the bibliography, the date at which papers were presented or meeting held is given in square brackets following this reference.



## Introduction

Historically and historiographically, shell-shock is disputed territory. During the war of 1914-18, the military and medical authorities, patients and public all brought their own definitions to the term, and all contributed to shaping its meaning. No one group was ever able, or even perhaps willing, to establish the primacy of its claim. Shell-shock was simultaneously administrative category, medical diagnosis, self-ascribed affliction, bargaining tool, and cultural metaphor. These meanings (and no doubt others) shaded into each other to form a nebulous whole, a concept which belonged to everyone and therefore to no-one, which consistently resisted attempts both to stake out its boundaries and to stamp it out entirely. Its refusal to be reduced or confined to any one meaning enabled its diffusion and ultimately ensured its survival, albeit in diluted form, in the English vernacular to the present day. The historiography of shell-shock has been shaped by, and reflects, these messy origins. Its history also belongs to everyone and to no-one. Historians of civilian or military psychiatry jostle for space alongside those colleagues with primarily social, cultural, or literary interests. Their research is read or neglected by a public whose understanding of shell-shock derives from other sources: from newspaper reports of questions raised in parliament over the legitimacy of military executions during the war, or of current debates over the spread of post-traumatic stress disorder and ‘counselling culture’, from the war poetry taught in schools, from television programmes of all genres (documentary, drama, even comedy or ‘reality’), from films, biographies, and novels. After ninety years, shell-shock still resists appropriation by any one group, and this is surely one reason why it is still culturally and historically resonant.

This thesis unpicks the ways in which British doctors constructed and bestowed meaning on shell-shock during the First World War. For this group no less than any other, shell-shock was an ambiguous category, open to diverse definitions and explanations. Throughout the current work, one aim is to underline the contemporary flux within concepts of shell-shock. However, another main theme is the points of convergence between apparently divergent theories of the war neuroses. It is argued that at the most basic level, these theories were formulated within an intellectual framework governed by the concept of evolution. This analysis provides the key to the two remaining major themes of the thesis. The first is the extent to which theories of

shell-shock displayed continuity with the precepts of pre-war British psychological medicine. The second chapter unravels how diagnoses of hysteria and neurasthenia were constructed in pre-war medicine, and argues that historians have misinterpreted the content and relation of the categories both before and after 1914. This chapter demonstrates that a nuanced approach to concepts in the history of psychiatry reveals areas of continuity within pre-war and wartime thought, and therefore undermines historiographical arguments based on the construction of hysteria and neurasthenia as opposed diagnostic concepts. It also analyses the social and political fears surrounding the neuroses before the war, and therefore points forwards to the second major theme: the conceptualisation of the war neuroses as a regression which threatened the ideals of civilised, human identity.

The prevalence and significance of this conceptualisation can only be realised once contemporary understandings of shell-shock are made the focus of analysis, rather than the later definition of the war neuroses as a psychological response to trauma. This argument, and the relation of the present work to the historiography of shell-shock, is made in the first chapter. It also argues that in order to reconstruct the internal coherence of theories of shell-shock, it is necessary to reinstate the evolutionary framework within which they were formulated. Historians have focussed on a perceived division into physical and psychological theories of the war neuroses. As chapter five shows, however, 'physical' theories were never as prominent as has been assumed, and those explanations retrospectively identified under this heading display a complex and subtle understanding of mind-body relations. It is also demonstrated in chapter six that physiological and biological explanations played a large part in theories of shell-shock, and therefore the contemporary meaning of the disorder is not best understood through a rigid division into the 'physical' and 'psychological'.

In fact, explanations of the war neuroses made by a range of medical writers coalesced around the concepts of emotion and will. As shown in chapter three, particular attributes were attached to these concepts in pre-war psychological medicine. Emotion was associated with the body, animal and instinct, and will was perceived as the highest attainment of civilised man. In chapters six and seven, it is shown that although emotion and will were deployed in diverse ways in the theories and therapies devised around shell-shock, they retained their evolutionary meaning. Shell-shock was

therefore always conceptualised as a regression from the highest level of human development, and as a disorder which threatened a return to the animal. Although the war neuroses were perceived to undermine an ideal of masculine behaviour, a historiographical argument examined in chapter four, they were not understood only or even primarily in terms of gender, but in relation to the whole complex scale of evolutionary development. They provoked fears concerning human identity, not just its masculine form. The last chapter examines how theories of shell-shock were related to a wider complex of anxieties about the human and civilisation, particularly the relation of the individual to the social organism, which were given new urgency by war. The mental health of a civilian army reflected the mind of the nation it defended. On this basis, shell-shock held depressing prospects for civilisation. It was a locus for fears because it dramatically insisted on the persistence of the animal within the man, and seemed to show that civilisation itself caused this regression.

## Chapter 1

### Concepts and contexts in the history of shell-shock

#### Introduction

In February 1915, the academic psychologist Charles Myers (1873-1946), at this point attached to a volunteer medical unit in France, published an account of disturbances of the special senses found in soldiers. This article introduced the term 'shell-shock' to the wider medical public for the first time. The casual use of the expression, and Myers' later comment that he must have been 'one of the first' to employ it, suggests that 'shell-shock' was already familiar in France.<sup>1</sup> It may have originated among the fighting troops, but its exact provenance will never be known. Although cases of nervous and mental breakdown had been noted before this date, and Lord Knutsford had already made a public appeal to fund a recovery home for afflicted officers, once these disorders began to be described as shell-shock they seemed to assume a new level of importance.<sup>2</sup> In previous reports, nervous and mental symptoms in soldiers had been described under many headings, including 'shock', a familiar category in pre-war medicine.<sup>3</sup> But Myers' article went a step further and linked shock specifically to the effects of shell explosions. He was vague as to the details of this relationship, describing the symptoms as 'functional' and noting their similarity to hysteria, but also stating that the cases he had observed 'appear to constitute a definite class among others arising from the effects of shell shock'.<sup>4</sup>

The naming of shell-shock transformed a set of disparate symptoms into a condition. The sufferings of soldiers were all too real, and had been readily acknowledged, but the article Myers modestly offered as a 'contribution to the study of shell-shock' was

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<sup>1</sup> C.S. Myers, 'A contribution to the study of shell shock: being an account of three cases of loss of memory, vision, smell, and taste, admitted into the Duchess of Westminster's War Hospital, Le Touquet', *Lancet* 1915 (1), pp. 316-20; C.S. Myers, *Shell shock in France 1914-1918: based on a war diary* (Cambridge: C.U.P., 1940), p. 11.

<sup>2</sup> [Anon.], 'Mental and nervous shock among the wounded', *Lancet* 1914 (2), pp. 802-3.

<sup>3</sup> A detailed discussion of the terms used to describe nervous and mental symptoms in soldiers in the early months of the war is made in chapter five of this thesis. On the etymology of 'shock' and its particular military and technological connotations, see W. Schivelbusch, *The railway journey: the industrialization of time and space in the 19<sup>th</sup> century* (Leamington Spa, Hamburg and New York: Berg, 1986), pp. 150-8.

<sup>4</sup> Myers, 'A contribution to the study of shell shock', p. 320.

actually a creation. Although he did not invent the term shell-shock, Myers was responsible for its elevation into a syndrome. Others may have come to this understanding of the meaning of shell-shock before Myers, but he wrote this meaning down, sent it off to the *Lancet*, and gave it official existence in medical discourse, from whence it rapidly escaped into public ownership. In this sense, the baptism was also the birth. Myers was, by his own admission, only the step-father of shell-shock; he was less keen to acknowledge his role as midwife.

And who can blame him? It is one thing to foster an illegitimate child, but it is another to deliver a chimera into the world, and this is what Myers achieved. The monstrosity of shell-shock was clear enough in the twisted limbs and voiceless gestures of affected soldiers, and for this Myers could not be held responsible. But the naming of shell-shock also implied that a definite object existed to be named, that these cases 'constituted a definite class among others'. Yet Myers concluded that the contents of this class were unknown except in their grossest manifestations. He posited a shell explosion as the central aetiological event in these disorders, but offered no conclusions as to whether the symptoms originated in physical damage to the nervous system or a psychological reaction to the incident. He implied a definite chain of cause and effect, but balked at fashioning its links, or even suggesting the material from which they were made. He bestowed meaning on shell-shock through the act of naming it, but he simultaneously denied understanding of its meaning. The invention of the term 'shell-shock' moulded a set of symptoms into a definite, although amorphous and unidentifiable entity, and therefore created the conditions in which the hybrid creature could continue to mutate, as others discovered or denied further meanings and grafted them onto its misshapen shell.<sup>5</sup>

This thesis makes no pretence to chart comprehensively the totality of gestations, fusions and evolutions which comprises the long history of shell-shock. The more modest ambition of this undertaking is to examine how one group, medical clinicians, bestowed meaning on the nervous and mental disorders of war. The focus is on how

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<sup>5</sup> This interpretation of the 'creation' of shell-shock is influenced by Ian Hacking's theories of 'dynamic nominalism' and 'the looping effects of human kinds'. See I. Hacking, 'Making up people' in T.C. Heller *et al* (eds), *Reconstructing individualism: autonomy, individuality and the self in Western thought* (Stanford: Stanford University Press, 1986), pp. 222-36; I. Hacking, 'The looping effects of human kinds' in D. Sperber, D. Premack, and A.J. Premack (eds), *Causal cognition: a multidisciplinary approach* (Oxford: Clarendon Press, 1994), pp. 351-94.

their ideas related to the dominant modes of thought in pre-war psychological medicine, and how these theories were shaped within and by an evolutionary framework of understanding. The sole excursions made into the post-war world have the object of illuminating areas of continuity with conceptualisations of the war neuroses during 1914-18. The main aim of the thesis might therefore be described as to reconstruct crucial contemporary aspects of the meaning of shell-shock which appear to have been lost in recent histories.<sup>6</sup> The process of recovery also reveals the extent to which the nervous and mental disorders of war were always imbued with multiple meanings, even within the relative confines of medical discourse: as, for example, in the demonstration of interchange between ‘physical’ and ‘psychological’ theories of causation (chapter five), or the exploration of physiological ideas of emotion which happily co-existed with alternative explanations (chapter six).

This thesis takes the manifold meanings, and consequent essential ambiguity, of shell-shock as the defining feature of the disorder. This chapter examines how this ambiguity has shaped the writing of its history. It is argued that extant histories have implicitly or explicitly defined shell-shock as psychological disturbance, and that this definition has negatively impacted on understandings of how the disorder was conceptualised during the wartime period. These histories commonly divide theories of the war neuroses into ‘physical’ and ‘psychological’. This reading emphasises differences to the exclusion of the considerable similarities between doctors, and obscures the fecundity of contemporary understandings of the disorder. It is often associated with an insufficient appreciation of the nuances and complexities of pre-war psychological thought, and therefore when shell-shock is identified as the harbinger of ‘psychological modernity’, the change is measured against an illusory standard. These shortcomings reveal the extent to which the history of shell-shock has been written as a microcosm of the First World War: a catalyst within a cataclysm, a distinct episode forever trapped between eras, shaped by and shaping each but of neither, and difficult to conceptualise except as an agent of change because even at the distance of ninety years, it seems impossible that such destruction should not shatter the world.

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<sup>6</sup> Throughout this thesis, ‘contemporary’ refers to historical events or persons, and ‘current’ to present debates.

Before proceeding to show how the ambiguity inherent in the concept of shell-shock has nebulously affected the writing of its history, a brief explanation of a particular difficulty encountered writing this history is necessary. It should already be clear, although fuller exposition follows, that this thesis is guided by contemporary understandings of shell-shock rather than retrospective definitions. It therefore attempts to outline debates and examine theories without making judgments as to the actual aetiology of these disorders. It is impossible, however, to find a neutral descriptive term. Despite its overtones of physical damage, shell-shock is probably the closest approximation: it was coined because of and during the war, and it was fundamentally ambiguous from its inception. But because constant repetition of one phrase does not make for a pleasant reading experience, and all available descriptions are relatively inadequate, 'shell-shock', 'war psycho-neuroses', 'war neuroses' and 'mental and nervous disorders of war' are used interchangeably throughout. These were all employed by medical authors during 1914-18, but were defined differently across texts. In the present context, they are all intended to convey the possibility of physical, psychological, or psycho-physical explanations. 'Neuroses' is probably least suited to this purpose, but even in 1914 it was still used by some to describe actual nervous diseases, and therefore it has been allowed into this limited lexicon for the purpose of linguistic variation.

### **Names and numbers: shell-shock and the military, 1914-18**

The vagaries of the terminology of shell-shock are nowhere better demonstrated than in the response of the military authorities. The inability of the military to find a satisfactory description for the mental and nervous disorders of war, and the consequences of this failure, illustrates several points regarding their history: the clash of groups competing for rights of definition, the impact of diagnostic language at ground level, the multiple possible interpretations of aetiology and symptoms, and finally the ways in which contemporary ambiguities continue to set limits on the boundaries of historical knowledge. Although shell-shock first entered the historical record in a medical context, it was soon appropriated by the army. Until late in 1915, when the Army Council incorporated the term into its administrative procedures, men

presenting nervous and mental symptoms were classified under a variety of headings.<sup>7</sup> The Army Council then issued a writ commanding that cases be labelled either wounded ('shell-shock W') or sick ('shell-shock S') with the distinction made on the basis of whether the symptoms were a result of 'enemy action'. Only the former class would be entitled to wound stripes and military pensions.<sup>8</sup>

As Ben Shephard has argued, with this ruling the military officially recognised 'a grey area between cowardice and madness' for the first time, but immediately withdrew from this acknowledgement by imposing the traditional military distinction between 'battle-casualties' and 'sickness' on shell-shock.<sup>9</sup> There was widespread confusion among Regimental Medical Officers (RMOs) as to how cases should be classified under this scheme. Soldiers who fitted the criteria for shell-shock could be marked down as 'nervous', others who had not been exposed to shell-fire might be labelled 'shell-shock W', and cases of concussion were sometimes tagged as 'shell-shock' without the 'W', meaning they were not ranked as battle casualties.<sup>10</sup> A recent analysis of admissions and discharge registers from one neurological centre further suggests that at this hospital, most patients were initially labelled 'shell-shock W' regardless of individual history.<sup>11</sup> In June 1916 Myers, now chief 'specialist in nervous shock' to the British armies in France, proposed an alternative classificatory system which would have divided cases into 'concussion' or 'shock', with 'W' prefixed when the RMO considered that 'the soldier's condition deserved to rank as battle casualty, whether it be caused by shelling, bombing or mining, or be due to "nervous breakdown" occurring in an individual exposed to abnormal strain and believed to have previously been of normal and mental ability'. But this proposal was not taken up.<sup>12</sup>

It was not until June 1917 that the army changed its classification procedure, as part of a reorganisation of forward psychiatry occasioned by the manpower losses of the Somme. This involved the establishment of specialist units for rapid treatment of

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<sup>7</sup> P. Leese, *Shell shock: traumatic neurosis and the British soldiers of the First World War* (Basingstoke: Palgrave, 2002), p. 53.

<sup>8</sup> Myers, *Shell shock in France*, pp. 93-5.

<sup>9</sup> B. Shephard, *A war of nerves: soldiers and psychiatrists, 1914-1994* (London: Pimlico, 2002), p. 28-9.

<sup>10</sup> C.S. Myers, *Shell shock in France*, p. 94.

<sup>11</sup> E. Jones and S. Wessely, *Shell shock to PTSD: military psychiatry from 1900 to the Gulf War* (East Sussex: Psychology Press, 2005), p. 30.

<sup>12</sup> Myers, *Shell shock in France*, p. 14 and pp. 94-5. Myers offers no further details, but presumably under this scheme all soldiers ranked as 'W' would have been entitled to a pension.



nervous and mental cases, situated as close to the fighting lines as was compatible with safety. These were called NYDN centres. The acronym stood for Not Yet Diagnosed Nervous. Men were sent to these centres under this label, and there enquiries were made to their units to check whether they should be classified as 'shell-shock W' or 'shell-shock S'. The War Office Committee of Enquiry into "Shell-Shock" (1922) concluded that 'this procedure did not clear up the difficulties; although the method was logical, it turned out to be unfair and unworkable in practice'. It was not until September 1918 that 'it was decided to abolish the classification of "shell-shock wound" in France, and to determine a shell-shock wound only if the disability was of so serious a nature as to necessitate transfer to England', where 'the decision for classification as a battle casualty' would be made on 'the recommendation of a Neurological Board at a special centre in the United Kingdom'.<sup>13</sup>

Although the military eventually developed more effective procedures for managing the influx of shell-shock cases at both home and abroad, it never satisfactorily dealt with the classificatory and definitional problems posed by shell-shock. This failure had immediate consequences for the individual soldier, who might face years of wrangling with the Ministry of Pensions because of the label he had been given, but it also affects historians. One of the most basic aspects of the history of shell-shock, the number of men affected by the disorder, is unknown. The official history of the First World War medical services devotes several pages to discussing the problem of statistics. When it was published in 1923, the full statistics were not available, and the compilers were mainly working from the data of particular units at particular times.<sup>14</sup> They used Ministry of Pensions statistics which listed the total cases of shell-shock reported as battle casualties in France up to the end of 1917, doubled these to include those reported as 'sick', added an allowance to cover the period until the end of 1918, and arrived at the figure of 80,000.<sup>15</sup> Their methods of calculation did not take account of variations in the incidence of shell-shock over different phases of fighting (an influx

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<sup>13</sup> *Report of the War Office Committee of Enquiry into "Shell-Shock"* (London: Imperial War Museum, 2004) [1922], p. 119.

<sup>14</sup> In fact, the original scheme for the compilation of a full set of medical statistics was eventually recast because of insurmountable practical and (mainly) financial difficulties. See T.J. Mitchell and G.M. Smith, *History of the Great War based on official documents. Medical services: casualties and medical statistics of the Great War* (London: H.M.S.O., 1931), pp. x-xiii.

<sup>15</sup> W.G. Macpherson, W.P. Herringham, T.R. Elliot and A. Balfour (eds), *History of the Great War based on official documents. Medical services: diseases of the war, volume 2* (London: H.M.S.O., 1923), p. 1-7.

during battles, for example), for the possibility that there were not equal numbers of 'sick' and 'wounded', or that cases of relapse may have been counted twice.

These statistics, unreliable at face level, disintegrate when the problematic relation between diagnostic label and symptom is taken into account. The pressure of time and resources often led to a cursory examination which served only to shuttle the soldier along to a different point in the medical system. Adolphe Abrahams (1883-1967), the medical officer in charge of the Connaught Hospital at Aldershot, claimed to have received patients with every variety of inappropriate diagnosis attached, from 'a case of aneurysm sent up as myalgia' to 'a case of oesophageal carcinoma labelled "This man is always complaining"'.<sup>16</sup> These problems became even more acute when a disorder as ill-defined as shell-shock was involved. Cardiac irregularities and fits might be treated as somatic conditions by one doctor or as evidence of psychological disturbance by another, head injuries might be labelled shell-shock through misunderstanding, mentally deficient men might be put down under the same heading simply to remove them from active service, and doctors might even not give an official diagnosis in order to avoid stigmatising patients.<sup>17</sup> There is no way of knowing what symptoms were actually described under official headings, and therefore the figures for cases of nervous and mental disorders of war, itself an ill-defined category, cannot be approximated with any accuracy.

### **Orientations: historiographical definitions of shell-shock**

For the medical and military authorities, two of the main groups responsible for attempting to impose shape on the disorder, shell-shock was a slippery and stubborn entity. It was too wide-ranging to be a workable administrative or diagnostic category, while it resisted attempts to narrow down its meaning. The most accurate explanation of the term which can be found in the secondary literature is therefore virtually an anti-definition: 'there was no agreed theory, diagnosis or therapy relating to the condition among medical practitioners [...] Ultimately, shell shock became a usable political

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<sup>16</sup> A. Abrahams, 'The medical officer in charge of a division', *Journal of the RAMC* 33:1 (July 1919), pp. 79-94, pp. 83-5.

<sup>17</sup> These examples are taken from Leese's discussion of the problems of statistics. Leese, *Shell shock*, p. 53; on the misdiagnosis of hysteria, see M. Culpin, 'The early stage of hysteria', *BMJ* 1918 (1) [April 13 1918], pp. 225-6, p. 225.

issue, which meant different things to different people'.<sup>18</sup> But most historians, although tracing the torturous evolution of shell-shock over the course of the war and beyond, nevertheless make claims about its essential nature. The core of its meaning, found by cutting through the tangled web of contemporary construction, is identified as a psychological reaction to war.

This view of shell-shock is deployed, constructed or inferred with varying degrees of sophistication in different histories. The most basic and misleading interpretation of shell-shock along these lines states that it is a straightforward equivalent to modern psychiatric constructs. For example, David Stevenson, a historian of the First World War, states, 'Post-traumatic stress disorder, to give its modern name to the condition labelled "shell shock" in the English-speaking countries, had doubtless existed in earlier conflicts, but had not been diagnosed as such'.<sup>19</sup> The assumption here is that shell-shock was essentially the same condition which was later 'recognised' as post-traumatic stress disorder (PTSD), and by implication that there is a universal human psychological reaction to the stress of warfare which modern psychiatry has accurately identified. The same logic informs histories such as *Shell-shock: the psychological impact of war* or *Shell-shock: a history of the changing attitudes to war neurosis*. The First World War is pivotal in these accounts, but their aim is to tell the story of how psychiatric disturbances have been dealt with in several conflicts, before and after 1914.<sup>20</sup>

In most histories of shell-shock and of military psychiatry, sensitivity to the ways in which historical context actively shapes psychiatric categories co-exists with the positioning of these categories as actual psychological disorders. A claim is made about the essential nature of shell-shock: in spite of all the confusion surrounding it and the various ways in which it was constructed in contemporary medical accounts, it was a psychological disturbance caused by the experiences of war. Shell-shock is therefore described as the 'flight from an intolerable, destructive reality through illness',<sup>21</sup> one of

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<sup>18</sup> I.F.W. Beckett, *The First World War: the essential guide to sources in the UK National Archives* (Kew: Public Record Office, 2002), p. 145.

<sup>19</sup> D. Stevenson, *1914-1918: the history of the First World War* (London: Allen Lane, 2004), p. 208.

<sup>20</sup> A. Babington, *Shell-shock: a history of the changing attitudes to war neurosis* (London: Leo Cooper, 1997) and W. Holden, *Shell shock: the psychological impact of war* (London: Channel 4 Books, 2001).

<sup>21</sup> E. Leed, *No man's land: combat and identity in World War One* (Cambridge: C.U.P., 1979), p. 164.

many labels which has been applied to ‘the psychologically wounded soldier’,<sup>22</sup> to ‘soldiers with psychological problems’,<sup>23</sup> to those ‘men whose bodies were tortured by their minds’,<sup>24</sup> or to ‘the unexpected phenomenon of wholesale mental breakdown among men’,<sup>25</sup> ‘an early twentieth-century epidemic of hysteria’<sup>26</sup> which ‘advanced the understanding of psychological disorders’.<sup>27</sup> These histories, beginning from the premise that the disorder described and diagnosed as shell-shock was actually a psychological reaction to war, all outline a narrative of development, if not progress, in which shell-shock was gradually *recognised* as psychological suffering.<sup>28</sup>

The subject of these histories is therefore constituted as the varying responses and experiences to psychological disorder, and any attempt to outline its wartime construction as a category of diagnosis proceeds on the assumption that the actual nature of shell-shock is now known. This is a valid approach to the history of the concept of trauma, but it is only one way in which the history of shell-shock can be written. An alternative orientation, the line taken by this thesis, is to make contemporary understandings of the war neuroses the subject of enquiry. This does not exclude the concept of shell-shock as psychological disorder, but it moves this definition from the centre of the history in order to recover a fuller sense of the competing meanings it has displaced. The history which this method recreates and creates is not intrinsically superior to extant histories, but as its writing is governed by different questions, definitions, and aims, the history which emerges is also different. A more wide-ranging project, of a kind which cannot be encompassed within the limits of the space here, would attempt to join up these two kinds of analysis: to trace how the evolution of contemporary definitions of shell-shock generated the version of its history

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<sup>22</sup> H. Binneveld, *From shell shock to combat stress: a comparative history of military psychiatry* (Amsterdam: Amsterdam University Press, 1997), p. 106.

<sup>23</sup> Shephard, *A war of nerves*, p. xix.

<sup>24</sup> J. Bourke, *Dismembering the male: men's bodies, Britain and the Great War* (London: Reaktion Books, 1996), p. 108.

<sup>25</sup> E. Showalter, *The female malady: women, madness and English culture, 1830-1980* (London: Virago, 1987), p. 169.

<sup>26</sup> Leese, *Shell shock*, p. 1.

<sup>27</sup> Jones and S. Wessely, *Shell shock to PTSD*, p. 50.

<sup>28</sup> Allan Young's pioneering archaeology of the origins of PTSD as a ‘historical product’ which is ‘glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented, and by the various interests, institutions, and moral arguments that mobilised these efforts and resources’ has been extremely important in shaping my analysis of the historiography of shell-shock, and my approach to the concept itself throughout this thesis. A. Young, *The harmony of illusions: inventing post-traumatic stress disorder* (Princeton, New Jersey: Princeton University Press, 2005): quotations pp. 5-6.

which is now most prevalent. As it is, the story which follows should be read as another ‘contribution to the study of shell-shock’, which disrupts the established historiographical boundaries of its subject in the aim of instituting a more productive dialogue.

The approach taken by this thesis inevitably generates not only a different history, but different tensions. First is the risk that in relocating the meaning of shell-shock as the complex of contemporary understandings, it might be read as a denial of the historical reality of psychological suffering in soldiers. It should therefore be underlined that no such negation is intended or made. The aim is to analyse the intellectual currents which contributed to the formation of the medical concept of shell-shock. The thesis deals with how nervous and mental disorders were ‘framed’ or ‘constructed’ in British medical discourse during the First World War.<sup>29</sup> It therefore joins the growing number of histories of psychiatry inspired by the work of Michel Foucault, although it cannot claim any more direct methodological influence from this source.<sup>30</sup> It assumes the ‘integrative position’ outlined by Roy Porter to negotiate the potential minefield of realist versus constructionist debates in the history of psychiatry. Porter stated that insanity ‘is both a personal disorder (with a kaleidoscope of causes, ranging from the organic to the psychosocial), and is also articulated within a system of sociolinguistic signs and meanings’.<sup>31</sup> This approach is now common to the mainstream disciplines of the history of medicine and psychiatry, which assume that there is always an element of social construction in the creation of knowledges of physical diseases as well as mental

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<sup>29</sup> Charles Rosenberg avoids the term ‘social construction’ on the grounds that ‘it has tended to overemphasise functionalist ends and the degree of arbitrariness inherent in the negotiations that result in accepted disease pictures [...] It invokes, moreover, a particular style of cultural criticism and particular moment in time’. C.E. Rosenberg, ‘Disease in history: frames and framers’, in C.E. Rosenberg and J. Golden (eds), *Framing disease: the creation and negotiation of explanatory schemes*, *Milbank Quarterly* 67, Supplement 1 (1989), pp. 1-15, p. 3. In this thesis, ‘constructed’ and ‘framed’ are used interchangeably. These terms are not intended to imply adherence to any particular school of theory or history. Both terms are used rather to refer to the process of a complex of intellectual, social, and cultural currents which result in the formulation of a diagnosis at a particular historical point.

<sup>30</sup> See M. Foucault, *Madness and civilization: a history of insanity in the age of reason* (London: Routledge, 1971). As Gary Gutting argues, although Foucault remains a controversial figure, there is now a high level of support among historians of psychiatry for his ‘meta-level claims about how madness should be approached as a historiographical topic’, specifically the view that madness is ‘a variable social construct’ rather than ‘an ahistorical scientific given’. G. Gutting, ‘Michel Foucault’s *phänomenologie des krankengeistes*’ in M. Micale and R. Porter (eds), *Discovering the history of psychiatry* (Oxford and New York: O.U.P., 1994), pp. 331-47.

<sup>31</sup> R. Porter, *Mind-forg’d manacles: a history of madness in England from the Restoration to the Regency* (London: Penguin, 1990), p. 16.

disorders.<sup>32</sup> Indeed, the view that culture not only shapes medical responses, but even the manifestation of psychiatric symptoms, has recently been given empirical weight by the comparative studies of ‘war syndromes’ from different conflicts instituted by two historians of shell-shock.<sup>33</sup>

The second tension within this thesis arises from the particular intellectual and medical history of shell-shock it provides. Although this concept was constituted by a range of social, cultural, political, military, medical and other meanings, it could not have been formulated without the real, objective existence of soldiers in subjective, but equally real pain. This thesis deals with the medical conceptualisation of shell-shock, and is based primarily on evidence from the British medical press (of which more presently). The shell-shocked soldier was inevitably at the heart of theories of the war neuroses, but he is conspicuously absent from this thesis, which is a story of the thought-systems of doctors rather than the experiences of patients. Any history begins and ends by privileging certain elements above others, and in this case a detailed examination of the broad intellectual sweep of theories of shell-shock has precluded attention to other, crucial aspects which contributed to the formation of the diagnostic concept. In this respect, it is inevitably a lopsided and incomplete history; after all, the clinical encounter requires both doctor and patient, and the latter is not simply the passive recipient of a diagnosis, but a dynamic force which contributes to its shaping.<sup>34</sup> Although there are considerable difficulties in reconstructing patient experience, recent histories of shell-shock have indicated ways in which this can be done, as in Peter Leese’s analysis of hospital journals edited and contributed to by patients, or Peter Barham’s attempts to piece together the narratives of psychotic ex-servicemen through

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<sup>32</sup> See particularly L. Jordanova, ‘The social construction of medical knowledge’, *Social History of Medicine* 8 (1995), pp. 361-81. For a discussion of social constructionist views and their influence on the history of psychology, see K.J. Gergen and C.F. Graumann, ‘Psychological discourse in historical context: an introduction’, in C.F. Graumann and K.J. Gergen (eds), *Historical dimensions of psychological discourse* (Cambridge: C.U.P., 1996), pp. 1-13; for a discussion on their influence on the history of psychiatry, see R. Porter and M. Micale, ‘Introduction: reflections on psychiatry and its histories’ in Micale and Porter (eds), *Discovering the history of psychiatry*, pp. 3-36, especially pp. 3-14.

<sup>33</sup> E. Jones and S. Wessely, ‘Psychiatric battle casualties: an intra- and interwar comparison’, *British Journal of Psychiatry* 178 (2001), pp. 242-7; E. Jones *et al*, ‘Post-combat syndromes from the Boer war to the Gulf war: a cluster analysis of their nature and attribution’, *BMJ* 234 (9 February 2002), pp. 1-7; E. Jones and S. Wessely, ‘War syndromes: the impact of culture on medically unexplained symptoms’, *Medical History* 49 (2005), pp. 55-75.

<sup>34</sup> The classic statement on the importance of the patient in medical history is R. Porter, ‘The patient’s view: doing history from below’, *Theory and Society* 14:2 (1985), pp. 175-98.

diverse and scattered archival resources such as hospital case notes and letters written to the Ministry of Pensions.<sup>35</sup>

The charge of culpable neglect cannot simply be sidestepped, but perhaps mitigating circumstances might be allowed. Recent histories of shell-shock have consciously moved away from a reliance on the medical literature, rightly arguing that to understand 'the overall record', it is necessary to consult a variety of sources and viewpoints.<sup>36</sup> But it is dangerous to assume that this literature has been exhaustively, or even sufficiently, explored. The intellectual bases of mainstream theories of shell-shock remain obscure. Although a very few excellent studies have been made of the writings of individual doctors,<sup>37</sup> there has been no attempt at an exegesis of the medical literature in its entirety, which is necessary to contextualise these theories and to understand the intellectual milieu in which doctors operated. This reflects a more general neglect within the history of psychiatry. In 1990, Roy Porter lamented that 'curiously little attention has been given to the actual contents of psychiatry, its languages of diagnosis and prognosis, its classificatory schemes, its technological concepts, and their internal connexions and evolution'.<sup>38</sup> The history of psychiatry has itself evolved considerably in the intervening sixteen years, not least through Porter's own efforts, but the approach he outlined has not hitherto been applied to shell-shock. The history provided by this thesis is undoubtedly partial, but it nevertheless provides a point from which an identified gap in the historiography can begin to be filled.

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<sup>35</sup> Leese, *Shell shock*, pp. 85-120; P. Barham, *Forgotten lunatics of the Great War* (New Haven and London: Yale University Press, 2004). The latter example also demonstrates the potential pitfalls of such 'acts of recovery'. In a favourable review, Rhodri Hayward makes the critical point that the 'series of empathic conjectures' on which Barham's biographies depend 'may trap individuals in identities every bit as foreign as those fashioned in regimental field exercises or the ledgers of pension administration'. R. Hayward, 'Review: Peter Barham, *Forgotten Lunatics of the Great War*', *History of Psychiatry* 16:4 (2005), pp. 503-7, p. 506.

<sup>36</sup> Shephard, *A war of nerves*, p. xxi. See also Leese, *Shell shock*, p. 73.

<sup>37</sup> A. Young, 'W.H.R. Rivers and the war neuroses', *Journal of the History of the Behavioral Sciences* 35:4 (1999), pp. 359-78; D. Cantor, 'Between Galen, Geddes, and the Gael: Arthur Brock, modernity, and medical humanism in early-twentieth-century Scotland', *Journal of the History of Medicine and Allied Sciences* 60:1 (2005), pp. 1-41; R. Leys, 'Traumatic cures: shell shock, Janet, and the question of memory', *Critical Inquiry* 20 (Summer 1994), pp. 623-62.

<sup>38</sup> R. Porter, 'History of psychiatry in Britain', *History of Psychiatry* 2 (1991), pp. 271-9, p. 278.

## Shell-shock and its histories

The historiography of shell-shock reflects the fact that from its inception, the concept was constituted and defined by a variety of groups with different objectives, interests, and 'ways of seeing', in innumerable different contexts, both imagined and real. Its histories have been conceived as contributions to the reconstruction of several different pasts: civilian psychiatry and attitudes to mental health,<sup>39</sup> military psychiatry,<sup>40</sup> military discipline,<sup>41</sup> individual experience of mental disturbance,<sup>42</sup> the concept of trauma,<sup>43</sup> and the challenge of the First World War to established notions of identity.<sup>44</sup> These pasts inevitably overlap, and beyond a certain extent distinct lines cannot be drawn between these histories. Nevertheless, shell-shock has been written about from so many points of view because its meaning has always derived from multiple sources. These historians all have a claim to shell-shock because its history straddles disciplinary boundaries.

Shell-shock is not only a borderland concept because it was constructed from the competing definitions of manifold groups. Its historiography has also been shaped by its temporal location. The fact that shell-shock occurred during the First World War has influenced the way its history is written, and in particular has served to obscure the contemporary state of flux in understandings of the disorder. In histories of Britain, the long nineteenth century conventionally ends in 1914. There is an enormous scholarship

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<sup>39</sup> M. Stone, 'Shellshock and the psychologists' in W.F. Bynum, R. Porter and M. Shepherd (eds), *The anatomy of madness: essays in the history of psychiatry. Volume 1: people and ideas* (London and New York: Tavistock, 1985), pp. 242-71; H. Merskey, 'Shell-shock' in G.E. Berrios and H. Freeman (eds), *150 years of British psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 245-67; C. Feudtner, "'Minds the dead have ravished": shell shock, history, and the ecology of disease systems', *History of Science* 31 (1993), pp. 377-420; T. Bogacz, 'War neurosis and cultural change in England, 1914-22: the work of the War Office Committee of Enquiry into "Shell-shock"', *Journal of Contemporary History* 24 (1989), pp. 227-56 and E.T. Dean, 'War and psychiatry: examining the diffusion theory in light of the insanity defence in post-World War I Britain', *History of Psychiatry* 4 (1993), pp. 61-82; Showalter, *The female malady*, pp. 167-94.

<sup>40</sup> Binneveld, *From shell shock to combat stress*; Shephard, *A war of nerves*; Jones and Wessely, *Shell shock to PTSD*.

<sup>41</sup> W. Moore, *The thin yellow line* (Ware, Hertfordshire: Wordsworth Editions Limited, 1999), pp. 55-220; C. Corns and J. Hughes-Wilson, *Blindfold and alone: British military executions in the Great War* (London: Cassell and Co., 2001), especially pp. 52-104; A. Babington, *For the sake of example: capital courts martial 1914-1920* (London: Leo Cooper, 1983).

<sup>42</sup> Barham, *Forgotten lunatics*.

<sup>43</sup> R. Leys, *Trauma: a genealogy* (Chicago: University of Chicago Press, 2000); Leys, 'Traumatic cures'; Young, *The harmony of illusions: inventing post-traumatic stress disorder*.

<sup>44</sup> Bourke, *Dismembering the male*, pp. 105-23; J. Bourke, 'Effeminacy, ethnicity, and the end of trauma: the sufferings of "shell-shocked" men in Great Britain and Ireland, 1914-39', *Journal of Contemporary History* 35:1 (2000), pp. 57-69; Leed, *No man's land*, pp. 163-92.



on the war itself, a particular subset of military, political, and diplomatic histories which focus on the preceding years in the attempt to uncover the origins of the war, and recently there have been attempts to study the histories of the First and Second World Wars as a continuous period.<sup>45</sup> But as a rule, publications do not present the years 1870-1930 (for example) as a continuous narrative. This is of course a reflection of the status of the war itself in the British national memory. The conventional historiography views the war as marking a break with Victorian values, (and they are almost invariably characterised as Victorian despite the death of the queen in 1901).<sup>46</sup> More recent scholarship has emphasised that it is difficult to untangle the precise impact of the war as an agent of political and social change, and has traced the persistence of highly traditional modes of understanding in the cultural sphere.<sup>47</sup> But the war still stands apart as a distinct period in the historical imagination, divorced from what came before and itself taken as the measure for what happened afterwards.

The way in which the history of psychiatry has been written sustains the impression that shell-shock, like the First World War, constituted a break with the past.<sup>48</sup> Malcolm Pines introduces the section on 1914-18 in his account of the development of the psychodynamic movement in Britain with a quotation from Michael Holroyd stating that the 'war crumbled the cement of Victorian standards into disused rubble and opened up unmendable fissures in the gilded Edwardian way of life'. Unsurprisingly, he portrays shell-shock as the agent of destruction of traditional psychiatry.<sup>49</sup> In the edited volume *A century of psychiatry* the first chapter is on 'the 1900s and before', the

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<sup>45</sup> An idea of the range of works on these topics can be gained from A.G.S. Enser, *A subject bibliography of the First World War, 1914-1978* (London: Deutsch, 1979), although it does not, of course, include recent scholarship. P. Liddle, J. Bourne and I. Whitehead (eds), *The Great World War 1914-45*, 2 vols (London: HarperCollins Publishers, London, 2000/2001), and A. Shaw, *World in conflict, 1914-45* (London: Fitzroy Dearborn, 2000) both attempt to treat 1914-45 as a continuous period.

<sup>46</sup> The classic statement of this view is P. Fussell, *The Great War and modern memory* (Oxford and New York: O.U.P., 1975).

<sup>47</sup> See particularly J. Winter, *Sites of memory, sites of mourning: the Great War in European cultural history* (Cambridge: C.U.P., 1995); J. Stevenson, *British society 1914-45* (London: Penguin, 1984), pp. 21-77.

<sup>48</sup> In a similar way, war has traditionally been portrayed as a modernising force within medicine, and this relation has also been challenged by recent scholarship. See R. Cooter, 'War and modern medicine' in W.F. Bynum and R. Porter (eds), *Companion encyclopedia of the history of medicine, volume 2* (London: Routledge, 1993), pp. 1536-74; M. Harrison, 'The medicalization of war – the militarization of medicine', *Social History of Medicine* 9 (1996), pp. 267-76; R. Cooter and S. Sturdy, 'Of war, medicine and modernity: introduction', in R. Cooter, M. Harrison and S. Sturdy (eds), *War, medicine and modernity* (Gloucestershire: Sutton, 1998), pp. 1-21.

<sup>49</sup> M. Pines, 'The development of the psychodynamic movement', in G.E. Berrios and H. Freeman (eds), *150 years of British psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 206-231, pp. 213-5; see also R.D. Hinshelwood, 'Psychodynamic psychiatry before World War I', in G.E. Berrios and H. Freeman (eds), *150 years of British psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 197-205, p. 203

second on shell-shock, and the third on the emergence of psychoanalysis.<sup>50</sup> In these accounts, and in the impression created by histories of the asylum which stop dead at 1900 or 1914, or histories of twentieth-century psychiatry which begin in 1918, shell-shock is constructed as the mediating event which led from the asylum to the analyst's couch.<sup>51</sup>

The theme of war as a catalyst for the reorientation of approaches to mental health is central to histories of shell-shock, whether the subject is the dissemination of psychological ideas in the civilian sphere, 'lessons learned' by the military in its dealings with the 'psychiatrically damaged soldier', or the suggestion that the war neuroses became 'the rallying point for an alternative sensibility or ethos'.<sup>52</sup> Although shell-shock has many histories, all tend towards a narrative of development in which over the course of the war, psychological modes of understanding mental and nervous disorders superseded older physical models. This narrative has tended to obscure the diversity of contemporary definitions of shell-shock because theories are therefore retrospectively divided into 'physical' and 'psychological'. The following chapters of this thesis argue that these divisions have little relation to the complex ideas of mind-body relations found in theories of the war neuroses, or to the various modes of explanation (physical, psychological, physiological, biological) which were employed separately or in combination to make sense of these disorders.

The historiographical argument regarding the role of shell-shock in fostering psychological approaches to mental disorder is directly invoked in many chapters. The thesis itself might even be conceived as a response to this historiographical interpretation, in that it looks backwards rather than forwards. It attempts to measure not the extent to which shell-shock was an agent for change, but the degree to which theories of the war neuroses demonstrate continuity with the conceptual frameworks of pre-war psychological medicine and its broader intellectual milieu. These are, of

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<sup>50</sup> H. Freeman (ed.), *A century of psychiatry* (London: Mosby-Wolfe, 1999), pp. 1-47.

<sup>51</sup> Some random examples: J. Oppenheim, *"Shattered nerves": doctors, patients, and depression in Victorian England* (New York and Oxford: O.U.P., 1991); A. Scull, *The most solitary of afflictions: madness and society in Britain, 1700-1900* (New Haven and London: Yale University Press, 1993); M. Neve, 'A commentary on the history of social psychiatry and psychotherapy in twentieth-century Germany, Holland and Great Britain', *Medical History* 48 (2004), pp. 407-12.

<sup>52</sup> Stone, 'Shellshock and the psychologists', pp. 244-7; Jones and Wessely, *Shell shock to PTSD*, pp. xv-xvii; B. Shephard, "'Pitiless psychology": the role of prevention in British military psychiatry of the Second World War', *History of Psychiatry* 10 (1999), pp. 491-524; Barham, *Forgotten lunatics*, p. 83.

course, two sides of the same question. But extant histories of shell-shock give little space to notions of mental disorder in pre-war British psychiatry.<sup>53</sup> The ‘divisive and condemnatory rhetoric of psychiatric orthodoxy’ is often presented as a received truth.<sup>54</sup> This is particularly true of histories which tackle shell-shock en route to a different aspect of war experience, as in a recent book on military executions. The inclusion of a chapter on ‘mental health in Britain in 1914’ appears promising, but it begins by stating that, ‘Psychiatry as we know it had not been invented in 1914. Before the Great War “mental illness” was an unknown concept [...] In 1914 a person was considered either mad or sane – there was no grey area’. The discussion continues in the same vein for a few pages, before concluding that ‘great strides were made in the recognition and treatment of mental illness during the war’.<sup>55</sup>

This portrait would be unrecognisable to historians of Victorian and Edwardian psychological medicine. It introduces, however, another area of tension which has been identified in this thesis. The focus here is on the relation of concepts in pre-war psychiatry to shell-shock, in order to correct a perceived imbalance in the historiography of the disorder. The most obvious danger is that the extent to which continuity was the order of the day may be overstated as a reaction against this historiographical trend, but this risk must be taken in the attempt to provide an alternative history which can help to open up the boundaries within which shell-shock is debated. The neglect of developments in post-war psychiatry which might alter the picture presented by this thesis is a more serious charge. In reply, the reader is referred to the histories of shell-shock in the bibliography, any one of which will give some account of the relevant events. Again, selection is a necessary component in the writing of any history, and the sins of omission can only be expiated by the virtues of what is added instead. In this case, the exegesis of diagnostic categories in the period 1900-14, neglected years in the history of psychiatry for reasons discussed above, makes a genuinely new contribution to understandings of shell-shock. The attempt made as the thesis proceeds to analyse responses to the war neuroses as an expression of far older

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<sup>53</sup> The most extensive discussions of pre-1914 approaches to mental disorder are in histories of military psychiatry, but these do not engage with the civilian discipline. An exception is Shephard, *A war of nerves*, pp. 5-20.

<sup>54</sup> Barham, *Forgotten lunatics*, pp. 150-1.

<sup>55</sup> Corns and Hughes-Wilson, *Blindfold and alone*, pp. 52-9.

and more widespread fears also adds a new layer of understanding to the particular significance shell-shock held for contemporaries.

There is another aspect to this tension. The attempt to demonstrate continuity begs the question of what concepts and ideas constituted pre-war psychological medicine. It has now been shown that British pre-war psychiatry was a more variegated and dynamic field than older histories suggested. Although organic approaches to mental disorder gained ascendancy in the later years of the nineteenth century, these were superimposed upon and did not entirely supersede an older tradition of psychological thinking.<sup>56</sup> Analyses of nineteenth-century concepts of the unconscious mind have demonstrated the existence of a tradition of thought about the 'obscure recesses of the mind' which pre-dated the arrival of Freudianism in Britain.<sup>57</sup> Research on the reception of Freud in Britain, the spread of popular psychology, and early British approaches to psychoanalysis all suggest that multifarious modes of psychological thought were gaining momentum in the years before the war.<sup>58</sup> In the other direction, it is accepted that Freud's work was steeped in late nineteenth-century neurology and biology, and engaged with contemporary psychological thought. This does not alter the fundamental fact of Freud's originality, or the revolution which psychoanalytical thought occasioned.<sup>59</sup> It does, however, raise the question of the extent to which the deployment of concepts which seem to be derived from Freud in theories of shell-shock were refashioned by British authors in the image of the psychology they knew.<sup>60</sup> This aspect

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<sup>56</sup> M.J. Clark, 'The rejection of psychological approaches to mental disorder in late nineteenth-century British psychiatry', in A. Scull (ed.), *Madhouses, mad-doctors and madmen: the social history of psychiatry in the Victorian era* (Philadelphia: University of Pennsylvania Press, 1981), pp. 271-312; Oppenheim, "Shattered nerves".

<sup>57</sup> J. Miller, 'Going unconscious', in R.B. Silvers (ed.), *Hidden histories of science* (London: Granta, 1997), pp. 1-35; J.B. Taylor, 'Obscure recesses: locating the Victorian unconscious', in J.B. Bullen (ed.), *Writing and Victorianism* (London and New York: Longman, 1997), pp. 137-79.

<sup>58</sup> R. Porter, 'Two cheers for psychiatry! The social history of mental disorder in twentieth century Britain', in H. Freeman and G.E. Berrios (eds), *150 years of British psychiatry, volume 2: the aftermath* (London and New Jersey: Athlone, 1996), pp. 383-406, pp. 388-92; D. Rapp, 'The early discovery of Freud by the British general educated public, 1912-1919', *Social History of Medicine* 3 (1990), pp. 217-43; D. Rapp, 'The reception of Freud by the British press: general interest and literary magazines, 1920-1925', *Journal of the History of the Behavioral Sciences* 24 (1988), pp. 191-201; M. Thomson, 'The popular, the practical and the professional: psychological identities in Britain, 1901-1950', in G. Bunn, S. Lovie, and G. Richards (eds), *A history of British psychology: historical essays and personal reflections* (London: British Psychological Society/Science Museum, 2000), pp. 115-32; S. Raitt, 'Early British psychoanalysis and the Medico-Psychological Clinic', *History Workshop Journal* 58 (2004), pp. 63-85.

<sup>59</sup> See J. Forrester, "'A whole climate of opinion": rewriting the history of psychoanalysis' in M. Micale and R. Porter (eds), *Discovering the history of psychiatry* (Oxford and New York: O.U.P., 1994), pp. 174-90, p. 179.

<sup>60</sup> See particularly Young's analysis of the influence of Hughlings Jackson, Herbert Spencer, and Freud in shaping W.H.R. Rivers' theories. Young, 'W.H.R. Rivers and the war neuroses'.

will be raised at relevant points in the thesis, but it should be underlined at the outset that the topic under discussion is always British responses to Freud, rather than his original formulations of psychoanalytic theory.

### **Shell-shock in the British medical press, 1914-19**

This thesis aims to demonstrate not only areas of continuity between pre-war and wartime psychological medicine, but points of convergence within the medical literature on shell-shock. The conventional historiography has tended to divide doctors into camps based on their alleged adherence to physical or psychological theories of causation. It is argued throughout the present work that such lines are overdrawn, and that similarities can be demonstrated between apparently divergent theories. The analysis of authorship of theories of the war neuroses in this section aims to prove the validity of this viewpoint. Extant histories have for the most part relied on a small sample of theories to make general points about the conceptualisation of shell-shock. However, the extent to which certain theories are representative of wider trends of thought can only be judged when these are placed in the context of the broad sweep of the wartime literature on the war neuroses.

Appendix A provides a table of signed articles on the nervous and mental disorders of war from a range of medical journals covering the period 1914-19, and a chart displaying the chronological distribution of publication of these articles. Appendix B gives short details of the education and pre-war and wartime professional posts of these authors. Short biographies, including information on post-war professional interests where available, are provided in Appendix C.<sup>61</sup> These tables demonstrate firstly that interest in the nervous and mental disorders of war grew steadily year by year. In 1914, only one signed article on the topic was published; in 1915, eight; in 1916, twenty-three; in 1917, twenty-six; and in 1918, thirty-seven, before the figure fell back down to twenty-six in 1919. Secondly, they show that of the seventy-five authors named on this table, fifty-three wrote only one article each, and eleven wrote only two. Just over a

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<sup>61</sup> More detailed notes on the compilation of these appendices are given at the head of each. The analysis has been extended to 1919 as it is likely that at least some of these articles were in preparation when the armistice was declared. Even where this was not the case, these articles can be read as a summation of the author's views on the subject immediately after the cessation of hostilities but before the commencement of the post-war period proper. It also seems possible that it was only after demobilisation that some doctors had the chance to write up and publish their views.

quarter (thirty-two) were written by five doctors: Frederick Mott (ten), Arthur Hurst (seven) Robert Armstrong-Jones (six), Charles Myers (five) and William Rivers (four). Although this demonstrates the influence of a few prolific individuals, it also shows that an understanding of the field of wartime medical discourse must extend beyond their theories. The sixty-four scattered individuals who were together responsible for over half of the signed articles which appeared in the medical press contributed equally, and in sheer terms of numbers more, to these debates.

These tables also provide general information about the professional backgrounds of doctors who formulated theories of shell-shock and their places in the treatment network, and this allows some general conclusions to be formulated concerning the broad nature of wartime medical discourse on the war neuroses. Beginning with the wartime service of contributors, all but four of these authors definitely worked with shell-shocked men in some capacity.<sup>62</sup> The details available for forty-five of these authors makes it clear that they served on the home front, although it is possible that some also served abroad for a time.<sup>63</sup> It is known that a further nine served both in Britain and abroad at different points in the war. The only details available for seventeen of the authors are of overseas service. Of those doctors who served abroad at any point, two served in the Royal Navy, and only a further eight had experience of theatres of war outside France (the Mediterranean, Near East, Malta, Egypt, and India). The doctors who served in France worked mainly at neurological centres or base hospitals, although four were consulting physicians who toured hospitals within particular military districts, one worked with a field ambulance, and another at a Casualty Clearing Station. These figures show that the published medical literature is

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<sup>62</sup> There are no details available for the wartime posts of Albert Churchward and Lionel Weatherly, and their articles make no reference to experiences with shell-shocked men. A. Dinsley, the co-author of an article, served in the Royal Army Ordnance Corps, and does not appear to have held any medical qualifications. Judson Bury served on local medical boards, and so it is unlikely (although not impossible) that he treated shell-shocked men.

<sup>63</sup> Until the Military Service Act of 1916, doctors holding a temporary commission in the RAMC were engaged on a contract lasting for twelve months or until the end of the war, whichever was the sooner. At the expiry of this contract, doctors were free to return to civil practice with no further obligation. After 1916, doctors returning home became liable to compulsory service under the provision of the Acts, and had to enrol immediately to take advantage of the special arrangements made for the medical profession. (Until April 1918, the voluntary enrolment scheme was retained for the medical profession, in order to prevent undue disruption to civilian health services, and medical committees held statutory power to regulate the supply of doctors to the Army). The aim was to spare doctors in this position a second period of service so long as others, equally eligible, had not performed any service. This means that some doctors may have served abroad for a year, and then left the RAMC. I Whitehead, *Doctors in the Great War* (Barnsley: Leo Cooper, 1999), pp. 60-1

essentially a record of shell-shock in the army rather than other branches of the armed forces, that doctors working on the home front predominated among the authors, and that a majority of the physicians with overseas experience served in France.

This information is important because doctors at different points in the treatment network had different relations to their patients. There were three main possible stages to the encounter of the shell-shocked man with military medicine, although not all cases were deemed sufficiently serious to reach the final stage: contact with his Regimental Medical Officer (RMO), with doctors whose main aim was to temporarily patch him up, classify him and then move him on (whether at a Field Ambulance, a Casualty Clearing Station, a base hospital, an NYDN centre, or a clearing centre in England), and finally with doctors in Britain on whom responsibility for treatment ultimately devolved. Of most interest is the absence of RMOs among authors of the wartime literature. The RMO had the closest and the most distant relationship to the shell-shocked man. The efficient RMO was expected to have some understanding of every man in the battalion, but his responsibility was to maintain the health of the battalion as a whole. To this end, he had to not only prevent illness or injury where possible, but to discourage men from going sick and to weed out malingerers. Once a man had developed symptoms which were deemed sufficiently serious as to incapacitate him for this duty, it was the responsibility of the RMO to move him on as quickly as possible so that the regiment could still function as an efficient unit.

Although the RMO might have had considerable knowledge of a soldier's character, once that soldier had been defined as a shell-shock case he had little further contact with him until he was thought to have recovered. The RMO therefore had a particular view of shell-shock which was determined by his stated duty to the battalion rather than the individual, and by his minimal contact with such shell-shocked men as patients. There is also some evidence that his perception was influenced by the conditions in which he worked. The RMO shared the privations, and to some extent the dangers of the fighting men. This meant that he was much more likely both to understand the conditions which led men to break down, and to take a harsher view of men who did.<sup>64</sup>

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<sup>64</sup> See K. Simpson, 'Dr. James Dunn and shell-shock', in H. Cecil and P. Liddle (eds), *Facing Armageddon: the First World War experienced* (London: Leo Cooper, 1996), pp. 502-20 and I. Whitehead, 'Not a doctor's work? The role of the British Regimental Officer in the field', in H. Cecil and

Because they were not as a rule responsible for the treatment of shell-shocked men, RMOs did not have the opportunity for extended contact which might have led them to publish theories on the subject. They undoubtedly had opinions on the causes of the disorder, but these are not represented in the wartime medical literature.

The second group of doctors who dealt with shell-shocked men were those, either in England or France, who were responsible for classifying men and moving them on for more extended treatment. Although they did not spend a great deal of time with individual cases, over the course of months or years they might see thousands of men presenting with nervous or mental symptoms. They were responsible only for minimal attempts at treatment, but they did have to make an initial decision as to the basic nature of the case. Like RMOs, they were concerned to detect malingerers, but they were also forced to consider the medical aspects of shell-shock in a way the former were not. Their primary skill was in diagnosis, but this was an important part of formulating a theory of shell-shock. This may be why they are better represented in the literature. There was a basic difference between doctors in France and those in England who performed this function of classification and preliminary diagnosis. Doctors at base hospitals or advanced neurological centres in France had to decide whether a case was serious enough to justify evacuation to England, but as the war went on it also became clear that removing a man from the military environment completely tended to fix his symptoms and make them harder to cure. Once forward psychiatry was introduced, only the most severe cases were transferred to England for treatment, and therefore at any point in the war the cases which doctors at clearing hospitals in England saw were likely to be more severe.

This of course affected the way in which doctors at treatment centres in England viewed the subject. These form by far the largest section of doctors who published on shell-shock, over half the total number (although a few of these had also served abroad). By the time a man reached their hands, he had already been diagnosed at least twice and was now definitively a patient. Both because these initial judgments as to the status of the case had already been made, and because the case was likely to be more severe than those seen at other stages, these doctors were far less concerned with

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P. Liddle (eds), *Facing Armageddon: the First World War experienced* (London: Leo Cooper, 1996), pp. 466-74.



rooting out malingerers. They spent longer with these men as patients than doctors at any other stage in the process of labelling and diagnosing a man as shell-shocked, and so they had far more time to investigate individual cases and to formulate theories based on this knowledge. Their primary objective was also, unlike the other doctors discussed, to treat these cases. Their articles are therefore far more centred on methods of treatment, sometimes to the exclusion of a stated explanation of the causes of the disorder. Their theories should not be seen as more correct than those of doctors who saw the shell-shocked man at other stages in his journey, but rather as formulated in response to a particular class of case and shaped by specific objectives.

An analysis of the educational and pre-war professional backgrounds of medical theorists of the war neuroses justifies the approach taken by this intellectual history of shell-shock. The details of the education of all the doctors are not known, but a large number graduated from Cambridge (thirteen), Edinburgh (ten), or Oxford (eight). The majority had undertaken clinical training at one of a small handful of institutions: St. Bartholomew's Hospital (fourteen), Guy's Hospital (eleven), University College Hospital, London (nine), or St. Thomas' Hospital (six).<sup>65</sup> Although this reflects the nature of medical education, centred around a few key areas and institutions, it also emphasises that despite internal divisions, the medical profession constituted a homogeneous group at an extremely basic level. Even more interesting is that doctors who theorised and treated shell-shock were drawn from a wide array of medical and scientific specialisms. The heterogeneity of doctors contributing to the debates on the war neuroses was noted by contemporaries. A 1917 opinion piece in the *Lancet* approvingly noted 'the large number of useful contributions published in one journal or another by observers who would not describe themselves as expert neurologists or psychiatrists', and hoped that the marshalling of diverse resources towards issues of mental health would encourage the movement to make psychology part of general medical education.<sup>66</sup> The largest single group in this sample (nineteen) appear to have held general hospital appointments before the war. Thirteen worked within the asylum system, nine had a special interest in neurology, and seven could be defined as

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<sup>65</sup> It is also likely that doctors educated at Edinburgh had all undertaken clinical training in one of its main hospitals, such as the Royal Infirmary, although details are not known for all of these.

<sup>66</sup> [Anon.], 'The effect of the war upon psychiatry in England', *Lancet* 1917 (2) [September 1 1917], pp. 352-353, p. 352.

psychologists or psychiatrists.<sup>67</sup> The remainder were drawn from the fields of physiology, ophthalmology, surgery, pathology, anatomy, general practice, and even more esoteric areas.

The diverse professional backgrounds of these commentators has extremely important implications for the study of shell-shock. Theories cannot be easily divided according to such affiliations. Histories of shell-shock sometimes imply that there were considerable differences of opinion between psychologists and neurologists, or asylum psychiatrists. But only twenty-nine of the authors of signed articles surveyed here, just under a quarter of the total number, could confidently be described under these headings. The literature cannot be broken down in this way. If an attempt was made to analyse it along the lines of all the diverse professional interests represented, it would lose all internal coherence. It would also be predicated on the false assumption that there were distinct boundaries between professional specialisations. In the opening years of the century the emergence of neurology and psychiatry as separate disciplines was not entirely complete, psychology was still closely tied to philosophy and physiology, and there was still considerable hostility in some quarters to the concept of specialisation, which was felt to minister to a collection of parts rather than the totality of the sick individual.<sup>68</sup> The similarities which can (and will) be demonstrated across the literature suggest that professional background was not the most important force in shaping theories of shell-shock. The only intellectual system which undoubtedly influenced all was an evolutionary framework of understanding, basic to scientific education at this point. Once theories of the war neuroses are read within this framework, the points of contact between apparently divergent formulations becomes apparent, as does the attempt to place these theories within the context of broader debates regarding identity, civilisation, and war.

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<sup>67</sup> This is the largest possible number that could be defined as psychologists or psychiatrists. There is no problem defining the professional interest of individuals such as William Brown or Charles Myers, both academic psychologists. David Henderson does not appear to have held any professional posts before the war, but his training was clearly directed towards psychiatry. The others included under this heading – David Eder, David Forsyth, Ernest Jones, and William Rivers – all had a clear interest in psychology, although they worked in other areas as well. See Appendix C for further details.

<sup>68</sup> See R. Porter, *The greatest benefit to mankind: a medical history of humanity from antiquity to the present* (London: Fontana Press, 1999), pp. 493-524; J. Goldstein, 'Psychiatry' in W.F. Bynum and R. Porter (eds), *Companion encyclopedia to the history of medicine, Volume 2* (London and New York: Routledge, 1993), pp. 1350-72; R. Thomson, *The Pelican history of psychology* (Middlesex: Penguin, 1968), pp. 19-221; Taylor, 'Obscure recesses', p. 142; C. Lawrence, 'Incommunicable knowledge: science, technology and the clinical art in Britain, 1850-1914', *Journal of Contemporary History* 20 (1985), pp. 503-20, pp. 512-4.

## Conclusion

This thesis explores the intellectual history of medical concepts of shell-shock. The potential difficulties and dangers of its approach have been outlined here, but its advantages will also become apparent as chapter follows chapter. At the least, it reinstates a sense of the flux within contemporary definitions of the disorder. Shell-shock was claimed by several groups – military men, doctors, politicians, patients – and each imbued the concept with separate but overlapping, and almost invariably ill-defined, meanings. Shell-shock was accessible to so many because from its birth its boundaries were never clearly or authoritatively delimited by any one group. If it was ever only medical diagnosis, rather than also self-ascribed mental or emotional condition, military administrative category, or cultural metaphor, then it was only for the briefest of moments. This moment has never been and is never likely to be located by historians. The concept of shell-shock was always constituted from its several meanings, and all contributed to its nebulous totality. Although this history explores how only one group, and in some respects a self-divided one, sought to define shell-shock, this is nevertheless an important act of recovery which demonstrates how the war neuroses reflected and fuelled fears far beyond the exigencies of a military manpower crisis.

One of the aims of the history of psychiatry has been described as ‘to recover the internal coherence of now unfamiliar beliefs about the mind and madness, and to set them in their wider frames of meaning’.<sup>69</sup> Because current concepts in psychiatry can trace their history back to shell-shock, because veterans of the First World War are still (just) alive, and because the war itself is still so imprinted on Britain’s cultural landscape, the fact that this world is in need of sympathetic reconstruction is not immediately evident. One doctor who was a medical student during the war recalled the lectures given by Robert Armstrong-Jones (1857-1943), a doctor we will meet again as the thesis proceeds, as articulate, ‘yet so incomprehensible [...] He might have been some eloquent foreigner, fluently discussing in his own tongue a subject the nature of

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<sup>69</sup> Porter, *Mind-forg’d manacles*, p. x.

which nearly became apparent but always elusively escaped'.<sup>70</sup> If students of psychiatry in 1914 encountered these problems, the historian must be even more sensitive to the mental worlds both revealed and hidden in these medical texts. The next two chapters, which respectively focus on the disorders hysteria and neurasthenia, and the evolutionary model of mind dominant in pre-war medical discourse, lay the foundations for and contribute to this retrieval of the contemporary meaning of shell-shock. There are limits to the possibilities of recreation; but this thesis lingers on those possibilities, and shows that in relation to shell-shock, these are greater than hitherto realised.

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<sup>70</sup> Geoffrey Bourne, 1963, quoted in T. Turner, "Not worth powder and shot": the public profile of the Medico-Psychological Association, c. 1851-1914', in G.E. Berrios and H. Freeman (eds), *150 years of British psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 3-16, p. 9.

## Chapter 2

### Languages of diagnosis: hysteria and neurasthenia in British medical discourse, c.1910-c. 1918

#### Introduction

Shell-shock is a controversial topic, but there is one point on which virtually all its historians are agreed: that prior to 1914 hysteria and neurasthenia were the two main nervous disorders recognised by British psychiatry, and that the diagnosis of shell-shock was comprised of these categories.<sup>1</sup> A complex of related and influential arguments regarding the socio-cultural significance of shell-shock, reducible to three main strands, has been formed on the basis of this perceived division of the war neuroses into hysteria and neurasthenia. The first of these is that before the war hysteria and neurasthenia were differentially distributed along class lines, and that this trend continued in wartime with officers diagnosed as neurasthenic and ranking men as hysterical.<sup>2</sup> The second is that these were also gendered diagnoses. The ranking soldier was feminised through association with the weakness and emotionalism of the hysterical female, while the neurasthenic officer was portrayed as closer to an acceptable male ideal.<sup>3</sup> The third is that different treatments were applied according to diagnostic label. Hysterical soldiers were punished by disciplinary therapies, but neurasthenic officers were sympathetically treated with 'talking cures' which sought to uncover repressed complexes and emphasised self-knowledge.<sup>4</sup> A précis this brief is unavoidably reductive. Not all historians agree with every aspect of this three-pronged analysis, and recent scholarship has undermined each to some degree.<sup>5</sup> However, no revisionist account has questioned the basic use of the hysteria/neurasthenia divide in these interpretations.

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<sup>1</sup> The only accounts I have found which do not mention this diagnostic division of shell-shock are Merskey, 'Shell-shock', and Jones and Wessley, *Shell shock to PTSD*.

<sup>2</sup> Leed, *No man's land*, pp. 163-4.

<sup>3</sup> Showalter, *The female malady*, p. 175.

<sup>4</sup> Leed, *No man's land*, pp. 169-80; B. Shephard, 'Shell-shock', in H. Freeman (ed.), *A century of psychiatry* (London: Mosby, 1999), pp. 33-40, p. 35-6.

<sup>5</sup> See, for example, Leese's survey of the wartime treatment network which has shown that pragmatic rather than ideological considerations usually determined modes of treatment Leese, *Shell shock*, pp. 68-140.

The accurate identification of the clinical content of hysteria and neurasthenia in pre-war British medical discourse is crucial to historiographical interpretations of shell-shock. Arguments based on the hysteria/neurasthenia divide accumulate force as a further cluster of dichotomous pairings appear to align themselves irresistibly with these categories: body/mind, female/male, nature/culture, lower/upper class, ancient/modern disease. These attributes are presented as natural accompaniments to the diagnostic concepts, the established background against which subsequent interpretations of shell-shock are made rather than an equally contestable part of the interpretation itself.<sup>6</sup> Yet although historians of these disorders have emphasised the need to be ‘thoroughly and conscientiously contextualist’ with concepts of such ‘highly elusive and protean’ character, very little has been written on clinical constructions of hysteria and neurasthenia in early twentieth-century Britain.<sup>7</sup> The bibliography of nearly four hundred secondary works appended to Mark Micale’s magisterial study of hysteria and its historiography contains only a few items relevant to this period.<sup>8</sup> The majority of scholarship on neurasthenia has focussed on America or taken a pan-Western perspective, although some recent studies on Britain have argued that the diagnosis evolved differently in this national context.<sup>9</sup> If the tripartite socio-cultural analysis of shell-shock outlined above is to stand, it must be shown that British medicine conceived hysteria and neurasthenia as distinct and opposed categories, and deployed these diagnoses accordingly in framing the war neuroses.

Hysteria and neurasthenia featured prominently in the pre-war British medical press, although historians have often dated the end-point of the gradual dismantling of both

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<sup>6</sup> See, for examples, E. Showalter, ‘Hysteria, feminism and gender’ in S. Gilman et al, *Hysteria beyond Freud* (Berkeley, Los Angeles and London: University of California Press), pp. 286-344, p. 321-27; Shephard, *A war of nerves*, pp. 8-10.

<sup>7</sup> M. Micale, ‘Hysteria and its historiography: the future perspective’, *History of Psychiatry* 1 (1990), pp. 33-124, p. 45-6; M. Gijswijt-Hofstra, ‘Introduction’ in M. Gijswijt-Hofstra and R. Porter (eds), *Cultures of neurasthenia: from Beard to the First World War* (Amsterdam and New York: Rodopi, 2001), pp. 1-30, p. 20.

<sup>8</sup> M. Micale, *Approaching hysteria: disease and its interpretations* (Princeton, New Jersey: Princeton University Press, 1995), pp. 295-316.

<sup>9</sup> Classic accounts of neurasthenia in America and Europe are B. Sicherman, ‘The uses of a diagnosis: doctors, patients, and neurasthenia’, *Journal of the History of Medicine and Allied Sciences* 32 (1977), pp. 33-54; G.F. Drinka, *The birth of neurosis: myth, malady and the Victorians* (New York: Simon and Schuster, 1984); A. Rabinbach, *The human motor: energy, fatigue, and the origins of modernity* (New York: BasicBooks, 1990), pp. 146-78; on Britain, see the essays by Mathew Thomson, Chandak Sengoopta, Hilary Marland, and Michael Neve in Gijswijt-Hofstra and Porter (eds), *Cultures of neurasthenia*.

disorders to 1914.<sup>10</sup> Neurasthenia was perceived as almost too ubiquitous, with one physician describing it as a ‘capacious wastepaper basket’ which collected all manner of theories.<sup>11</sup> This depiction is borne out by a 1911 special issue of the *Practitioner* devoted to the disorder, which covered every aspect from its differing manifestations in men, women, and children to its relation to movable kidney and eyestrain.<sup>12</sup> Although neurasthenia was endlessly discussed, there was little agreement on its definition, aetiology, symptomatology or treatment, as illustrated by the varied opinions voiced at a meeting of the Medical Society of London in November 1913.<sup>13</sup> The circumstances in which hysteria was debated were somewhat different. It was readily acknowledged that British medicine had produced ‘comparatively little of an authoritative character’ on the disorder, and that the ‘gallant attempts’ of British theorists to provide physiological explanations for its symptoms had failed.<sup>14</sup> Nevertheless, a range of psychologically-oriented theories emanating from Continental Europe were disseminated in articles and reviews in the British medical press.<sup>15</sup> There was a national buzz surrounding these theories, as evidenced by reports on papers delivered to a range of regional societies.<sup>16</sup> Yet another lengthy exposition of modern theories of hysteria spread over three issues of the *Lancet* in early 1914 proves that this was still a hot topic on the eve of the war.<sup>17</sup>

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<sup>10</sup> M. Micale, ‘On the “disappearance” of hysteria: a study in the clinical deconstruction of a diagnosis’, *Isis* 84 (1993), pp. 496-526, p. 501; S. Wessely, ‘Old wine in new bottles: neurasthenia and ME’, *Psychological Medicine* 20 (1990), pp. 35-53, p. 47-8.

<sup>11</sup> S.A.K. Wilson, ‘Abstract of a lecture on some common errors in the diagnosis of nervous disease’, *Lancet* 1913 (2), pp. 1676-80, p. 1677.

<sup>12</sup> Special issue on neurasthenia, *Practitioner* 86 (January-June 1911).

<sup>13</sup> J.S.R. Russell, ‘The treatment of neurasthenia’, *Lancet* 1913 (2), pp. 1453-56; [Anon.], ‘Medical societies: Medical Society of London’, *Lancet* 1913 (2), pp. 1469-72 and pp. 1542-44.

<sup>14</sup> [Anon.], ‘Modern views of hysteria’, *Lancet* 1911 (1), pp. 951-2, p. 951; J.A. Ormerod, ‘Two theories of hysteria’, *Brain* 33:3 (January 1911), pp. 269-87, p. 270. For physiological theories of hysteria, see H.C. Bastian, *Various forms of hysterical or functional paralysis* (London: H.K. Lewis, 1893); T.D. Savill, *Lectures on hysteria and allied vaso-motor conditions* (London: Henry J. Glaister, 1909).

<sup>15</sup> [Anon.], ‘Modern views of hysteria’; J.S. Fowler, ‘Recent literature: critical summaries and abstracts. Medicine: modern theories of hysteria – Babinski, Janet, and Freud’, *EMJ* 6:5 (May 1911), pp. 443-8; B. Hart, ‘Freud’s conception of hysteria’, *Brain* 33:3 (January 1911), pp. 339-66; Ormerod, ‘Two theories of hysteria’; S.A.K. Wilson, ‘Some modern French conceptions of hysteria’, *Brain* 33:3 (January 1911), pp. 293-338; [Anon.], ‘Freud’s theory of dreams’, *Lancet* 1913 (1), p. 1327; W. Brown, ‘Freud’s theory of dreams’, *Lancet* 1913 (1), pp. 1114-18 and pp. 1182-84; T.R. Glynn, ‘Abstract of the Bradshaw lecture on hysteria in some of its aspects’, *Lancet* 1913 (2), p. 1303.

<sup>16</sup> [Anon.], ‘Medical societies: Liverpool Medical Institution’, *Lancet* 1910 (1), pp. 1001-2; [Anon.], ‘Medical societies: Nottingham Medico-Chirurgical Society’, *Lancet* 1911 (2), p. 1338; [Anon.], ‘Sheffield Medico-Chirurgical Society: some recent conceptions of hysteria’, *Lancet* 1913 (1), pp. 1024-25.

<sup>17</sup> J.A. Ormerod, ‘The Lumleian lectures on some modern theories concerning hysteria’, *Lancet* 1914 (1), pp. 1163-69, pp. 1233-39, and pp. 1299-1305.

This chapter aims to demonstrate the importance of a nuanced and contextualised reading of pre-war British psychological medicine for understandings of the historical meaning and significance of the war neuroses. This is first achieved through a deconstruction of the historiographical ‘social class thesis’, which argues that the differential diagnosis of hysteria and neurasthenia reflected the social prejudices of medical observers. For the duration of the war, the majority of doctors made no comment on the differential distribution of symptoms, and when such observations were made they do not confirm the view that hysteria and neurasthenia were perceived as separate and opposed categories. This historiographical misunderstanding has been facilitated by the conflation of neurasthenia with anxiety neurosis. The complex history of these concepts, their construction and relation to each other in pre-war medical discourse, and their shifting definitions over the course of the war itself underlines the necessity for careful attention to the language of diagnosis, the place of particular theories within the corpus of contemporary work on shell-shock, and the chronological development of ideas throughout 1914-18 and into the post-war period.

The final sections of the chapter argue that in pre-war British medical discourse hysteria and neurasthenia were not conceptually opposed but rather linked through their definition as functional diseases and the crucial role attributed to hereditary predisposition in the aetiologies of both. The conceptual closeness of hysteria and neurasthenia undermines historiographical arguments built on their difference, while a more precise understanding of these diagnoses not only highlights the degree of continuity between pre-war and wartime psychological medicine, but also uncovers ideas which were crucial to the framing of shell-shock. These aspects are explored further in the next two chapters, which respectively examine the evolutionary model of mind prevalent in pre-war medicine, and the trends which contributed to the gendering of shell-shock. It is also shown here that the category of functional disorder was an ambiguous space which paradoxically enabled psychological concepts to infiltrate pre-war British medicine through its allegiance to the somatic paradigm. The argument that shell-shock forced the transition from physical to psychological understandings of mental disorder, the subject of chapter five, is destabilised by the knowledge that the foundations for such approaches had been laid before the war. Finally, the perception that heredity played a dominant role in the development of hysteria and neurasthenia



ties these disorders to debates on the state of the nation. Even before shell-shock, the mental health of the individual was a matter of social and political significance.

### **The 'social class thesis'**

The historiographical argument that hysteria and neurasthenia were differentially diagnosed according to social class has long held the field.<sup>18</sup> The only significant objection has been made by Peter Leese, who has argued that there was no straightforward equation between social class and military rank, but concludes that expectations attached to rank did influence the differential application of diagnostic labels.<sup>19</sup> There is still universal historical consensus regarding the broad outlines of the social class thesis. The central tenets on which this argument rests are that hysteria and neurasthenia were differentially diagnosed according to social class before the war, and according to military rank in shell-shock, and that this practice reflects the negative and positive attributes ascribed to these disorders. It is shown here that this distribution of diagnoses was not characteristic of either pre-war or wartime British psychological medicine, although it was retrospectively described in post-war texts as a typical feature of shell-shock.

The first point to tackle is the pre-war social distribution of hysteria and neurasthenia. Historians of these disorders agree that the original class connotations of these disorders had undergone significant change by 1914. Hysteria, traditionally associated with the upper classes and viewed as 'a kind of pathological by-product of middle-class

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<sup>18</sup> In some formulations of this thesis, there has been confusion as to whether the labels attached to soldiers are evidence of the actual distribution of symptoms, or rather proof of social prejudices which informed diagnostic procedure. See for example J. Bourke, 'Psychology at war, 1914-1945', in G. Bunn, S. Lovie, and G. Richards (eds), *A history of British psychology: historical essays and personal reflections* (London: British Psychological Society/Science Museum, 2000), pp. 133-49, p. 137-8. It has been convincingly argued that the medical literature is not a good guide to symptom distribution. The reality of hysterical manifestations in officers may have been hidden by diagnosis of organic disorder; neurasthenic symptoms might have been more rapidly recognised in this group than in rankers because of their greater social contact with RMOs and the opportunities for informal diagnosis it enabled; and these symptoms might have been taken more seriously in officers because the responsibility of their military role meant that incipient breakdown threatened the safety of the unit. See Young, *The harmony of illusions*, p. 62; C. May, 'Lord Moran's memoir: shell-shock and the pathology of fear', *Journal of the Royal Medical Society* 91 (1998), pp. 95-100, p. 99; M. Thomson, 'Status, manpower and mental fitness: mental deficiency in the First World War', in R. Cooter, M. Harrison and S. Sturdy (eds), *War, medicine and modernity* (Gloucestershire: Sutton, 1998), pp. 149-66, p.154. Bearing these points in mind, it is assumed here that hysteria and neurasthenia were differentially diagnosed rather than manifested.

<sup>19</sup> Leese, *Shell shock*, p. 85 and pp. 110-116. For this reason, military rank rather than social class will be referred to when discussing the contemporary literature on shell-shock.

Victorian and Wilhelminian society' was recognised as widespread among the working classes by this later date.<sup>20</sup> Although British accounts of the disorder rarely included specific comments on its social bases, it is clear from discussions of individual case histories that doctors were not surprised to find hysteria in all ranks of society.<sup>21</sup> A similar pattern is found with regard to neurasthenia. Although it was initially perceived as an affliction of the comfortable classes, historians are agreed that by 1900 it had spread to the working classes in most countries, including Britain.<sup>22</sup> The contemporary medical literature supports this conclusion. It was often asserted that neurasthenia occurred 'more frequently in civilised societies', but its association with insanity, tuberculosis, syphilis, alcoholism and factors such as 'bad home surroundings, insufficient food and clothing' suggests that the lower echelons were not immune.<sup>23</sup> Although it might be expected that the 'more delicate central nervous mechanism of the highly educated classes' rendered this group particularly susceptible to neurasthenia, it was nevertheless found 'in all ranks and at all ages'.<sup>24</sup>

The belief that hysteria and neurasthenia were uniformly associated with different social classes therefore does not hold so far as pre-war Britain is concerned. It transpires that its alleged distribution according to military rank rests on an extremely slim basis of wartime evidence. The social class thesis is bulwarked almost entirely by post-war writings.<sup>25</sup> Across the entire historiography of shell-shock, only five wartime texts have been cited in its support, and only two of these, *War neuroses* (1918) by the Canadian psychologist John MacCurdy (1886-1947) and an article by William Rivers from October 1918, actually correspond to the historiographical argument in its

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<sup>20</sup> Micale, 'Hysteria and its historiography', pp. 85-93.

<sup>21</sup> Hysterical patients from a range of social backgrounds are discussed in E. Jacob, 'Remarks on functional aphemia', *British Medical Journal* 1890 (2), pp. 622-3; H.C. Bastian, 'On different kinds of aphasia, with special reference to their classification and ultimate pathology', *BMJ* 1887 (2), pp. 985-90; J. Wyllie, *The disorders of speech* (Edinburgh: Oliver and Boyd, 1894), pp. 42-4.

<sup>22</sup> Sicherman, 'The uses of a diagnosis', pp. 42-4; S. Wessely, 'Neurasthenia and fatigue syndromes: clinical section' in G.E. Berrios and R. Porter (eds), *A history of clinical psychiatry: the origin and history of psychiatric disorders* (London: Athlone, 1995), pp. 509-32, p. 513; C. Sengoopta, "'A mob of incoherent symptoms"? Neurasthenia in British medical discourse, 1860-1920' in Gijswijt-Hofstra and Porter (eds), *Cultures of neurasthenia*, pp. 97-116, p. 98-9; M. Neve, 'Public views of neurasthenia: Britain, 1880-1930' in Gijswijt-Hofstra and Porter (eds), *Cultures of neurasthenia*, pp. 141-60, p. 143-5.

<sup>23</sup> R.H. Cole, *Mental diseases: a text-book of psychiatry for medical students and practitioners* (London: University of London Press, 1913), pp. 220-21; views of neurasthenia as both a disease of civilisation and a disease of primitive peoples are found in [Anon.], 'Medical societies: Medical Society of London', p. 1469 and p. 1543.

<sup>24</sup> R.A. Fleming, 'Neurasthenia and gastralgia', *Practitioner* 86:1 (January 1911), pp. 29-37, p. 31.

<sup>25</sup> The post-war sources most commonly cited are F.W. Mott, *War neuroses and shell shock* (1919); W.H.R. Rivers, *Instinct and the unconscious* (1920); W. Macpherson et al, *Medical diseases of the war* (1923); and C.S. Myers, *Shell-shock in France* (1940).

entirety.<sup>26</sup> Of the remaining three, two make no reference to either social class or military rank in relation to hysteria or neurasthenia.<sup>27</sup> The third, an article from November 1918 by William Aldren Turner (1864-1945), consulting neurologist to the British armies in France until March 1915 and then to the home troops, referred to MacCurdy's work to argue that anxiety neurosis was most common in officers, but also claimed that a mixed condition of anxiety and hysteria was frequently found in ranking men, and therefore provides only partial support for the social class thesis.<sup>28</sup>

MacCurdy based his book on observations made at hospitals where Rivers worked, and the latter provided its preface. Although there were some differences in the explanations these physicians put forward for hysteria and anxiety neurosis ('anxiety state' in MacCurdy's work), these were outweighed by those similarities on which historians have based the social class thesis. Both acknowledged almost in passing that a ranking soldier might suffer some kind of anxiety reaction, particularly on the removal of a hysterical symptom, but the overall trend of their theories was to associate hysteria with ranking men, anxiety neurosis with officers, and to rigidly separate these disorders at the intellectual level.<sup>29</sup> Each explained hysteria as a crude response to mental conflict in which a physical symptom satisfied the soldier's desire for escape from the trenches, and anxiety neurosis as a more complicated reaction in which conflict was caused and maintained by a heightened sense of duty.<sup>30</sup> The differences in these psychological responses were explained as the result of not only the military training, but the greater intelligence, education, idealism, and social responsibility of the officer.<sup>31</sup> In order for the social class thesis to be proven, it would need to be shown that these notions were representative of the general trend of wartime explanations: that hysteria and neurasthenia/anxiety neurosis were perceived to be differentially distributed according to rank; that they were also viewed as distinct syndromes with separate aetiological mechanisms; and that anxiety neurosis was seen as the result of

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<sup>26</sup> J.T. MacCurdy, *War neuroses* (Cambridge: C.U.P., 1918); W.H.R. Rivers, 'War-neurosis and military training', *Mental Hygiene* 2: 4 (October 1918), pp. 513-33

<sup>27</sup> These items are R. Armstrong-Jones, 'The psychology of fear and the effects of panic fear in war time', *JMS* 63:262 (July 1917), pp. 346-89, p. 389; J. Collie, *Malingering and feigned sickness*, 2nd edn (London: Edward Arnold, 1917), p. 186, both cited in Bourke, *Dismembering the male*, p. 112, fn 234.

<sup>28</sup> W.A. Turner, 'The Bradshaw lecture on neuroses and psychoses of war', *Lancet* 1918 (2), pp. 613-7, p. 613 and p. 616.

<sup>29</sup> MacCurdy, *War neuroses*, p. 17, p. 21, and p. 86; Rivers, 'War-neurosis and military training', pp. 514-6.

<sup>30</sup> MacCurdy, *War neuroses*, p. 23 and p. 88; Rivers, 'War-neurosis and military training', pp. 514-6.

<sup>31</sup> MacCurdy, *War neuroses*, pp. 122-4 and p. 88; Rivers, 'War-neurosis and military training', pp. 516-9 and pp. 524-7.

both the pre-war psychology and military functions of the officer class, and accordingly characterised as a positive diagnosis.

There is little evidence in the wartime literature that hysteria was seen as the affliction of the ranks and neurasthenia/anxiety neurosis the preserve of officers. It cannot be emphasised too strongly that the overwhelming majority of authors made no comment at all on the distribution of symptoms according to military rank. In fact, when a German professor argued that the neuroses manifested differently according to rank because 'the better mental equipment' of officers rendered them less liable to the strains of warfare, the *British Medical Journal* sarcastically suggested that 'the greater comfort of their existence' might be a more realistic explanation, adding that of course these observations were not relevant to British troops in any case.<sup>32</sup> Some British physicians did note two features specific to the neuroses of the officer class: the apparent rarity of hysterical symptoms, and the 'continual strain of heavy responsibilities' as a factor contributing to breakdown.<sup>33</sup> But officers did not hold sole claim to neurasthenia or anxiety neurosis, which were frequently observed in ranking men.<sup>34</sup> In the Gallipoli Expeditionary Force in 1915, neurasthenia was the most common 'nervous disease' (including shell-shock, epilepsy, and mental diseases) diagnosed in the other ranks.<sup>35</sup> Therefore although differential diagnosis appears to have been applied by a small sample of shell-shock doctors, it was not along the lines identified by the social class thesis. It centred on the apparent absence of hysteria on officers, rather than their particular susceptibility to neurasthenia/anxiety neurosis. Furthermore, the widespread acknowledgement of neurasthenia among rankers

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<sup>32</sup> [Anon.], 'Shell shock, gas poisoning, and war neuroses', *BMJ* 1917 (1), p. 656.

<sup>33</sup> C.S. Myers, 'Contributions to the study of shell shock (IV): being an account of certain disorders of speech, with special reference to their causation and their relation to malingering', *Lancet* 1916 (2), pp. 461-7, p. 461; F.W. Mott, 'The Lettsomian lectures on the effects of high explosives upon the central nervous system. II', *Lancet* 1916 (1), pp. 441-9, p. 443; W. Johnson, 'Hysterical tremor', *BMJ* 1918 (2), pp. 627-8, p. 627; [Anon.], 'The war and nervous breakdown', *Lancet* 1915 (1), pp. 189-90, p. 189; G.E. Smith, 'Shock and the soldier. I', *Lancet* 1916 (1), pp. 813-7, p. 817; [Anon.], 'The mind of the soldier', *BMJ* 1918 (2), pp. 188-9; W. Hale-White, 'An address on some applications of experience gained by the war to the problems of civil medical practice', *BMJ* 1919 (2), pp. 227-30, p. 228.

<sup>34</sup> See [Anon.], 'Special hospitals for officers: Lord Knutsford's appeal', *Lancet* 1915 (2), pp. 1155-57, p. 1155; [Anon.], 'Lord Knutsford's special hospitals for officers', *Lancet* 1915 (2), pp. 1201-2, p. 1201; C. McDowall, 'Functional gastric disturbance in the soldier', *JMS* 63:260 (January 1917), pp. 76-88; R. Armstrong-Jones, 'Mental and nervous states in connection with the war and their mechanism', *Practitioner* 103:5 (November 1919), pp. 321-42, p. 335; R. Eager, 'A record of admissions to the mental section of the Lord Derby War Hospital, Warrington, from June 17<sup>th</sup>, 1916, to June 16<sup>th</sup>, 1917', *JMS* 64:266 (July 1918), pp. 272-96, p. 277.

<sup>35</sup> Macpherson *et al* (eds), W.P. Herringham, T.R. Elliot, and A. Balfour (eds), *History of the Great War*, p. 2.

undermines the foundation of the historiographical argument in the depiction of these disorders as opposed categories.

The majority of medical authors did not hold that neurasthenia/anxiety neurosis and hysteria were incompatible or even entirely distinct disorders. It was frequently observed that war neurosis often manifested as a mixed condition of hysteria and neurasthenia.<sup>36</sup> The particular mechanisms by which MacCurdy and Rivers explained the development of these disorders were not invoked or even acknowledged by most contributors to the debates. The particular complexities of neurasthenia/anxiety neurosis will be elucidated presently, but most commentators viewed hysteria primarily as a disease of suggestion and seemed unaware of the notion of a defence mechanism.<sup>37</sup> Even where authors outlined processes leading to the development of hysterical or neurasthenic symptoms which were in some respects similar to those delineated by MacCurdy and Rivers, there were usually two crucial divergences from these authors. The first was that the military rank of sufferers was not mentioned, and the second was a tendency to undermine the putative difference between the two syndromes.

There were two main ways in which these differences were de-emphasised. Authors might accept distinct mechanisms of production, but label the disorders 'conversion hysteria' and 'anxiety hysteria' without reference to neurasthenia or anxiety neurosis.<sup>38</sup> This is not a niggardly matter of terminology. The use of 'hysteria' for both syndromes implied similarity at a fundamental level, and negates to some degree the historiographical weight placed on the stigmatising associations of the term (a point also relevant to the discussion of the gendering of diagnoses in chapter four). Some

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<sup>36</sup> T.R. Elliott, 'Transient paraplegia from shell explosions', *BMJ* 1914 (2), pp. 1005-6, p. 1005; H. Tilley, 'Two cases of functional aphonia (one including functional deafness) following the bursting of a shell in close proximity to the patient', laryngological section, *PRSM* 8:2 (1914-1915), p. 115; J.P.I. Harty, 'Experiences of an ear, nose and throat specialist at one of the bases', *Bristol Medico-Chirurgical Journal* 34:130 (July 1916), pp. 39-49, p. 41; E.F. Ballard, *An epitome of mental disorders: a practical guide to aetiology, diagnosis, and treatment for practitioner, asylum and R.A.M.C. medical officers* (London: J & A. Churchill, 1917), p. 158; A.F. Hurst, *Medical diseases of the war* (London: Edward Arnold, 1917), p. 1.

<sup>37</sup> J. Collie, 'Neurasthenia: what it costs the state', *Journal of the RAMC* 26:4 (April 1916), pp. 525-44, p. 532; A.F. Hurst, 'Observations on the etiology and treatment of the war neuroses', *BMJ* 1917 (2), pp. 409-14, p. 410; E.G. Fearnside, 'Essentials of treatment of soldiers and discharged soldiers suffering from functional nervous disorders', neurological section, *PRSM* 11 (1917-1918), pp. 42-8, p. 45.

<sup>38</sup> C.S. Read, 'A survey of war neuro-psychiatry', *Mental Hygiene* 2 (July 1918), pp. 359-87, p. 363-4; D. Forsyth, 'Functional nerve disease and the shock of battle: a study of the so-called traumatic neuroses arising in connexion with the war', *Lancet* 1915 (2), pp. 1399-1403, p. 1402; M.D. Eder, *War-shock: the psycho-neuroses in war psychology and treatment* (London: William Heinemann, 1917), p.8.

doctors also argued, contrary to Rivers and MacCurdy, that there was often an underlying condition of anxiety in hysteria.<sup>39</sup> The asylum psychiatrist Ernest Fryer Ballard, now in charge in the mental wards of a military hospital in Brighton, stressed that the removal of a somatic episode would leave a condition of 'agitated neurasthenia', because the 'mental wounds still gape and are not sufficiently healed to dispense with the dressing supplied by the episode'.<sup>40</sup> This argument was most fully developed by Thomas Ross (1875-1941), medical officer in charge of a division of Springfield War Hospital, who claimed that 'there was no fundamental difference between hysteria and what is termed neurasthenia or anxiety state'. The fundamental factor in the production of both disorders was anxiety, and although the conflict might be temporarily resolved by a hysterical symptom, the removal of the symptom would be quickly followed by anxiety neurosis if this aspect had not been treated.<sup>41</sup>

The differences could also be skated over because unlike Rivers and MacCurdy, most authors did not link neurasthenia/anxiety neurosis to the pre-war psychology of the officer. Although commentators frequently invoked fear of failure and the strain of responsibility as elements contributing to breakdown in officers (see footnote 33 above), these were described as the outcome of military function rather than any other factor. These comments may have masked social bias, but nevertheless it was still at most implicit. Before 1918, only two authors directed stated that 'superior education and knowledge' was the reason officers did not develop hysteria.<sup>42</sup> The first was the neurologist Edward Farquhar Buzzard (1871-1945), consultant to the London Command, and the second was Robert Armstrong-Jones in a citation of this article. But although in a different connection Armstrong-Jones had claimed that there were physical differences in the brain patterns of the 'poorer' and 'cultured' classes, this did

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<sup>39</sup> Both these authors argued that anxiety was *usually* absent in hysteria. MacCurdy, *War neuroses*, p. 91-2; Rivers, 'War-neurosis and military training', p. 527. Rivers had altered this opinion by the time he gave evidence to the War Office Committee of Enquiry. W.H.R. Rivers in *Report of the War Office Committee of Enquiry into "Shell-Shock"* (London: Imperial War Museum, 2004) [1922], p. 58.

<sup>40</sup> E.F. Ballard, 'Some notes on battle psycho-neuroses', *JMS* 63:262 (July 1917), pp. 400-5, p. 404; and E.F. Ballard, 'The psychoneurotic temperament and its reactions to military service', *JMS* 64 :267 (October 1918), pp. 365-377, pp. 368-9.

<sup>41</sup> T.A. Ross, 'Certain inter-relations between peace and war neuroses', section of neurology, *PRSM* 12 (parts 1 and 2), pp. 13-20, p. 14; T.A. Ross, 'Shell shock' in H. Joules (ed.), *The doctor's view of war* (London: George Allen & Unwin Ltd., 1938), pp. 48-55, p. 52; T.A. Ross, 'Anxiety neuroses of war', in A.F. Hurst, *Medical diseases of war* (London: Edward Arnold & Co., 1944), pp. 149-72, p. 170; see also W.D. Chambers, 'Mental wards with the British Expeditionary Force: a review of ten months' experience', *JMS* 65:270 (July 1919), pp. 152-80, p. 172.

<sup>42</sup> E.F. Buzzard, 'Warfare on the brain', *Lancet* 1916 (2), pp. 1095-99, p. 1097.

not impact on his overall explanation of the war neuroses. When he explained that there was a difference between the gradual erosion of self-control which characterised most cases of shell-shock, and the 'fear which comes on suddenly and in neuropathic or hysterical men', these two types of breakdown were each illustrated with examples from the officer class.<sup>43</sup>

The final point which illustrates that the theories of Rivers and MacCurdy were not representative of the mainstream medical literature is the absence of descriptions of neurasthenia/anxiety neurosis as a preferential or relatively positive diagnosis. The features of the 'neurasthenic personality' listed by one author were emotionalism, mood swings, and innate selfishness.<sup>44</sup> Another physician explained the 'anxiety state' of one patient on the basis that he came 'from a poor stock, had always been nervous and sensitive, and greatly devoted to his mother'.<sup>45</sup> In his study of neurasthenia in the home forces, Frederick Burton-Fanning (1863-1947) claimed that very few of his patients had 'enjoyed the traditional advantage of our old public schools', in which 'character and manliness are developed side by side with learning', and it showed in their symptoms. The self-obsessed neurasthenic had clearly never been told that his 'only rule' should be 'to play the man'.<sup>46</sup> These sentiments were echoed in a *British Medical Journal* review of a book on 'the anxious temperament', described as the 'fussy and meticulous' character displayed by 'old women of both sexes'. It concluded that these 'pseudo-politroons' would always be quite useless in battle.<sup>47</sup>

The published wartime medical literature does not support the social class thesis as formulated by historians. Historians have been guilty, however, of retrospective extrapolation rather than invention. In the post-war period the statement that officers and ranking men had been subject to different forms of neurosis became a standard feature of writings on shell-shock, usually by those who had been directly involved in

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<sup>43</sup> R. Armstrong-Jones, 'Drug addiction in relation to mental disorder', *JMS* 61:252 (January 1915), pp. 37-61, p. 41; Armstrong-Jones, 'The psychology of fear', p. 350; R. Armstrong-Jones, 'Mental states and the war – the psychological effects of fear. II', *Journal of State Medicine* 25:10 (October 1917), pp. 289-99, pp. 290-1.

<sup>44</sup> H.H. Tooth, 'Neurasthenia and psychasthenia', *Journal of the RAMC* 28: 3 (March 1917), pp. 328-45, p. 338.

<sup>45</sup> D.K. Henderson, 'War psychoses: an analysis of 202 cases of mental disorder occurring in home troops', *JMS* 64:265 (April 1918), pp. 165-89, p. 184.

<sup>46</sup> F.W. Burton-Fanning, 'Neurasthenia in soldiers of the home forces', *Lancet* 1917 (1), pp. 907-11, p. 907 and p. 910.

<sup>47</sup> [Anon.], 'Review: morbid anxiety', *BMJ* 1917 (1), pp. 457-8.

its treatment (see footnote 25 above). It is possible that the doctors who published on shell-shock after 1918 had chosen psychological medicine as a career path, in contrast to those who returned to different areas of practice after the war, and were therefore more likely to draw on sophisticated theories of the type put forward by Rivers and MacCurdy. But it is more likely that as the notion of differential distribution of symptoms was taken up with such alacrity in the post-war period, distinctions based on military rank had been made in wartime clinical encounters.<sup>48</sup> Even if this was not the case, their widespread adoption after 1918 suggests that they chimed with the social prejudices of many doctors. The fact remains that even if doctors observed or imposed divisions based on rank, they did not choose to publicly comment on the fact for the duration of the war. This is an important finding. It highlights the necessity for close attention to chronology, and the dangers of reading any theories as representative of the entire trend of medical opinion. But it also suggests that although the war did not dissipate social bias, the emphasis on social unity in wartime limited the expression of such opinions, at least in relation to serving men. In contrast to the standard historiographical argument, discriminations based on class or rank were not central to wartime medical discourse on shell-shock.

### **Neurasthenia, nervous exhaustion, and psychasthenia**

There is a further respect in which the social class thesis rests on a misconception. Before and during the war neurasthenia was most often defined as a primarily somatic malady with psychic elements. In contrast, histories of shell-shock imply that neurasthenia was understood as a psychological disorder. These historiographical descriptions conflate neurasthenia, Pierre Janet's psychasthenia, and a hybrid notion of anxiety neurosis derived from Rivers and Freud. It is the last of these which has most obviously and most often affected depictions of neurasthenia: historians variously use anxiety neurosis as a synonym of neurasthenia, make anxiety central to definitions of neurasthenia, or claim that neurasthenia was relabelled anxiety neurosis during the war.<sup>49</sup> In order to trace the twisted path by which this historiographical misreading has

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<sup>48</sup> The analysis of diagnostic language in case notes made by Peter Leese supports this conclusion, but too much weight should not be placed on a sample from such a small number of institutions. Leese, *Shell shock*, pp. 85-120.

<sup>49</sup> Barham, *Forgotten lunatics of the Great War*, p. 76; Bourke, *Dismembering the male*, p. 112; Leed, *No man's land*, p. 163; Binnevald, *From shell shock to combat stress*, p. 94; B. Shephard, "The early treatment of mental disorders": R.G. Rows and Maghull 1914-1918' in H. Freeman and G.E. Berrios



occurred, it is necessary to delineate how all these diagnostic concepts were employed in pre-war and wartime British medical discourse. This examination further demonstrates the importance of a broad reading of the wartime literature as a basis for general statements, and the need for sensitivity to chronological shifts in explanation. It also brings in two new elements: the role of pre-war diagnostic concepts in shaping clinical perceptions of shell-shock, and the importance of nuances in the language of diagnosis.

In pre-war British medical discourse, a wide-ranging and shifting set of symptoms were attached to neurasthenia by different commentators. It is impossible to pin down a single accepted definition of the disorder. The situation is further complicated by the fact that in the years before the war neurasthenia was undergoing fundamental changes, as theorists including Janet and Freud sought to make it more manageable by redistributing some of its features among new diagnoses such as psychasthenia and anxiety neurosis.<sup>50</sup> However, it seems that for most British authors 'true' neurasthenia constituted a somatic condition of nervous exhaustion, in which 'psychic' elements might exist as adjuncts but were not essential to its definition. This conception of neurasthenia is apparent in textbooks of nervous and mental diseases, which gave popular synonyms as 'nervous prostration', 'nervous debility' and 'nervous exhaustion'. The most prominent somatic symptoms were nervous exhaustion and fatigue, particularly constant tiredness and general aches and pains which might affect any or several bodily functions (circulation, digestion, sexual activity). Attached to these were a set of 'psychic' symptoms which were perceived as further manifestations of this nervous weakness: inability to concentrate, particularly on mental labour, headache, insomnia, depression, excitability, irritability, introspection, and excessive emotion.<sup>51</sup>

This mixture of somatic and mental manifestations contributed to a certain ambiguity in views of neurasthenia. The neurologist and physician John Risien Russell (1863-1939) acknowledged that practitioners might use this label to avoid stigmatising terms such as

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(eds), *150 years of British psychiatry, volume 2: the aftermath* (London: Athlone, 1996), pp. 434-64, p. 435.

<sup>50</sup> Wessely, 'Old wine in new bottles', p. 47.

<sup>51</sup> J.D. Nagel, *Nervous and mental diseases: a manual for students and practitioners* (London: Hodder and Stoughton, 1905), p. 171-2; C.S. Potts, *Nervous and mental diseases for students and practitioners*, 2nd edn (London: Henry Kimpton, 1908), p. 405-7.

melancholia, delusional insanity, or hysteria, but also warned that equally often 'some grave organic affection is in the background, underlying the manifestations ascribed to neurasthenia', the true nature of which was only revealed by autopsy.<sup>52</sup> The similarities neurasthenia shared with the opening stages of several recognised organic disorders, including various syphilitic affections and arterio-sclerosis both further aligned it with the body, and meant that it was difficult for practitioners to entirely rule out the possibility that this nebulous set of symptoms signalled not neurasthenia, but a more serious disease.<sup>53</sup> This ambiguity also reflects the extent to which body and mind were perceived as inseparable entities in pre-war medicine. Few accounts insisted on a solely somatic aetiology for neurasthenia, and even rarer were authors who claimed that the 'malady is essentially mental'.<sup>54</sup> Most common was a compromise position, such as the view that there was an undetected organic lesion in some, but not all, cases of neurasthenia, or that body and mind 'may alike be implicated and demand the same attention'.<sup>55</sup>

Philosophical pragmatism was therefore one way of negotiating the ambiguities posed by a concept as elastic as neurasthenia. Another was the attempt to delineate different types of neurasthenia.<sup>56</sup> The approach which eventually gained greater currency, however, was the removal of psychological symptoms from neurasthenia in order to create new diagnoses and to strip the old one down to its bare essentials. This process was underway some years before the war. In 1911 William Aldren Turner stated that 'several pseudo-neurasthenic states', including manic-depressive psychosis, dementia praecox, psychasthenia, and Freud's 'anxiety neurosis' had been eliminated from the diagnosis. This had left a pure core of nervous exhaustion or 'true neurasthenia', a primarily somatic category which incorporated a psychic dimension.<sup>57</sup> Other authors argued that it was impossible to draw 'hard and fast lines' between these conditions, and that they might be best regarded as a clinical group in which 'but shadowy

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<sup>52</sup> Russell, 'The treatment of neurasthenia', p. 1453.

<sup>53</sup> F.W. Mott, 'Neurasthenia and some associated conditions', *Practitioner* 86:1 (January 1911), pp. 1-10; see also G. Rankin, 'The borderland of disease', *BMJ* 1914 (2), pp. 821-4, p. 822.

<sup>54</sup> D. Ferrier, 'Neurasthenia and drugs', *Practitioner* 86:1 (January 1911), pp. 11-15, p. 11; for a rare somatic explanation, see [Anon.], 'Bradford Medico-Chirurgical Society', *Lancet* 1911 (1), pp. 308-9, p. 308.

<sup>55</sup> C. Oldfield, 'Some pelvic disorders in relation to neurasthenia', *Practitioner* 91:3 (September 1913), pp. 335-43, p. 335; [Anon.], 'Review: The conquest of nerves by J.W. Courtney', *Lancet* 1912 (2), pp. 239-40.

<sup>56</sup> See Russell, 'The treatment of neurasthenia', p. 1453.

<sup>57</sup> [Anon.], 'Medical societies: Nottingham Medico-Chirurgical Society', p. 1338.

borderlands exist between one member of it and another, and in which it is occasionally, indeed frequently, impossible for us to delimit by any boundary line the features peculiar to one or all of them'.<sup>58</sup> Nevertheless, it appears that within British medical discourse, neurasthenia was seen as the nervous weakness which remained when psychic symptoms were parcelled out among other diagnoses, rather than these new diagnoses altering this core definition.

The importance of somatic elements to British definitions of neurasthenia is supported by uses of 'psychasthenia', increasingly listed alongside hysteria and neurasthenia in pre-war discussions of functional disorders, and sometimes even given as a synonym of the latter.<sup>59</sup> The category of psychasthenia was formulated by Janet as a psychological disorder in which depression, phobias, and obsessions existed with certain somatic symptoms.<sup>60</sup> In British formulations, however, psychasthenia was often reconfigured to accommodate a physical basis. In one account, psychasthenia was attributed to 'some physiological error in the mechanism controlling the emotions'.<sup>61</sup> For example, Robert Cole (1866-1926), a physician and lecturer on mental diseases at St. Mary's Hospital, stated that psychasthenia was often found in conjunction with neurasthenia, but conceived of the former as a separate disorder which was a stepping-stone to insanity. He also gave psychasthenia a physical aetiology, positing 'a weakened state of health in a predisposed individual' which had disturbed the action of the higher cortical neurons as the main cause.<sup>62</sup> On the one hand, psychasthenia was a repository for elements which had been stripped from neurasthenia; on the other, Janet's model of psychological functioning was jettisoned by some British authors in favour of an emphasis on possible somatic aetiologies. The essence of neurasthenia was understood as somatic. This conception gained further ground as a result of the removal of psychological symptoms to form separate diagnostic entities, but the dominance of the somatic paradigm in Britain was such that even these new entities were inflected with physical elements.

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<sup>58</sup> H. Macnaughton-Jones, 'The relation of puberty and the menopause to neurasthenia', *Lancet* 1913 (1), pp. 879-81, p. 879.

<sup>59</sup> Ormerod, 'Two theories of hysteria', p. 279; E.L. Ash, 'The combined psycho-electrical treatment of neurasthenia and allied neuroses', *Practitioner* 91:1 (July 1913), pp. 123-31, p. 123.

<sup>60</sup> S. Shamdasani, 'Claire, Lise, Jean, Nadia, and Gisèle: preliminary notes towards a characterisation of Pierre Janet's psychasthenia' in Gijswit-Hofstra and Porter (eds), *Cultures of neurasthenia*, pp. 363-85, pp. 367-70.

<sup>61</sup> H. Thursfield, 'Review of children's diseases', *Practitioner* 87:1 (July 1911), pp. 117-22, p. 118-9.

<sup>62</sup> Cole, *Mental diseases* [1913], p. 225.

The use of neurasthenia to connote primarily nervous exhaustion, perhaps attended by a selection of ‘psychic’ symptoms, continued in a range of medical discussions on shell-shock during and after the war.<sup>63</sup> Those authors who defined neurasthenia in this way usually preferred to designate hysteria and psychasthenia as separate ‘mental’ conditions.<sup>64</sup> As in pre-war British medical discourse, however, neurasthenia slid imperceptibly into psychasthenia by degrees. This is particularly well-illustrated in an article by Howard Tooth (1856-1925), the neurologist in charge of the 1st London General Hospital and later consulting physician to the British forces in Malta and Italy. He divided the war psycho-neuroses into four overlapping classes: fatigue, neurasthenia, psycho-neurasthenia, and psychasthenia.<sup>65</sup> The capaciousness of the neurasthenia concept meant that its psychological aspects could be emphasised without occasioning a major re-definition or writing nervous exhaustion out of the picture. Several wartime authors chose to take this course. Burton-Fanning, for example, explained that neurasthenia was produced by the using up of nerve force by ‘mental preoccupation’, while the neurologist Edward Fearnside (1883-1919) took up the hybrid term ‘psycho-neurasthenic’.<sup>66</sup> Others, such as the psychoanalyst David Eder (1865-1936), elected instead not to use the term neurasthenia at all, because the amorphous symptoms lumped under this heading resulted in the ‘impossibility of apprehending the disease’.<sup>67</sup>

In 1914 neurasthenia was a confused and confusing diagnostic category. The little coherence it ever had as a clinical entity was being gradually undermined by the redistribution of its symptoms. Those who used the term could be fairly certain that it

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<sup>63</sup> Collie, ‘Neurasthenia’, p. 532; Buzzard, ‘Warfare on the brain’, p. 1096; Ballard, *An epitome of mental disorders*, p. 128; T.E. Lumsden, ‘Correspondence: “shell shock”’, *Lancet* 1917 (1), p. 34; E.D. Adrian and L.R. Yealland, ‘The treatment of some common war neuroses’, *Lancet* 1917 (1), pp. 867-72, p. 868; M. Craig, *Psychological medicine: a manual on mental diseases for practitioners and students*, 3rd edn (London: J & A. Churchill, 1917), p. 254; F.C. Forster, ‘The management of neurasthenia, psychasthenia, shell-shock, and allied conditions’, *Practitioner* 100:1 (January 1918), pp. 85-90, p. 85; H.C. Marr, *Psychoses of the war, including neurasthenia and shell shock* (London: Henry Frowde and Hodder & Stoughton, 1919), p. 46; A.F. Grimby, ‘Neuroses and psycho-neuroses of the sea’, *Practitioner* 102:5 (May 1919), pp. 243-58, p. 244 and p. 248; R.G. Gordon, ‘War neuroses’, *Practitioner* 103:5 (November 1919), pp. 358-65, p. 358-9; A. Hurst, *Medical diseases of war* 4<sup>th</sup> edn (London: Edward Arnold & Co., 1944), pp. 136-8.

<sup>64</sup> Ballard, *An epitome of mental disorders*, p. 124; Hurst, ‘Observations on the etiology and treatment of the war neuroses’, p. 409-10; Marr, *Psychoses of the war*, p. 125.

<sup>65</sup> Tooth, ‘Neurasthenia and psychasthenia’, pp. 336-8.

<sup>66</sup> Burton-Fanning, ‘Neurasthenia in soldiers’, p. 908; Fearnside, ‘Essentials of treatment’, p. 45.

<sup>67</sup> Eder, *War-shock*, pp. 6-7.

signified to their audience at the very least a condition of nervous weakness, but only context could determine which of the other manifold possible meanings an individual might also intend to convey. This situation continued into the war, where in some accounts neurasthenia continued to describe an essentially somatic entity with attendant psychological symptoms. Historians of shell-shock have not adequately realised the contemporary state of flux within diagnoses of neurasthenia, and have proceeded instead with a 'one size fits all' definition which conflates nervous exhaustion, psychasthenia, and anxiety neurosis. The last of these categories has been particularly important in fuelling the social class thesis, one component of which is the argument that hysteria was perceived as a primitive defence mechanism and neurasthenia/anxiety neurosis as a psychologically sophisticated response to trauma.<sup>68</sup> It has already been seen that this explanation was invoked by only a few shell-shock doctors. It remains to be shown how the historiographical misapprehension has arisen from specific interpretations of the concept of anxiety neurosis, and the shifting meanings of neurasthenia itself over the course of the war.

### **Neurasthenia and anxiety neurosis**

The concept of anxiety neurosis was first formulated by Freud in the 1895 paper, 'On the grounds for detaching a particular syndrome from neurasthenia under the description "anxiety neurosis"'. Freud separated a cluster of symptoms described as 'neurotic disturbances' from the neurasthenia diagnosis, arguing that these differed in their 'aetiology and mechanism'. These neurotic disturbances (including general irritability, anxiety attacks, night terrors, vertigo, agoraphobia and phobias relating to general physiological dangers, digestive disturbances, and paraesthesias) were grouped around the chief symptom of anxiety.<sup>69</sup> The symptoms left over which comprised 'neurasthenia proper' were 'intracranial pressure, spinal irritation, and dyspepsia with flatulence and constipation'. The aetiology of both 'genuine neurasthenia' and anxiety neurosis was sexual, but the first resulted from an inadequate release of sexual tension,

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<sup>68</sup> Shephard, *A war of nerves*, p. 57; E. Jones and S. Wessely, 'The impact of total war on the practice of British psychiatry', in R. Chickering and S. Förster (eds), *The shadows of total war: Europe, East Asia, and the United States, 1919-1939* (Cambridge: C.U.P., 2003), pp. 129-147, p. 136-7; Leese, *Shell shock*, p. 80 and p. 95.

<sup>69</sup> S. Freud, 'On the grounds for detaching a particular syndrome from neurasthenia under the description "anxiety neurosis"' (1895) in J. Strachey (general editor), *The Standard Edition of the complete psychological works of Sigmund Freud*, vol. 3 (London: The Hogarth Press and the Institute of Psychoanalysis, 1962) [hereafter *SE*], pp. 90-117, p. 90 and pp. 92-9.

such as masturbation or spontaneous emission, while the second was 'the product of all those factors which prevent the somatic sexual excitation from being worked over psychically'.<sup>70</sup> In his concluding comments Freud also considered the relation of anxiety neurosis to hysteria. He stated that the two were extremely similar in terms of both symptomatology and aetiological mechanism, but that anxiety neurosis was 'the somatic counterpart to hysteria'. The displaced tension expressed in anxiety neurosis was 'somatic sexual excitation' and 'purely somatic', whereas that expressed in hysteria was 'psychical', 'provoked by conflict'.<sup>71</sup>

In this paper, anxiety neurosis was conceived as a purely somatic category which was similar to the psychological category of hysteria in terms of symptomatic content and mode of operation of aetiological mechanism. This anxiety neurosis does not correspond to that invoked by historians of shell-shock, either of itself or in its relation to hysteria. The historiographical anxiety neurosis is a hybrid created from a later Freudian version and that put forward by Rivers, an elision facilitated no doubt by Rivers' well-known support for certain aspects of Freudian theory. The specific concept of anxiety neurosis formulated by Rivers, however, was clearly not derived directly from the Freudian version. The Freudian anxiety neurosis historians nebulously invoke is a revision from *Inhibitions, symptoms and anxiety* (1925), which retained the term and symptomatology but posited a different set of causal ideas, and also described obsessional neurosis as a relatively sophisticated psychological process compared with 'true conversion hysteria'.<sup>72</sup> Rivers is a far more obvious source of the historiographical confusion, particularly in regard to the conflation of neurasthenia and anxiety neurosis.

Throughout his 1917 paper 'The repression of war experience', Rivers used the term anxiety neurosis to refer to a disorder which resulted from such repression and in which anxiety was a prominent symptom. His use of the term was questioned by one audience member, who pointed out that this was not the standard Freudian meaning of anxiety neurosis. Rivers replied that 'experience arising out of the War has shown conclusively that the term "anxiety-neurosis" has hitherto been used by the followers of Freud in too narrow a sense', and that he followed 'a usage now coming widely into vogue according to which anxiety-neurosis is the most appropriate term for a syndrome of

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<sup>70</sup> Ibid., p. 90 and p. 109.

<sup>71</sup> Ibid., pp. 114-5.

<sup>72</sup> S. Freud, 'Inhibitions, symptoms and anxiety' (1925), *SE*, vol. 20, pp. 87-172, pp. 111-8.

which the essential underlying condition is anxiety'.<sup>73</sup> A year later he introduced anxiety neurosis in another paper by stating that the disorder was 'usually known as neurasthenia in this country', and ended his explanation of its production by commenting that as the specific Freudian meaning of the term had hitherto had 'little effect on the general body of medical practice', his redefinition was not likely to occasion much confusion.<sup>74</sup>

Famous last words perhaps, but from his perspective Rivers had a point. The term anxiety neurosis was rarely used in British medical discourse before 1914, and certainly not as a synonym for neurasthenia. It is not found even in contexts where it might be most expected, such as certain discussions of the redistribution of the symptoms of neurasthenia, or accounts of sexual neurasthenia in men which referred to different Freudian precepts.<sup>75</sup> The entire pre-war medical literature consulted for this chapter has only unearthed four references to anxiety neurosis.<sup>76</sup> It was also extremely rare in wartime discussions of shell-shock, but when employed usually implied nothing more than a condition in which anxiety was prominent as cause or symptom, without the specific mechanisms invoked by Rivers or Freud.<sup>77</sup> Rivers did, however, correctly identify a shift taking place in the meaning of neurasthenia. By the end of the war, anxiety was increasingly (although never uniformly) emphasised as a prominent symptom of neurasthenia in a range of texts, and neurasthenia was only separated from British formulations of anxiety neurosis by a thin and ever-diminishing wedge.<sup>78</sup>

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<sup>73</sup> Stoddart and Rivers in 'Discussion: the repression of war experience', section of psychiatry, *PRSM* 11:3 (1917-1918), pp. 18-20, p. 19 and p. 20.

<sup>74</sup> Rivers, 'War-neurosis and military training', pp. 529-30.

<sup>75</sup> Macnaughton-Jones, 'The relation of puberty and the menopause to neurasthenia', p. 879; G. Holmes, 'The sexual element in the neurasthenia of men', *Practitioner* 86:1 (January 1911), pp. 50-60, p. 50.

<sup>76</sup> [Anon.], 'Freud's theory of hysteria and other psychoneuroses', *Lancet* 1910 (1), pp. 1424-25, p. 1424; [Anon.], 'Medical societies: Nottingham Medico-Chirurgical Society', p. 1338; [Anon.], 'Medical societies: Medical Society of London', p. 1470; F.W. Mott, *Nature and nurture in mental development* (London: John Murray, 1914), p. 71.

<sup>77</sup> I have only found three authors using the term before 1918, excluding Rivers. Two of these employ the more general meaning: A. Abrahams, 'A case of hysterical paraplegia', *Lancet* 1915 (2), pp. 178-9, p. 179 and F.W. Mott, 'Opening paper and concluding response: special discussion on shell shock without visible signs of injury', sections of psychiatry and neurology, *PRSM* 9:3 (1915-1916), pp. i-xliv and pp. xliv, p. vi and p. xx. Fryer Ballard used the term in a similar way to Rivers. Ballard, 'Some notes on battle psycho-neuroses'; Ballard, *An epitome of mental disorders*, p. 128.

<sup>78</sup> P. Bousfield, 'The relation of blood-pressure to the psycho-neuroses', *Practitioner* 101:5 (November 1918), pp. 266-70, p. 266-7; Chambers, 'Mental wards', p. 168; Marr, *Psychoses of the war*, p. 47; Macpherson *et al* (eds), *History of the Great War*, p. 20.

This shift, and the manner in which it became tied to the social class thesis, can be illustrated through the work of William Aldren Turner. In 1915 Aldren Turner defined neurasthenia along conventional lines as ‘attributable to the exhaustion of the nervous system induced by physical strain, sleeplessness, and other stressful conditions associated with the campaign’. He also acknowledged that several modifications of the usual type of neurasthenia were found among soldiers. These included a type ‘characterised by *anxiety* as the main feature’, particularly ‘apprehension as to [the man’s] ability to do his duty, or fear of being left alone, or of having made a serious mistake in his work’.<sup>79</sup> When he returned to the subject in 1918, he differentiated between neurasthenia as nervous exhaustion and anxiety neurosis. He further claimed that in its pure state, anxiety neurosis was most often found in young officers. He concluded, citing MacCurdy’s work as evidence, that this could be explained as a result of ‘the position of greater responsibility in which the officer is placed, and to the mental struggle which he undergoes in order to banish from his mind doubting as to his adequacy or competency’.<sup>80</sup>

The final part of the puzzle is how the British version of anxiety neurosis, developed in response to shell-shock, became associated with the Freudian concept. The textbook of *Psychological medicine* written by Maurice Craig (1866-1935), physician for psychological medicine at Guy’s Hospital, helps to answer this question. The first two editions of this book included discussions of Freud, but it was not until 1917 that Craig felt it necessary to incorporate an explanation of anxiety neurosis. He gave an accurate précis of the sexual aetiology of the disorder as outlined by Freud, but his catalogue of symptoms differed in a significant respect. Alongside anxiety, Freud enumerated general irritability, anxious expectation, anxiety attacks, *pavor nocturnus*, vertigo, two groups of phobias (the first were those relating to general physiological dangers, and the second agoraphobia), digestive disturbances, and paraesthesias. Although Craig did not mention the war neuroses, his list of symptoms corresponded exactly to those routinely given in accounts of non-hysterical forms of shell-shock, rather than those provided by Freud: fear, terror, tachycardia, altered respiration, perspiration, giddiness, tremors, disturbed sleep and terrifying dreams.<sup>81</sup> Although anxiety neurosis was not in

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<sup>79</sup> W.A. Turner, ‘Remarks on cases of nervous and mental shock observed at the base hospitals in France’, *BMJ* 1915 (1), pp. 833-5, p. 833 and p. 835: emphasis in the original.

<sup>80</sup> Turner, ‘The Bradshaw lecture’, p. 616.

<sup>81</sup> Craig, *Psychological medicine*, p. 260.



widespread use even by 1918, all the conditions were in place for its post-war adoption. When Cole, who had also not employed the term in his 1913 textbook, included it as an alternate term for neurasthenia in the second edition of 1919, the circle was complete.<sup>82</sup>

### **Hysteria, neurasthenia, and functional disease**

It has been shown that although the historiographical argument regarding the differential diagnosis of hysteria and neurasthenia finds some support in post-war writings on shell-shock, it cannot be taken as representative of majority opinion during the span of the war itself. The argument also founders on the fundamental misinterpretation of crucial diagnostic concepts in both their pre-war and wartime contexts. It has already been shown that in certain crucial respects, such as in the class connotations of each, hysteria and neurasthenia were not constructed as distinct and opposed categories. It can also be shown that in pre-war British medical discourse these disorders were actually linked at the conceptual level, both through their designation as functional disorders and the role attributed to heredity in their aetiologies. An examination of these aspects of hysteria and neurasthenia not only further undermines all branches of the tripartite historiographical analysis outlined at the beginning of this chapter, but also introduces topics which are extremely important to understanding the historical significance of shell-shock: its impact on psychological medicine, and its construction as a social and political threat.

The most basic shared feature of hysteria and neurasthenia was the classification of both as functional diseases. In Daniel Hack Tuke's *Dictionary of psychological medicine* (1892), functional disease ('a synonym of hysteria') was defined as phenomena 'which result from some disturbance or change in the functions of an organ without presenting any definite organic lesion by which the disease may be distinguished'.<sup>83</sup> This classification provides the key to understanding the relations of psyche and soma in hysteria and neurasthenia. The transposition of the concept of trauma from the physical to the psychological sphere during this period is now well

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<sup>82</sup> R.H. Cole, *Mental diseases: a text-book of psychiatry for medical students and practitioners*, 2nd edn (London: University of London Press, 1919), p. 224.

<sup>83</sup> *DPMI*, p. 518.

established.<sup>84</sup> The same process occurred in regard to hysteria and neurasthenia.<sup>85</sup> It is argued here that the category of functional disease facilitated this development. The concept originated as a convenient designation for disorders for which no organic cause could be found, and thus described effects without ascribing first causes. It was therefore acknowledged to be a fundamentally ambiguous category.<sup>86</sup> Although the dominant somatic paradigm of British psychiatry meant that initially the body was the first point of reference within the concept of functional disease, this ambiguity also provided a space within which psychological theories could develop (or be transplanted into) when the right set of historical conditions arose. It is therefore the necessary background against which the shifting roles attributed to psyche and soma in hysteria and neurasthenia should be discussed.

Today, the meaning of 'functional' is often loosely interpreted as equivalent to describing a disorder as 'psychologically based'. But in the late nineteenth and early twentieth centuries, British psychiatry lacked a psychological paradigm, and so what remained when organic change had been excluded was not automatically referred to the mind. The concept of functional disease was predicated on the notion of an organic non-event. This non-event was also, however, positive: functional disease was defined as such by the *presence* of an organic absence. The body was not merely the first, but the only point of reference within the definition of functional disease. This is shown by the stated allegiance of British commentators to an as-yet undiscovered organic basis for hysteria, the archetypal functional disease. In the 1890s, it was still possible to suppose that when 'examined by the light of improved knowledge and experience', many of the symptoms of hysteria would be revealed as of organic origin after all.<sup>87</sup> The optimism faded slightly in subsequent years, but it was still insisted that 'hysteria is a real disease, as real as smallpox or cancer, and that it has a physical basis'.<sup>88</sup> Even in the immediately pre-war years, psychological theories were framed by British commentators only as a useful stopgap measure before the organic foundation of the

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<sup>84</sup> M. Micale and P. Lerner, 'Trauma, psychiatry, and history: a conceptual and historiographical introduction' in M. Micale and P. Lerner (eds), *Traumatic pasts: history, psychiatry, and trauma in the modern age, 1870-1930* (Cambridge: C.U.P., 2001), pp. 1-27; I. Hacking, 'Memory sciences, memory politics' in P. Antze and M. Lambek (eds), *Tense past: cultural essays in trauma and memory* (New York and London: Routledge, 1996), pp. 67-88, p. 75-6.

<sup>85</sup> Neve, 'Public views of neurasthenia: Britain, 1880-1930', p. 141.

<sup>86</sup> Bastian, *Various forms of hysterical or functional paralysis*, p. 2.

<sup>87</sup> T. Buzzard, 'Simulation of hysteria by organic disease of the nervous system' in *DPMI*, pp. 1161-63, p. 1163.

<sup>88</sup> J.P. Stewart, *The diagnosis of nervous diseases* (London: Edward Arnold, 1906), p. 307.

disorder was discovered.<sup>89</sup> In the event, when improved diagnostic techniques revealed that some of the symptoms traditionally associated with hysteria did have an organic basis, the result was the contraction of the disorder rather than the provision of a physical explanation for it.<sup>90</sup>

The catalogue of disorders under the heading of functional disease in textbooks of nervous and mental diseases also reveals that this category was understood by reference to bodily, rather than psychic, processes. One book listed epilepsy, chorea, paralysis agitans, tetanus, aphasia, muscular spasm, writers' cramp, facial hemiatrophy, exophthalmic goitre, and various kinds of paralysis.<sup>91</sup> Most of this list is utterly at odds with modern notions of functional disorder, but makes sense when placed against the background of the predominantly somatic paradigm of pre-war psychiatry. In the early twentieth century, 'functional' was not yet a metaphor, and so it could not be a dead one. It was rather a crucial way in which diseases which did not fit the somatic paradigm could be understood through reference to it. This is evident in the pains taken by Joseph Ormerod (1848-1925), a specialist in nervous diseases, to reiterate the physiological meaning of function in order to introduce and make plausible the notion of disruption of psychological function.<sup>92</sup> Psychological concepts became comprehensible only when filtered through the lens of physiological (and thus concrete, knowable, and scientifically palatable) processes.

This example not only demonstrates that functional disease was still at this point understood by reference to the body: it is also evidence of how the somatic paradigm acted to facilitate the infiltration of psychological ideas into mainstream British medical discourse. During this period, hysteria was mainly discussed in the British medical press in relation to the theories of Babinski, Janet, and Freud. These theorists had 'to a great extent superseded the doctrines of Charcot, though [...] none of them has passed into the region of accepted fact'.<sup>93</sup> British commentators overwhelmingly (re)presented these theories via reference to the somatic paradigm, in the process normalising them.

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<sup>89</sup> Wilson, 'Some modern French conceptions of hysteria', pp. 336-7; Ormerod, 'Two theories of hysteria', pp. 285-7; Ormerod, 'Lumleian lectures. I', p. 1169.

<sup>90</sup> Micale, 'On the "disappearance" of hysteria', pp. 504-10.

<sup>91</sup> Nagel, *Nervous and mental diseases*, pp. 138-90; see also Potts, *Nervous and mental diseases*, pp. 385-437.

<sup>92</sup> Ormerod, 'Two theories of hysteria', p. 275; Ormerod, 'Lumleian lectures. II', p. 1238-39.

<sup>93</sup> [Anon.], 'Freud's theory of hysteria', p. 1424.

This approach undoubtedly proceeded in part from an inability to comprehend psychological theorisation. The nameless doctor who alluded to Babinski in the course of a discussion at the Liverpool Medical Institution but confessed himself unable to ‘fully follow this distinguished French physician’ seems to have articulated the secret sentiments of many.<sup>94</sup> This was not the whole story, however: precisely because they were unable to think far outside the somatic paradigm, for the most part the doctors discussed here greeted these theories with a surprising degree of openness.

One example of this openness is found in discussions of Freud. It is common to find historians, particularly of shell-shock, arguing the British medical establishment was almost uniformly hostile to Freud before the First World War.<sup>95</sup> Although there is clear evidence of extreme hostility in some circumstances, such as the famous silent exodus of the entire audience from a psychoanalytic paper given by David Eder, when the theories were presented in a less proselytising fashion many members of the medical community cocked an interested ear.<sup>96</sup> In his memoirs, published in 1959, Ernest Jones claimed that ‘the frequently made statement that psycho-analysis was unknown in England before the war experiences of “shell-shock” is exaggerated’. Although it was ‘likely that the general interest in psychotherapy was a good deal stimulated by the war neuroses [...] the background for the work had already been developed in the years before the war and the time was ripening for the more general recognition of it’.<sup>97</sup> In the pre-war literature surveyed for this chapter, Freud was viewed as just one of many thinkers who had contributed to the study of hysteria, and like these others, his theories did not have to be swallowed whole. For example, Ormerod thought the idea that the expression of repressed emotion could help to relieve symptoms was extremely useful, if somewhat overrated by Breuer and Freud. Although he could not stomach the inductive basis of Freud’s theories – described as ‘very unsubstantial, and literally such stuff as dreams are made of’ – he was still able to appreciate some of the general insights it offered.<sup>98</sup>

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<sup>94</sup> [Anon.], ‘Medical societies: Liverpool Medical Institution’, p. 1001.

<sup>95</sup> Stone, ‘Shellshock and the psychologists’, p. 243; Showalter, *The female malady*, p. 189.

<sup>96</sup> E. Glover, ‘Eder as psycho-analyst’ in J.B. Hobman (ed.), *David Eder: memoirs of a modern pioneer* (London: Victor Gollancz, 1945), pp. 89-116, p. 89.

<sup>97</sup> E. Jones, *Free associations: memories of a psycho-analyst* (London: Hogarth Press, 1959), p. 230

<sup>98</sup> Ormerod, ‘Two theories of hysteria’, pp. 286-7.

This magpie approach was typical of the British commentators. They not only picked and chose those theoretical aspects which they perceived as useful, but re-inflected and tamed the whole as well. Paradoxically, this openness to new ideas was only possible because of their allegiance to the somatic paradigm. As long as it was accepted that hysteria had an organic basis which had not yet been discovered, psychological theories could be viewed simply as useful adjuncts to this supposed foundation. The outcome of this process – perhaps more accurately described as welding than assimilation – can appear incongruous to the modern reader. Cole incorporated the psychological theories into the account of hysteria in his textbook, which referred to Babinski, Janet, and Freud, and initially defined hysteria as ‘a disorder of the subconscious mind; it is a peculiar mental state in which the psychical and physical symptoms are largely due to auto-suggestion’. Yet only a few pages later, he proposed some possible physiological explanations: perhaps hysteria was caused by an alteration in the state of nutrition of the cortex, or a secondary derangement of the lower nerve centres.<sup>99</sup>

This was not how Babinski, Janet or Freud intended their theories to be read. There is clear evidence of misunderstanding, such as when Cole referred to Janet’s theory of ‘neuronic dissociation’ or attributed to Freud the view that the ‘generative organs’ always had ‘direct aetiological influence’ in hysteria.<sup>100</sup> Nevertheless, it would be a mistake to view either these misapprehensions, or the plucking of certain features from the Continental theories from their context, simply as misappropriations which distort their ‘true’ nature. They are evidence rather of an interpretative strategy available to British commentators which seems alien to modern thought. They did not perceive psychological and physiological categories of explanation as irreconcilable, and this allowed them to have an open-minded approach to the former, even if it was limited by final adherence to the latter. They sought in these theories practical solutions to the problems of diagnosis and treatment rather than intellectual satisfaction. Therefore it is possible that the frequent substitution of ‘subconscious’ for ‘unconscious’ in discussions of Freud was not made only because the former concept was comprehended and the latter was not, but because these commentators afforded the difference little weight in comparison with those aspects of the theory they felt could be used.<sup>101</sup> The

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<sup>99</sup> Cole, *Mental diseases* [1913], pp. 216-9.

<sup>100</sup> *Ibid.*, p. 217 and p. 219.

<sup>101</sup> H.C. Thomson, ‘Mental therapeutics in neurasthenia’, *Practitioner* 86:1 (January 1911), pp. 76-83, pp. 77-9; [Anon.], ‘Modern views of hysteria’, p. 951.

consequence of such re-castings was the piecemeal incursion of psychological theories into the somatic framework of understanding. The groundwork had been laid for the acceptance of psychological paradigms before shell-shock burst onto the psychiatric scene.

### **Hysteria, neurasthenia and the neurotic temperament**

An examination of aetiological theories of hysteria and neurasthenia also demonstrates that these disorders were not constructed as opposed or even entirely distinct categories within pre-war British medical discourse. They were connected by the crucial aetiological role attributed to heredity or inheritance. It was through this aspect, which emphasised a dialogue between the individual body and the environment conceived in various ways (the environment of the individual body, of the family, and of the nation) that hysteria and neurasthenia took on a social and political dimension. In textbooks, aetiological factors of disease were usually divided into predisposing and exciting causes. The most frequently cited predisposing causes of hysteria were sex, age, heredity, 'anything tending to weaken the nervous system', and race. The exciting causes most commonly listed were traumatism (especially when accompanied by emotion), emotional shock, disease, and toxæmia. Medical authors were less agreed on the division between predisposing and exciting causes in neurasthenia. Various factors such as worry, overwork, sexual or other lifestyle excesses, prolonged mental or physical pain, infectious and exhausting diseases, auto-intoxication, physical injury and emotional shock were given as predisposing or exciting causes, usually the latter. All, however, were agreed on one general predisposing cause: a 'neuropathic tendency', 'inheritance', or 'taint'. This was usually defined as the existence of some neurosis or neurotic disease in the family.<sup>102</sup>

Hysteria and neurasthenia were therefore conceptually linked through the notion of faulty inheritance. The predisposing and exciting causes for both listed above also have another common denominator: the concept of a weakened nervous system. This was either inborn (the result of heredity) or acquired (the result of an element in the environment, be it an undesirable mode of life or an accident such as shock or illness).

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<sup>102</sup> Nagel, *Nervous and mental diseases*, p. 163 and p. 171; Potts, *Nervous and mental diseases*, pp. 414-5; J.M. Clarke, *Hysteria and neurasthenia* (London and New York: John Lane, 1905), pp. 5-11 and p. 176.

Nervous weakness was not only fundamental to the definition of neurasthenia, but was also perceived as a precondition for the development of hysteria and mental disorder such as hypochondria and melancholia.<sup>103</sup> This perception helps explain the ambiguous status of neurasthenia as a 'borderland' diagnosis. Nervous weakness was seen as a stepping stone to disorders with a more pronounced 'psychic' element, and so it was impossible to demarcate where this element began and ended in neurasthenia. Although understood as primarily a somatic disorder, neurasthenia therefore always potentially contained this psychic element. The role of nervous weakness as the defining factor of neurasthenia and as an aetiological factor in hysteria also underlines that these were linked rather than opposed categories. This explains not only the occasional conflation of hysteria with neurasthenia despite the efforts of most authorities to keep them separate, but also the existence of otherwise confusing designations such as 'hystero-neurasthenia'.<sup>104</sup>

The fact that heredity was conceived as the most important factor in the aetiologies of both diagnoses also acted to neutralise the importance of exciting causes, and thereby to locate the cause of the disorder in the individual rather than the social environment. Although it was stated that an specific, external stimulus was always necessary for the actual development of hysteria or neurasthenia, the emphasis on heredity as a predisposing cause meant that once this development had occurred, the disorder was usually seen as a pre-existing potential of the individual which had been latent until the right circumstances for its expression arose. The apparent and immediate cause was always at most only 'a coefficient, and often merely serves as the spark which falls into the explosive matter'.<sup>105</sup> In practice, the specific stimulus was almost always constructed as only of secondary importance once the disorder had been diagnosed. This did not mean that the social environment was unimportant, but that its importance was conceived mainly in terms of its possible modification to prevent the appearance of outward manifestations of nervous disorder, rather than in terms of its ability to effect a permanent change in the nervous individual. This is demonstrated by an account of neurasthenia in children in which it was claimed that 'childhood necessarily supplies the material out of which adult neurasthenics are made'. Although neurasthenia 'in its

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<sup>103</sup> Potts, *Nervous and mental diseases*, pp. 411-2.

<sup>104</sup> Cole, *Mental diseases* [1913], p. 94; [Anon.], 'Medical societies: Liverpool Medical Institution', p. 1001.

<sup>105</sup> F.W. Mott, 'Preface', *Archives of Neurology* 3 (1907), pp. iii-vii, p. iii-iv.

developed form' was 'an acquired affection', which would not positively manifest without a specific stimulus, it was most likely to develop in the nervous or neurotic child, who was 'born not made'.<sup>106</sup>

A recurring motif in discussions of nervous disorders and the neurotic temperament was analogies to plant life. These metaphors further demonstrate this conception of the relations of biological inheritance and social environment, and neurasthenia and hysteria. However, the different ways in which the trope was applied over time suggest that biological determinism became more entrenched in medical discourse in the early years of the twentieth century. An article by the German psychiatrist Rudolf Arndt (1835-1900) in Hack Tuke's *Dictionary* described neurasthenia as 'to a certain degree the starting-point of all the more severe nervous disorders, and the soil from which they grow'.<sup>107</sup> William Playfair (1835-1903), an obstetrician with a large private practice of neurasthenic patients, claimed that the 'rank weeds of neurotic disease will only grow and flourish in suitable soil – that is, in a state of depressed vitality; improve the soil, and the unhealthy growth will disappear'.<sup>108</sup> The outlook here was positive: although nervous exhaustion was the 'bad soil' which fostered the growth of neurotic disorders, it was a modifiable state and these more serious disorders could be prevented if the right measures were taken. Nervous exhaustion was portrayed simply as an illness which affected the individual, not a pathology which defined her. Only a few years later the metaphor was used instead to describe how 'the seeds' of neuroses were 'sown by stupid or ignorant parents or nurses through want of recognition of the signs of the nervous predisposition and temperament of the child'.<sup>109</sup> The social environment, in terms of inadequate care on the part of family and unpropitious physical surroundings, was implicated as a factor which allowed and encouraged the disorder to develop, but the ultimate cause of the neurosis was the child's 'nervous predisposition and temperament'. This was an illness which was embodied rather than contracted, and the aim was not to cure but to prevent its worst potentialities from manifesting.

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<sup>106</sup> C. Riviere, 'Neurasthenia in children', *Practitioner* 86:1 (January 1911), pp. 38-49, p. 38, p. 44, p. 46 and p. 49.

<sup>107</sup> R. Arndt, 'Neurasthenia' in *DPM2*, pp. 840-50, p. 840 and p. 842.

<sup>108</sup> W.S. Playfair, 'Neuroses, functional, the systematic treatment of (so-called Weir Mitchell treatment)', in *DPM2*, pp. 850-57, p. 853.

<sup>109</sup> H. Macnaughton-Jones, 'The sexual element in the neurasthenia of women', *Practitioner* 86:1 (January 1911), pp. 61-75, p. 69; Clarke, *Hysteria and neurasthenia*, p. 7.



In pre-war British medical discourse, temperament was conceived not as a personality trait, but in terms of biology. Robert Jones (later Armstrong-Jones), superintendent of Claybury Asylum, stated that in the individual temperament was a tendency determined by nation and race, and which therefore differed according to evolutionary development.<sup>110</sup> His colleague Frederick Mott put forward a similar definition of the ‘neuropathic temperament’ as an inborn tendency determined by biological inheritance.<sup>111</sup> This concept of the neurotic temperament was fundamental to medical understandings of hysteria and neurasthenia. In discussions of neurasthenia, the notion of ‘hereditary neuropathic taint’ in conjunction with ‘nationality and temperament’ was presented as crucial to understanding and treating the disorder.<sup>112</sup> In one account, it was even suggested that doctors ‘had frequently to deal with a neurasthenic temperament – not really a disease’.<sup>113</sup> It is no coincidence that etymologically, the hysterical and the hysteric precede hysteria. Helen King has shown that the English adjective ‘hysterical’ dates from 1615, and the term ‘hysteric’ to describe a person prone to the symptoms from 1657; whereas the first known usage of the English noun “hysteria”, in a London medical journal, is in 1801.<sup>114</sup>

Hysteria and neurasthenia were such large and ill-defined categories that the concept of a neurotic temperament was the glue which held each together as a discrete clinical entity in the absence of an identifiable pathology. The conceptualisation of the neurotic temperament as a biologically determined quality also meant that the actual appearance of hysteria or neurasthenia was merely the final stage of a preordained process, the disease itself simply confirmation of a pathological identity. The neurasthenic or hysteric was not only pathological, but her whole being provided the pathology, literally embodied it at a level beyond the body, so deep that no autopsy or microscope would ever uncover it. At the core of these amorphous clinical entities, what was left when all the extraneous symptoms and abstruse jargon were removed, was the neurotic temperament. This was the internal environment on which the outside world acted either to stunt or develop, but never to *cause*, the neurosis. It was the difference

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<sup>110</sup> R. [Armstrong-] Jones, ‘An address on temperaments: is there a neurotic one?’ *Lancet* 1911 (2), pp. 1-6, p. 1-2.

<sup>111</sup> Mott, *Nature and nurture in mental development*, pp. 68-71.

<sup>112</sup> Russell, ‘The treatment of neurasthenia’, pp. 1453-54.

<sup>113</sup> [Anon.], ‘Medical societies: Medical Society of London’, p. 1469.

<sup>114</sup> H. King, ‘Once upon a text: hysteria from Hippocrates’ in S. Gilman et al, *Hysteria beyond Freud* (Berkeley, Los Angeles and London: University of California Press), pp. 3-89, p. 73-4.

between the neurosis as an essential manifestation of self or as an attack from without, an invading agent which altered the self.

Hysteria and neurasthenia were both viewed as evidence of the biologically determined neurotic or neuropathic temperament. The influence of theories of degeneration on late nineteenth-century European conceptualisations of hysteria is historically well established.<sup>115</sup> Some historians of neurasthenia have also argued that this was a prominent theme in European, as opposed to American, constructions of the disorder.<sup>116</sup> This aspect of constructions of neurasthenia has been glossed over by historians of shell-shock in their analyses of its relation to hysteria. They have highlighted instead views of neurasthenia as a fashionable ‘disease of civilisation’, a focus which has heightened the contrast with hysteria.<sup>117</sup> The construction of neurasthenia as a malady fostered by the conditions of modern life is present in the pre-war literature, but commentators were equally likely to refer more generally to the increase of nervous disorders (including hysteria) as a concomitant of the ‘rise in the general level of culture and civilisation in a race’.<sup>118</sup> Moreover, the view that nervous disorders were more prevalent in civilised societies dovetailed with theories of degeneration. Nervous disorder might be attributed to a more highly evolved and therefore more ‘delicate’ and ‘sensitive nervous system’, but the ultimate cause was therefore still ‘embryonic error or the congenital or hereditary factor’.<sup>119</sup> The rise of eugenics, particularly from the turn of century, meant that any putative claim neurasthenia might have had as a symbol of status was outweighed by fears that it signalled the beginning of biological, and therefore social, political, and imperial decline.<sup>120</sup>

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<sup>115</sup> See discussion in Micale, *Approaching hysteria: disease and its interpretations*, pp. 205-20.

<sup>116</sup> Drinka, *The birth of neurosis*, pp. 213-4; see also R. Nye, ‘Degeneration, neurasthenia and the culture of sport in *belle époque* France’, *Journal of Contemporary History* 17 (1982), pp. 51-68.

<sup>117</sup> Leed, *No man’s land*, pp. 163-4; Showalter, *The female malady*, pp. 174-6; Barham, *Forgotten lunatics*, pp. 76-8.

<sup>118</sup> On neurasthenia as a modern disease, see E. Clarke, ‘Neurasthenia and eyestrain’, *Practitioner* 86:1 (January 1911), pp. 24-8; I.G. Cobb, ‘The diagnosis of neurasthenia’, *Practitioner* 90:5 (May 1913), pp. 745-51, p. 745; for similar comments on nervous diseases in general, see [Anon.], ‘The increase of nervous instability’, *Lancet* 1911 (2), p. 1572.

<sup>119</sup> Fleming, ‘Neurasthenia and gastralgia’, pp. 32-3.

<sup>120</sup> On the rise of eugenics, see G. Searle, *Eugenics and politics in Britain, 1900-1914* (Leyden: Noordhoff, 1976); D. Pick, *Faces of degeneration: a European disorder, c.1848-c.1918* (Cambridge: C.U.P., 1989), pp. 189-203.

## Race, nation, and politics

Hysteria and neurasthenia were seen as biologically determined, and so both disorders were increasingly conceptualised as social dangers. Committed eugenicists argued that nervous and mental disorders 'are certainly on the increase, and incipient disease of mind is apt to lead to even more disastrous results than is disease of body'.<sup>121</sup> Mott framed these fears of national degeneration explicitly in relation to neurasthenia. If it was accepted that 'irritable nervous weakness – neurasthenia – may be the starting-point of an unstable nervous condition in a stock', that this nervous instability might intensify under the continued influence of an unfavourable environment, and that this condition was 'a special outcome of modern civilization', the prognosis for modern societies was not favourable.<sup>122</sup> The fear of latent nervous and mental instability was apparent even in accounts which attempted to strike a more optimistic note. Sir George Savage (1842-1941), a lion of the pre-war psychiatric establishment, warned against believing too much in 'the tyranny of the organism', arguing that the right conditions were necessary for the development of insanity. In order to make this point he compared heredity to 'the mycelium of the mushroom', which 'spreads far and wide and is not recognised till suitable conditions lead to what we call the mushroom comes to the surface'. His audience probably took little comfort from his conclusion that similarly, 'the neurotic inheritance spreads far and wide and is deeply seated, but the occasion for its development may be wanting'.<sup>123</sup> After all, if this was the case, what would happen in a national crisis?

Hysteria and neurasthenia were also framed as indicators of national and political health in other ways. A 1910 comment piece in the *Lancet* took issue with the French neurologist Jules Déjerine's contention that emotional shock was the main aetiological factor in the development of hysteria. The author argued that as individuals and in the aggregate, the Latin races were less emotionally stable than the Teutonic, linking the prevalence of both hysteria and social upheavals in France to this fact. It was well known that the Parisian mob became 'inflamed by any passing wind of emotion', while such events were uncommon in England. These differences could only be explained as

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<sup>121</sup> A.F. Tredgold, 'Neurasthenia and insanity', *Practitioner* 86:1 (January 1911), pp. 84-95, p. 95.

<sup>122</sup> F.W. Mott, 'Is insanity on the increase?', *Sociological Review* 6:1 (January 1913), pp. 1-29, p. 26-8.

<sup>123</sup> G.H. Savage, 'An address on mental disorders', *Lancet* 1912 (2), pp. 1134-37, p. 1136.

the result of 'national and racial differences'. As a nation, the English were 'less emotional, less exuberant, less gesticulative': in short, less hysterical.<sup>124</sup> Samuel Kinnier Wilson (1874-1937), a leading neurologist, put forward a similar argument, pointing to the moment in the 1880s when 'the telegraphic announcement of an insignificant reverse at Langson provoked a fury in Paris and France, and brought about the instantaneous overthrow of the Government' when a 'much more serious reverse undergone by our English expedition to Khartoum produced only a slight emotion, and no ministry was overturned'.<sup>125</sup> Here hysteria moved from individual to social and political pathology, and was constructed as a fundamentally un-English disorder. Hysteria was deemed to be more prevalent among Jews as well as the Latin races; the former group were also seen as more liable to neurasthenia.<sup>126</sup> By association, English neurotics were not part of the nation, but aligned with the threatening forces clustered on its borders, awaiting their chance to attack or worse, silently infiltrate the body politic.

It is therefore no coincidence that the dialogue between medicine and politics on the eve of the war featured hysteria and neurasthenia, both as actual diagnosis and as linguistic trope. Historians usually locate three main sources of disruption to British political life in 1914: the threat posed to industrial productivity by trade union activity, the militant suffrage campaign, and the crisis around Home Rule for Ireland.<sup>127</sup> As regards the first of these, the relationship between medicine, the state, and the labour force was still being worked out in the wake of the Workmen's Compensation Acts (1897, 1900, and 1906). Possibly the most vexed aspect of these debates was the issue of compensation for traumatic neurosis, in which hysteria and neurasthenia were clearly implicated.<sup>128</sup> The militant suffragettes, meanwhile, were stigmatized as hysterical for their 'unwomanly' violence to private property, and by extension the

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<sup>124</sup> [Anon.], 'Emotion as a factor in the development of neuropathic and psychopathic symptoms', *Lancet* 1910 (2), pp. 572-3, p. 572.

<sup>125</sup> Wilson, 'Some modern French conceptions of hysteria', p. 322.

<sup>126</sup> Clarke, *Hysteria and neurasthenia*, pp. 4-5; Stewart, *The diagnosis of nervous diseases*, p. 308; Oldfield, 'Some pelvic disorders in relation to neurasthenia', p. 335.

<sup>127</sup> D. Read, *The age of urban democracy: England 1868-1914*, revised edn (Essex: Longman, 1994), p. 483-97; S. Hynes, *A war imagined: the First World War and English culture* (New York: Atheneum, 1991), p. 6-7.

<sup>128</sup> K. Figlio, 'How does illness mediate social relations? Workmen's compensation and medico-legal practices, 1890-1940' in P. Wright and A. Treacher (eds), *The problem of medical knowledge: examining the social construction of medicine* (Edinburgh: Edinburgh University Press), pp. 174-224, pp. 192-6.

state.<sup>129</sup> The labels of hysteria and neurasthenia were not applied to figures in the debates around the Irish Question, although the Celtic races were seen as more liable to both disorders.<sup>130</sup> However, when seeking to explain the mechanism of hysterical dissociation in early 1914, Ormerod plucked a prescient metaphor from political life: in the hysterical mind, he wrote, the 'central government is weak, and there results a turbulent home rule all round'.<sup>131</sup>

## Conclusion

Reading back from a partial selection of post-war theories of shell-shock, historians have misinterpreted the intellectual construction and relation of hysteria and neurasthenia within pre-war and wartime medical discourse. An entire thesis regarding the social class relations of doctors and their soldier patients has been based on this misreading. This argument depends on the conflation of anxiety neurosis and neurasthenia, and the retrospective application of particular and particulate definitions of these terms to the mainstream medical community. The fact that hysteria and neurasthenia do not appear to have been differentially diagnosed according to military rank/ social class for the duration of the war, although this division was rapidly taken up afterwards, may be extremely significant. It would suggest that doctors responded to the crisis of war by, at least nominally, temporarily dropping social prejudices as part of a 'democratisation of suffering'. Most importantly, the examination made here has demonstrated the importance of a precise and nuanced approach to the language of diagnosis, with detailed attention to national and chronological context. It is only through such a reading that the complex relations of diagnostic categories, their meanings in pre-war British medical discourse, and therefore the degree of continuity or change which their deployment in shell-shock entailed, can be understood.

The recognition that hysteria and neurasthenia were fundamentally linked at the conceptual level also undermines other historiographical arguments, relating to the gendering and treatment of shell-shock, which are based on the depiction of these disorders as opposed categories. The *particular* ways in which they were linked,

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<sup>129</sup> A. Wright, *The unexpurgated case against woman suffrage* (New York: Paul Hoeber, 1913), pp. 166-88.

<sup>130</sup> Clarke, *Hysteria and neurasthenia*, pp. 4-5 and p. 175.

<sup>131</sup> Ormerod, 'Lumleian lectures. II', p. 1236.

however, are also significant for constructing a different interpretation of the historical significance of shell-shock. It has been argued here that in the years before the war, the total allegiance of doctors to the somatic paradigm paradoxically enabled psychological theories to infiltrate medical discourse. Although these theories were widely reconfigured in somatic terms, they also created a space in which psychological explanations could be transplanted when the time was right. The degree to which shell-shock itself served to promote psychological understanding must be measured with these pre-war foundations in mind. It has also been argued the biological dimension of hysteria and neurasthenia meant that both were linked to prevalent socio-political concerns and were thus highly charged categories on the eve of the war. Before 1914, medical discourse implied that neurotic Britons were not just ill or bad, but unpatriotic. They were enemy aliens at the most basic biological level, latent lesions on the body of the nation which might erupt and threaten the health of the whole at the first serious crisis. In the years before the war, the neuroses were seen as of fundamental importance because they signified a pathology which was always social as well as individual. The next chapter demonstrates that the evolutionary model of mind dominant in pre-war British medical discourse, the foundation on which theories of shell-shock were formulated, encapsulated fears regarding the nature of human identity and the security of civilisation. It will become apparent as this thesis proceeds that although the specifics of the perceived threat were different in shell-shock, the broader nature of these fears remained the same.

## Chapter 3

### Frameworks of understanding: emotion, will, and the evolutionary mind

#### Introduction

Hysteria and neurasthenia were not conceived as distinct and opposed disorders in either pre-war or wartime psychological medicine. In fact, the nebulous category of shell-shock was not even built on this simple bifurcation. A range of symptom groups were discussed under the heading of nervous and mental disorders of war: at the most basic level, hysteria, neurasthenia, and ‘shell-shock proper’, but also physiological malfunction, epilepsy, insanity, and a host of manifestations which might more properly be classified as psychotic disorders. In the midst of this taxonomic jungle two concepts, rather than diagnoses, can be discerned around which constructions of shell-shock coalesced: emotion and will. This chapter focuses on understandings of emotion and will in pre-war psychological medicine, and argues that these were conceptualised within an evolutionary framework. It was through this infusion with, and immersion in, evolutionary thought that shell-shock was linked to older and more far-reaching debates about human identity and modern civilisation. Later chapters will discuss the prominence and diverse modes of deployment of the concepts of emotion and will in relation to the war neuroses, but the present discussion demonstrates that their significance in this later context can only be understood by reference to their pre-war meanings.

This chapter illustrates the particular strains the concept of human identity was placed under in the wake of the Darwinian evolution. The first sections discuss post-1860 theories of speech, language and voice across several disciplines in order to demonstrate the prevalence and impact of evolutionary ideas in intellectual and scientific thought. Theories of evolution predated Darwin, and even in 1914 continued to be influenced by various other strands such as Lamarckian notions of inheritance of acquired characteristics.<sup>1</sup> Nevertheless, 1859 marks a point at which fears regarding the

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<sup>1</sup> On the pre-1859 history of evolutionary thought, see J. Burrow, *Evolution and society: a study in Victorian social theory* (London: C.U.P., 1966), pp. 19-21; D. R. Oldroyd, *Darwinian impacts: an introduction to the Darwinian revolution*, 2nd rev edn (Milton Keynes: Open University Press, 1983) pp. 1-60.

nature and direction of human development and civilised 'progress' were given a new inflection. Darwin gave scientific credence to the notion that humans were not only related to animals by physical characteristics, but by instinct and emotion.<sup>2</sup> The review of debates on speech, voice, and language given here shows how high/low dichotomies such as those between human and animal, mind and body, and civilisation and the primitive were employed in the attempt to understand human identity in the post-Darwinian world.<sup>3</sup> The intellectual organisation of the world into opposed categories also preceded Darwin,<sup>4</sup> but the theory of evolution emphasised that such concepts were not separated by boundaries of absolute difference, but joined by a series of transitional steps which ultimately emphasised the similarities between 'high' and 'low' aspects of existence. The evolutionary model of mind prevalent in pre-war psychological medicine internalised this notion of transition, particularly in the roles it attributed to emotion and will. The evolutionary significance of emotion and will underpinned the conceptualisation of shell-shock, which can be seen as part of the longer attempt to work out the human and animal attributes of 'civilised' persons, and therefore to delineate the boundaries of a specifically 'human' identity. The concern with the animal, the savage and the primitive in the human and in civilisation haunted the imagination up to and beyond the First World War.

### **Between psyche and soma: understandings of language, speech and voice, c.1860 – c. 1900**

The existence of fears regarding the nature of identity and civilisation in the post-Darwinian and pre-First World War world could doubtless be illustrated by reference to many areas of Victorian and Edwardian thought. Some focus, however, is necessary in

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<sup>2</sup> See for example C. Darwin, *The descent of man, and selection in relation to sex* (London: Penguin, 2004) [1879, 2nd edn], pp. 127-37.

<sup>3</sup> The terms 'primitive', 'savage', and 'civilised' had particular, if ill-defined, meanings in nineteenth- and early twentieth-century discourse. They cannot be replaced without losing an important sense of how contemporaries viewed the world. Therefore they are used throughout this thesis in the attempt to recreate as accurately as possible these thought worlds, although it must be emphasised that the judgments they imply are not accepted. A similar line has been taken with regard to gendered language. Nineteenth century writers almost invariably used the term 'man'. The inclusive term 'human' is used here where possible, but occasionally when quoting other authors it has been impossible to do this without becoming tied up in linguistic knots. In other instances, 'man' conveys more accurately the sense of contemporary texts or ideas, precisely because it is not inclusive, and has been deliberately preferred.

<sup>4</sup> See, for example, S. Horgan, *Nature and culture in Western discourses* (London and New York: Routledge, 1988), p. 1-10, and R. Porter, 'History of the body' in P. Burke (ed.), *New perspectives on historical writing* (Cambridge: Polity Press, 1991), pp. 206-32, p. 212-214.



order for the discussion to have coherence. Debates on language, speech and voice seem particularly suitable for the purposes of this thesis. It has been argued by Peter Stallybrass and Anton White that the ‘fault-lines’ where concepts of high and low meet reveal the most about the contents of these categories and their relations to each other.<sup>5</sup> If this view is accepted, then speech, voice and language are particularly productive areas to examine. The relation of each to the other is complex. To take voice as an example: language is a human institution; speech is the (usually) vocal expression of this human institution; voice itself is animal, yet the means by which one becomes human; more than this, it is the means by which one projects and one is perceived as a *particular* human. Voice is therefore perhaps the ultimate expression of individuality, but it is also social in that its primary purpose is communication. People speak in order to be heard, and so voice attests to the existence of a social world. Voice therefore occupies a position between the individual and the social, and between nature, culture, and history.<sup>6</sup> It also occupies an unusual position between mind and body (and therefore the human and the animal): it comes into being through the physical body, but it is an expression of individual self.<sup>7</sup> Voice is therefore uniquely located on the cusp of the high/low dichotomies which early twentieth-century thinkers used to understand the human condition.

Language, speech and voice were also particularly crucial to post-1859 debates on evolution. In the mid-nineteenth century, debates around speech were a significant part of the question of whether man was to be fitted into the general scheme of evolution, or whether he ‘must have developed in some special manner’.<sup>8</sup> The avowedly anti-evolutionary Max Müller (1823-1900), the foremost academic in comparative philology from at least the 1850s until the 1870s, declared that ‘Language is our Rubicon, and no brute will dare to cross it’. He concluded that animals had no communicative abilities which corresponded to language, defined as ‘the outward sign and realisation of that inward faculty which is called the faculty of abstraction, but

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<sup>5</sup> See P. Stallybrass and A. White, *The politics and poetics of transgression* (London: Methuen, 1986).

<sup>6</sup> This discussion of voice draws on J. Rée, *I see a voice: deafness, language and the senses – a philosophical history* (New York: Metropolitan Books, 1999) and S. Connor, *Dumbstruck: a cultural history of ventriloquism* (Oxford: Oxford University Press, 2000).

<sup>7</sup> Voice has been described as ‘a genuinely psychosomatic phenomenon’ because it expresses both the state of the speaker’s psyche and soma (body), but also has an effect on the psyche and soma of the person hearing it. See P. Butcher, A. Elias, and R. Raven, *Psychogenic voice disorders and cognitive behaviour therapy* (London: Whurr Publishers, 1993), p. 2 and p. 20; Connor, *Dumbstruck*, p. 8.

<sup>8</sup> See [Anon.], ‘Primitive man: Tylor and Lubbock’, *Quarterly Review* 137 (July-October 1874), pp. 40-77, pp. 40-3.

which is better known to us by the homely name of Reason'.<sup>9</sup> The fact that articulate language was seen as inextricably entwined with the capacity for reason and abstract thought, and that animals did not possess such a language, was a stumbling block that evolutionists had to overcome in order to make the application of Darwinian theory to humans plausible.

The explanation Darwin offered in *The descent of man* (1871), which many subsequent commentators have found less than convincing, was that the difference between animal communication and human language was one of degree rather than kind.<sup>10</sup> He accepted that articulate language was 'peculiar to man', but drew attention to the shared use of inarticulate sounds, gestures, and facial expressions to express emotions 'which are but little connected with our higher intelligence'. He claimed that the 'mental powers in some early progenitor of man must have been more highly developed than in any existing ape, before even the most imperfect form of speech could have come into use', but 'the continued use and advancement of this power would have reacted on the mind by enabling and encouraging it to carry on long trains of thought'. This argument lacked strength because it elided the exact relation between thought and language, a flaw Darwin seemed to have been aware of when he weakly concluded that at the very least, 'the faculty of articulate speech in itself [does not] offer any insuperable objection to the belief that man has been developed from some lower form'.<sup>11</sup> Simply to state that language was a product of the higher development of the mental faculties in man did not explain how or why this had occurred. An anonymous article in the *Quarterly Review* argued that Darwin's evidence of communication in the lower animals had not dealt with the entity which needed to be considered, which was 'rational language — the external manifestation, whether by sound or gesture, of general conceptions'. It was not the ability to express emotion, but evidence of the existence of thought which was crucial. As this author saw it, the missing link in the evolutionary chain was 'a speechless condition of man' at some stage, which the anthropologists had thus far failed to find.<sup>12</sup>

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<sup>9</sup> F.M. Müller, *Lectures on the science of language*, vol. 1 (London: Longmans, Green, and Co., 1875), pp. 403-5.

<sup>10</sup> For a summary of contemporary and subsequent responses to Darwin's theory of language, see J. Rachels, *Created from animals: the moral implications of Darwinism* (Oxford and New York: O.U.P., 1990), pp. 137-43.

<sup>11</sup> Darwin, *The descent of man*, pp. 106-114.

<sup>12</sup> [Anon.], 'Primitive man: Tylor and Lubbock', pp. 45-50.

The acceptance in this debate of emotion as a shared attribute of humans and animals, and of thought as the vital difference, illustrates that Darwin's theory raised the spectre of a dangerous closeness to animals, and hints at the particular features which were perceived as animal and those which acted as the guard of a uniquely human identity. The high/low dichotomies set out earlier are also apparent in the account of the evolution of language given by Edward Tylor (1832-1917), the towering figure of British anthropology from the 1860s until at least the turn of the century.<sup>13</sup> Again and again Tylor stressed that the languages of savage races, associated with emotion and bodily expression, were closer to those of animals than the languages of civilised races, which expressed abstract thought and rely almost entirely on oral articulation. He argued that all existing languages contained 'some articulate sounds of a directly natural and directly intelligible kind', which were 'sounds of interjectional or imitative character'. These 'interjections' or imitations, like 'pantomimic gestures', were 'capable of conveying their meaning in themselves, without reference to the particular language they are used in connexion with'. In terms of contemporary thought, it followed logically that these sounds imitated from nature, which formed the basis of all speech, were to be found especially in the languages of 'lower' races or savages. Like the savages themselves, primitive languages were therefore seen as living examples of an earlier stage in the evolutionary development of civilised man, although not the earliest stage.<sup>14</sup>

Tylor perceived the primitive status of savage languages to be manifested in two main ways. Firstly, primitive languages were used to express emotion rather than thought, as shown by their reliance on the body as much as voice. Although in civilised men, 'speech is habitually accompanied by gesture', gesture held a much more important place in primitive languages, to the extent that it even encroached on the position 'which articulate speech holds among ourselves'. Tylor emphasised the difference between speech dependent on such gestures and expressions and that employed by civilised men. The speech of civilised men was seen as closer to written language, at this point perceived as the ideal standard for speaking even to the extent that speech

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<sup>13</sup> On Tylor see Kuper, *The invention of primitive society*, p. 77, p. 82, p. 105 and p. 152-89.

<sup>14</sup> E.B. Tylor, *Primitive culture: researches into the development of mythology, philosophy, religion, language, art and custom, vol. 1*, 4th rev edn (London: John Murray, 1903), pp. 160-3 and p. 237.

which deviated significantly from this standard was barely 'language'.<sup>15</sup> This expression of emotion rather than thought, and use of the body rather than voice, was linked to Tylor's second point: the perceptible similarity between primitive languages and the communication of animals. The 'interjections' of primitive languages expressed emotions which could be understood by comparing 'the voices of the lower animals to our own', and therefore enabled observers 'to trace phenomena belonging to the mental state of the lower animals up into the midst of the most highly cultivated human language'. This was a 'language' shared by the most civilised men, the most primitive savages, and animals.<sup>16</sup> Tylor's schema therefore imposed the set of dichotomies earlier discussed (mind versus body, emotion versus intelligence, animal versus human, and civilised versus the primitive), but also argued that there were identifiable transitional steps linking these opposed pairs. His work therefore unavoidably suggested a dangerous closeness between high and low categories and attributes. The human contained the animal, and the primitive was always ready to intrude on the civilised.

The treacherous proximity of high to low which an evolutionary framework entailed is also apparent in early works of child psychology. Tylor described the less complex and developed savage languages as displaying 'that childlike simplicity of operation which befits the infancy of human civilization'.<sup>17</sup> The comparison between savages and children was common in late Victorian thought. Herbert Spencer (1820-1903), in a paper on 'The comparative psychology of man' presented to the Anthropological Society in 1876 argued that the best way to understand racial differences in mental complexity was to recall 'that unlikeness between the juvenile mind and the adult mind among ourselves, which so well typifies the unlikeness between the minds of savage and civilised'.<sup>18</sup> Explaining the savage mind by reference to that of the child was more than an analogy. It was widely believed that civilised men started out as infants on a par with savages, but whereas they continued to develop, savages remained at the mental level of children.<sup>19</sup> This view was of a certain utility for those interested in the mental development of the race or the individual. Hippolyte Taine (1828-1893) wrote that 'the

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<sup>15</sup> Ibid., pp. 163-4 and p. 167. See also p. 174 for comments on the inadequacy of written as compared to spoken language as a means of expressing emotion.

<sup>16</sup> Ibid., p. 175, pp. 183-4, and pp. 232-3.

<sup>17</sup> Ibid., pp. 236-7 and pp. 445-6.

<sup>18</sup> H. Spencer, 'The comparative psychology of man', *Mind* 1 (1876), pp. 7-20, p. 9; H. Taine, 'The acquisition of language by children', *Mind* 2 (1877), pp. 252-9, p. 258.

<sup>19</sup> G.W. Stocking, *Victorian anthropology* (New York: Free Press, 1987), p. 95.

child represents in a passing state the mental characteristics that are found in a fixed state in primitive civilisations, very much as the human embryo presents in a passing state the physical characteristics that are found in a fixed state in the classes of inferior animals'.<sup>20</sup> This was a common version of Ernst Haeckel's (1834-1919) biogenetic law tying the individual to his racial development. If ontogeny did indeed recapitulate phylogeny, travel to far-flung lands was unnecessary: one needed venture no further than the nearest nursery to witness first-hand the stages of evolutionary development.<sup>21</sup>

The evolutionary scale employed by anthropologists was therefore also a feature of accounts of the development of speech in the child. This can be illustrated particularly through the work of John Wyllie (1844-1916), an Edinburgh-based physician credited with laying the foundations for modern speech therapy,<sup>22</sup> and the child psychologist Wilhelm Preyer (1841-1897). Wyllie argued that the first stage of this development was the 'inherited rather than acquired' expression of emotion, and graded manifestations of expressive inarticulate sounds and gestures (such as screaming, crying, and laughing) according to the degree to which they were inherited or acquired.<sup>23</sup> The implication of this schema was that the child gradually developed from an animal to a human as it attained the tools of language. In Preyer's explanation, the child's progress in speech was linked to his acquirement of will. The inarticulate sounds and body language of the child were part of the development from 'the incoördinate, aimless, partly impulsive, partly reflexive, and instinctive muscular contractions that [the infant] brings with him into the world'. The following stages, the refinement of facial expression and gesture, were the means by which 'the will of the child is expressed before he can speak with the tongue'. This development of will was in fact the preliminary stage to 'the child's becoming a human being, a process completed by the acquirement of speech'.<sup>24</sup>

Before intelligent speech could be developed the child proceeded through a stage of mechanical repetition of sounds, viewed by Wyllie and Preyer as equivalent to

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<sup>20</sup> Taine, 'The acquisition of language by children', p. 259. For similar statements demonstrating the point of view of an anthropologist and a child psychologist respectively, see Tylor, *Primitive Culture*, p. 237 and W. Preyer, *Mental development in the child* (London: Edward Arnold, 1894), p. 160.

<sup>21</sup> For the influence of Haeckel's theory and its relation to scientific thought in the late nineteenth century, see L. Otis, *Organic memory: history and the body in the late nineteenth and early twentieth centuries* (Lincoln and London: University of Nebraska Press, 1994), pp. 1-49.

<sup>22</sup> D. Rockey, *Speech disorders in nineteenth century Britain: the history of stuttering* (Croom Helm: London, 1980), p. 13.

<sup>23</sup> Wyllie, *The disorders of speech*, pp. 89-92.

<sup>24</sup> Preyer, *Mental development in the child*, pp. 99-106.

imitation in savage races, and further evidence that ontogeny recapitulated phylogeny. This not only explained how 'every human being that comes into the world in sound condition shows no trace at first of articulate speech, and yet after a year's time has in part acquired this extremely complex function', but also proved the anthropologists' contention that the original basis of speech must have been the imitation of 'natural sounds'.<sup>25</sup> Imitation was a necessary starting point for language in both the child and the race, but it was only through the acquirement of intelligent speech that, as Preyer put it, the child became human. The means of communication employed by savages and young children were characterised as 'lower' because they possessed in only a small degree the components which were seen to make up the articulate speech of civilised adults: namely intelligence. Articulate speech, on the other hand, demonstrated the first action of 'the higher and more conscious functions of the Cerebrum', a 'higher Intellectual Consciousness' in which the 'ruling faculties of the nervous system – namely, the *intelligence* and the *will*' took command of the mere reflex mechanism of speech.<sup>26</sup>

The attributes involved in the production of articulate speech (intelligence, consciousness and will) were not only constructed as uniquely human: they were again both symbolically opposed, yet joined by the developmental schema to those qualities utilised by inarticulate and gestural language (emotion and inherited, reflex action) and will. In the ordinary course of development a child progressed from the bodily and animal expression of emotion to the human production of intelligent and articulate speech. If a child failed to complete this transition, it was therefore seen to lack the necessary qualities of intelligence, consciousness and will.<sup>27</sup> In the same way, the speech of persons whose minds had become 'disordered or degenerate' demonstrated a reversal of individual (and evolutionary) development.<sup>28</sup> The reasoning which established this scale of judgment meant that it had to logically include even those sane people in whom 'Great Mental Fatigue or Depression may cause, for the time, a little carelessness or want of precision in the articulation of difficult words'.<sup>29</sup> Everyone, at some point, was equally able to be placed on a pathological spectrum if language was

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<sup>25</sup> Wyllie, *Disorders of speech*, p. 97; Preyer, *Mental development in the child*, pp. 121-2.

<sup>26</sup> Wyllie, *Disorders of speech*, p. 107 and p. 117. My italics.

<sup>27</sup> *Ibid.*, p. 120.

<sup>28</sup> *Ibid.*, pp. 182-9.

<sup>29</sup> *Ibid.*, p. 218.

taken as the key to diagnosis. The animal and the primitive were constitutive parts of even the most civilised human, and could rise to the surface at any time under sufficient stress. If concepts of the primitive formed a vital part of the definition of the civilised by virtue of their symbolic opposition, their location at opposite ends of the evolutionary spectrum, then the necessity of delineating a series of transitional steps in between also served to underline the precariousness of civilisation and the human itself.

Explanations of 'degenerate' speech therefore served to prove that the primitive survived within civilisation, within the outward trappings of articulate speech itself. Wyllie argued that although articulate language was the expression and engine of the uniquely human faculty of abstract thought, it could also degenerate to the level of an expression of emotion, on a par with a simple gesture. Wyllie explained that this was partly because many words and sounds had departed so far from their original meanings and had come to be used 'as mere sounds to give an emphasis to speech, such as might otherwise be given by mere loudness of tone; or they might come to be used as mere emotional or conventional expressions, whose meaning is contained as much in the tone of the voice as in the words employed'.<sup>30</sup> Degenerate speech was a type of purely emotional expression, characteristic of savage speech, which persisted in civilised society. The work of the foremost British neurologist of the nineteenth century, John Hughlings Jackson (1835-1911), provides the final link between views of language and theories of degeneration. Jackson, who was heavily influenced by Herbert Spencer's theory of nervous evolution from reflex to controlled action,<sup>31</sup> believed that the nervous system consisted of 'levels' laid down at different evolutionary moments which corresponded to functions rather than anatomical structures. The functions performed at the most ancient levels were simple, highly organized, and automatic. At higher levels, activity was more complex, less organized, more voluntary and provided the basis for consciousness. Pathological conditions such as aphasia developed when the higher levels were impaired and lower levels were released from their control. Jackson named this process 'dissolution' and believed it recapitulated the evolutionary

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<sup>30</sup> Ibid., p. 242.

<sup>31</sup> For a précis of this theory, see Spencer, 'The comparative psychology of man', pp. 9-12. For a sustained account of Spencer's psychology, see R. Rylance, *Victorian psychology and British culture, 1850-1880* (Oxford: O.U.P, 2000), pp. 203-50; for the role of the reflex model in his theories of social evolution, R.G. Perrin, 'Herbert Spencer's four theories of social evolution', *American Journal of Sociology* 81 (1976), pp. 1339-59, pp. 1346-50; on Spencer's relation to social Darwinism, see P. Dickens, *Social Darwinism* (Buckingham and Philadelphia: Open University Press, 2000), pp. 20-26.

history of the species. Symptoms and behaviours called pathological were once representative of the highest level of phylogenetic development.<sup>32</sup>

Swearing was such a symptom, one which Jackson believed was worthy of study as an aid to tracing 'the gradations of motions, thought and language'. In the aphasic patients he studied, several were 'speechless' yet could utter oaths. He explained this by arguing that there were two modes of expression, one emotional and the other intellectual. 'By the one we show what we feel, and by the other we tell what we think'; emotional expression could be achieved without words, but for intellectual expression words were necessary. Swearing was an emotional rather than intellectual action, consisting of 'phrases which emotion has filched from the intellect'. It thus had more in common with a reflex action than with intelligent speech, and it existed in otherwise 'speechless' patients because it was 'easily elaborated by long habit, and can thus be brought out by a slight stimulus'. It was a pathological symptom even and especially in those not suffering from neurological damage; all such defects of expression were 'defects of mind, as well as of that part or phase of mind which enables us to think aloud in words'.<sup>33</sup> Hughlings Jackson began by examining how structural changes to the brain affected the speech of some patients, and ended by making a wider argument that those who habitually used certain types of language were 'defective'. Their language revealed them to be placed on a lower evolutionary plane than those whose mode of expression was primarily intellectual. Animal and human, savagery and civilisation, emotion and intellect: in the imagined space between these symbolically opposed constructs, speech and language acted as bridging concepts, which revealed the closeness by which the vital separation could be made. They simultaneously proved the humble origins of the human and instituted a distinguished distance from the animal, and were therefore also perceived as the integral components of a distinctly *human* psyche and psychology.

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<sup>32</sup> Young, 'W.H.R. Rivers and the war neuroses', p. 363.

<sup>33</sup> J.H. Jackson, 'Notes on the physiology and pathology of language', in J. Taylor (ed.), *Selected writings of John Hughlings Jackson, vol. 2: Evolution and dissolution of the nervous system; speech; various papers, addresses and lectures* (London: Hodder and Stoughton, 1932), pp. 121-8, pp. 121-3.



## The evolutionary model of mind in pre-war psychological medicine

The reflex model of nervous structure and function formulated by Jackson is also a fitting place to begin a discussion of the evolutionary model of mind employed by pre-war psychological medicine, which drew on neurology to legitimate its claims to scientific status.<sup>34</sup> It has been argued that this reflex model, used to legitimate explicitly somatic-pathological approaches to mental disorder, only overlaid ‘a thin veneer of modernity’ on established views. Stephen Jacyna suggests that although there was substantial interest in the ‘more static aspects of neurology’, and particularly the search for organic lesions which gave rise to mental disturbance, the view that sound nervous function depended on the inhibition of the lower nervous centres by the brain amounted to little more than a scientific-sounding restatement of the theory of insanity as a disorder of will.<sup>35</sup> The view of neurological development put forward by Jackson was also, however, a source of inspiration for Freud.<sup>36</sup> The model of reflex action most influential in British psychological medicine around 1900 was therefore poised between earlier nineteenth-century views of mind and later psychodynamic views, helping to account for continuities and areas of convergence during the First World War.

The interplay between neurology, psychiatry and psychology leads on to the question of how the relationship between body and mind was conceptualised in the pre-war period. The doctrine of psycho-physical parallelism, defined as the notion that ‘modifications of consciousness emerge simultaneously with corresponding changes in nervous process’, was often identified as the most popular view of mind-body relation.<sup>37</sup> The advantage of this conception was that it did not involve an explicitly

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<sup>34</sup> Clark, ‘The rejection of psychological approaches’, pp. 283-4; on the development of neurology and its relations to psychiatry in the nineteenth century, see W.F. Bynum, ‘The nervous patient in eighteenth- and nineteenth-century Britain: the psychiatric origins of British neurology’, in W.F. Bynum, R. Porter and M. Shepherd (eds), *The anatomy of madness: essays in the history of psychiatry. Volume 1: people and ideas* (London and New York: Tavistock, 1985), pp. 89-102, p. 96.

<sup>35</sup> L.S. Jacyna, ‘Somatic theories of mind and the interests of medicine in Britain, 1850-1879’, *Medical History* 26 (1982), pp. 233-58, p. 240 and p. 244; see also Clark, ‘The rejection of psychological approaches’, pp. 275-7.

<sup>36</sup> See F.G. Sulloway, *Freud, biologist of the mind: beyond the psychoanalytic legend* (Suffolk: Fontana Paperbacks, 1980), pp. 270-1, and R.G. Goldstein, ‘The higher and lower in mental life: an essay on J. Hughlings Jackson and Freud’, *Journal of the American Psychoanalytic Association* 43 (1995), pp. 495-515.

<sup>37</sup> E.J. Foley, ‘Consciousness and sensation’, in G. Rhodes (ed.), *The mind at work: a handbook of applied psychology* (London: Thomas Murby & Co., 1914), pp. 58-66, p. 64-5. T.C. Shaw, *Ex cathedra: essays on insanity* (London: Adlard and Son, 1904), p. 113; R. Armstrong-Jones, ‘The psycho-pathology of

articulated relationship of cause and effect, but only stated that ‘throughout life there is a chain of psychical events which runs parallel to another chain of physical events, and that these chains are in some way connected; but the theory does not commit itself as to how this connection occurs.’<sup>38</sup> It was therefore possible to maintain allegiance to a theory of the organic causation of mental disorder while focussing on the more apparent ‘psychic’ symptoms. For a psychologist such as William Brown, parallelism could also be invoked as support for the formulation of psychological theories, as ‘our knowledge of mental processes is very much more precise than our knowledge of the corresponding processes in the cerebral cortex, and explanations of mental disturbances in terms of memory, ideas, imaginations, desires, and wishes are really more logical than those in terms of hypothetical nerve cells and nerve fibres’.<sup>39</sup>

Psycho-physical parallelism acted to link psychiatry, physiology, neurology, and psychology. It reflected the incomplete separation of these disciplines, but also glossed the differences between them. The relatively insecure discipline of psychiatry was therefore able to claim common ground with more established and ‘scientific’ neurological and physiological approaches.<sup>40</sup> Ormerod, for example, compared physiologists and psychologists to men looking at a coin from opposite sides and arguing whether it was heads or tails: ‘the two sides are indissolubly connected, just as there is some unknown but certain connexion between mind and matter’.<sup>41</sup> For other authors, psycho-physical parallelism appeared to act as a convenient (although no doubt intellectually sincere) way to avoid internecine disputes. William White (1870-1937) and Smith Ely Jelliffe (1866-1945), early proponents of a psychodynamic approach to mind, were able to simply state in the opening pages of their manual on the modern treatment of nervous and mental diseases that the nervous system was ‘here regarded as a whole and as inclusive of the mind’.<sup>42</sup>

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the barbed wire’, *Nature* 100 (September 1917-February 1918), pp. 1-3, p. 1; and Craig, *Psychological medicine*, p. 1, all state that parallelism was the most commonly held view of mental processes.

<sup>38</sup> Craig, *Psychological medicine*, pp. 1-2.

<sup>39</sup> Brown, ‘Freud’s theory of dreams’, p. 1115.

<sup>40</sup> Laurence Ray argues that apparently contradictory models of madness in the Victorian period, as a physical and/or a moral or volitional disorder enabled psychiatry to claim a special interest in the treatment of the insane, and therefore to remain ‘at the same time within, yet distinct from, general medicine’. L.J. Ray, ‘Models of madness in Victorian asylum period’, *Archives européennes de sociologie* 22 (1981), pp. 229-264, p. 243 and p. 251-2.

<sup>41</sup> Ormerod, ‘Lumleian lectures. I’, p. 1164.

<sup>42</sup> W.A. White and S.E. Jelliffe, ‘Preface’ in W.A. White and S.E. Jelliffe (eds), *The modern treatment of nervous and mental diseases, by American and British authors* (London: Henry Kimpton, 1913), pp. v-vi, p. v.

Even where a direct identification of the mind with ‘the mechanical processes of material structures’ was rejected, as in the work of the psychologist William McDougall (1871-1938), the evolution of mind was perceived as coterminous with the evolution of the nervous system. The human brain had ‘gradually evolved by steps of increasing complexity of organisation from a nervous system of a very simple type’, and ‘each step of mental evolution’ was ‘regarded as the effect or expression of a corresponding step of nervous evolution’.<sup>43</sup> The evolutionary narrative was fundamental to neurology, psychiatry, psychology and physiology. The physiologist Edward Schäfer (1850-1935; later Sharpey-Schafer) stated that whether ‘exhibited as the amoeboid movement of the proteus animalcule or of the white corpuscle of our blood; as the ciliary motion of the infusorian or of the ciliated cell; as the contraction of a muscle under the governance of the will; or as the throbbing of the human heart responsive to every emotion of the mind’ all life was ‘alike subject to and produced in conformity with the general laws of matter, by agencies resembling those which cause movements in lifeless material’. For Schäfer, man’s ‘psychical achievements’ were ‘but the result of the acquisition by a few cells in a remote ancestor of a slighter greater tendency to react to an external stimulus’. These nerve cells had, ‘in the progress of time’, ‘become the seat of perception and conscious sensation, of the formation and association of ideas, of memory, volition, and all the manifestations of mind’.<sup>44</sup> Cole’s textbook of psychiatry attempted an ambitious synthesis of psychological and neurological theories, although his sympathies were clearly with the latter. He concluded that mind was best regarded from ‘the Evolutionary standpoint’, as a study of the animal kingdom demonstrated ‘the gradual development of Mind *pari passu* with the evolution of the Brain’.<sup>45</sup> Few would have disagreed with him on the eve of the First World War.

The first two points of importance regarding the general model of mind in pre-war British psychological medicine are therefore an emphasis on the parallelism, or even interrelation, of mental and bodily processes, and the evolutionary framework within

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<sup>43</sup> W. McDougall, *Psychology: the study of behaviour* (London: Williams and Norgate, 1914), pp. 73-4 and p. 140-1.

<sup>44</sup> E. Schäfer, ‘Presidential address on the nature, origin, and maintenance of life,’ *Lancet* 1912 (2), pp. 675-85, p. 676 and p. 682.

<sup>45</sup> Cole, *Mental diseases* [1913], pp. 14-5.

which mind was conceived. A further area of significance is the depiction of mind as a unified and integrated structure. It was emphasised that all 'mental processes are so closely connected and are interdependent' that it was 'scarcely possible for one process or function to be disordered without implication of the others'.<sup>46</sup> The most basic classification of mental processes was into three basic faculties: feelings, thoughts, and conation (volition), otherwise expressed as the division into cognitive, affective, and conative functions.<sup>47</sup> These faculties were aligned with nervous processes, as the path from sensation to action was mediated in the mental sphere by thought and emotion.<sup>48</sup> They were also therefore hierarchically incorporated in the model of nervous evolution, in which the transition from reflex to voluntary action measured the development from animal to human behaviour.<sup>49</sup> The presence of feeling, thought, and volition in their correct proportions was essential to healthy mental functioning, which was therefore conceived as a matter of balance. Because these faculties were perceived as integrated and interdependent, malfunctioning in any sphere affected the proper action of the others.

The focus here is on the characterisation of emotion and will, and their place within the evolutionary model of mind, because these were the crucial concepts invoked in theories of shell-shock. The apex of volition, or the development of will, was perceived as both a uniquely human attribute and as the aim of education. Although heredity was all-important in the constitution of the individual mind, will was therefore conceptually aligned with the influence of nurture rather than nature. Emotion, on the other hand, was perceived primarily as a racially inherited attribute. Because continuity was an essential aspect of the evolutionary narrative, emotion and will were not constructed as absolutely opposed categories, but rather as mental processes situated at different levels of the same scale. As the asylum psychiatrist William Coupland stated, in 'entering fairly the domain of emotion, we are already in the neighbourhood of will'.<sup>50</sup> The incorporation of emotion and will in the evolutionary scale of development underlined

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<sup>46</sup> Ibid., p. 70. See also Shaw, *Ex cathedra*, p. 24.

<sup>47</sup> A. Bain, *The emotions and the will* (London: John W. Parker and Son, 1859), p. 3; G. Rhodes, 'Introduction', in Rhodes (ed.), *The mind at work*, pp. 1-13, p. 1; W.C. Coupland, 'Philosophy of mind', in *DPMI*, pp. 27-49, p. 43; Cole, *Mental diseases* [1913], p. 14; McDougall, *Psychology*, p. 63.

<sup>48</sup> Cole, *Mental diseases* [1913], pp. 69-70.

<sup>49</sup> H.H. Donaldson, 'On the relation of neurology to psychology', *American Journal of Psychology* 1:2 (February 1888), pp. 209-221, p. 213.

<sup>50</sup> Coupland, 'Philosophy of mind', p. 40.

that the animal was a constituent part of the human, and constructed any disorder of emotion or will as perilous return to these primitive origins.

### **Emotion in the evolutionary model of mind**

In Darwin's *The expression of the emotions in man and animals* (1872), four main groups were studied in order to observe emotion in its purest, unmediated state: infants, the insane, 'savage' races, and 'the commoner animals'.<sup>51</sup> Later writers on psychological medicine added women and the working classes to the roll call of those guided more by emotion than 'self-control and education'.<sup>52</sup> These peoples were portrayed as lower on the evolutionary scale because emotion, aligned with the animal and the body, was perceived to dominate their behaviour. Emotion was also deemed to be largely instinctive, and therefore at the most only a step away from the most basic nervous reflex response.<sup>53</sup> There was no agreement on the exact relation of emotion and instinct: emotion was variously conceived as originating in instinct, as constituted by an arrangement of instincts, or as the 'psychic accompaniment' of the motor reactions which composed instinct.<sup>54</sup> Although their exact relation was disputed, these attributes were always conceptualised as existing on the same, lower plane of mind: therefore emotion always operated in essentially the same way whether it expressed 'sensations of a cat when she sees a mouse' or the 'sensations of a lover who sees his sweetheart walking with another man'.<sup>55</sup>

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<sup>51</sup> C. Darwin, *The expression of the emotions in man and animals* [based on 2nd edn of 1889] (London: Fontana Press, 1999), pp. 20-24; see also Bain, *The emotions and the will*, pp. 4-6, which used examples of animal and infant behaviour to demonstrate the bodily and instinctive nature of emotion.

<sup>52</sup> Cole, *Mental diseases*, [1913], p. 50, p. 53 and p. 71; W.H.B. Stoddart, *Mind and its disorders: a text-book for students and practitioners*, 2nd edn (London: H.K. Lewis, 1912), p. 103.

<sup>53</sup> Instinct was defined as 'comprising all those faculties of mind which are concerned in conscious and adaptive action, antecedent to individual experience, without necessary knowledge of the relation between means employed and ends obtained, but similarly performed under similar and frequently recurring circumstances by all individuals of the same species'. G. Romanes, 'Instinct' in *DPM2*, pp. 704-6, p. 704. Instinct was comparable to reflex action, but whereas reflex consisted of a single act, instinct usually consisted of 'a series of separate movements co-ordinated to bring about (although not consciously) a certain state of things necessary for the well-being of the individual', and therefore had greater significance for the psychological life of the organism. E.J. Foley, 'Cognition and ideation' in Rhodes (ed.), pp. 154-87, p. 156; [Anon.], 'The science and philosophy of instinct', *Nature* 92 (Sept. 1913-Feb. 1914), p. 627.

<sup>54</sup> T. Ribot, *The psychology of the emotions*, 2nd edn (New York and Melbourne: The Walter Scott Publishing Co., Ltd, 1911), p. vii-viii; A.F. Shand, *The foundations of character: being a study of the tendencies of the emotions and sentiments* (London: Macmillan and Co., Limited, 1914), pp. 188-192; Cole, *Mental diseases* [1913], p. 55 and p. 59.

<sup>55</sup> Stoddart, *Mind and its disorders*, p. 69.

Because emotion was perceived as a quality similar to instinct, it was also aligned with the body and in opposition to will. Darwin emphasised that emotion consisted of an inborn and involuntary nervous reaction.<sup>56</sup> The high water-mark of the association of emotion with the body, however, was an essay published by the American psychologist William James (1842-1910) in 1884. In 'What is an emotion?', James argued that bodily changes do not take place as a consequence of emotion, but rather the perception of bodily change *is* the emotion. He claimed that a 'purely disembodied human emotion' was inconceivable: if a strong emotion was analysed and its 'characteristic bodily symptoms' abstracted, there was 'nothing left behind, no "mind-stuff" out of which the emotion can be constituted, and that a cold and neutral state of intellectual perception is all that remains'.<sup>57</sup> This theory was by no means universally accepted, but writers on psychological medicine generally believed that its great merit was to demonstrate 'the capital importance of physiological factors in emotion'.<sup>58</sup> The relation of emotion to the animal body against human mind and will was also furthered by its constitution as a hereditary, biologically inscribed attribute. Darwin's discussion was predicated on the assumption that the main emotions were 'innate or inherited', and therefore beyond 'the will of the individual'.<sup>59</sup> It continued to be argued in later texts that the 'major part' of emotion was 'due to historical antecedents registered in the susceptible individual', 'the cumulative and permanent effect of racial influence', and therefore little modified by the 'experience of the individual'.<sup>60</sup>

It was accepted that emotion was a necessary element of life, which imbued the world with 'warmth' and 'human value', but also argued that emotion was only useful insofar as it existed in proportion to intelligence.<sup>61</sup> Actions based on emotion were deemed to be uncritical, impulsive, and based on primitive suggestion and belief rather than the outcome of reasoned volition.<sup>62</sup> It is no coincidence that Hack Tuke's *Dictionary* defined 'emotional' as 'the mental condition in which ... emotions are easily evoked by

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<sup>56</sup> Darwin, *The expression of the emotions*, p. 69 and p. 86.

<sup>57</sup> W. James, 'What is an emotion?', *Mind* 9 (1884), pp. 188-205, pp. 188-93.

<sup>58</sup> Ribot, *The psychology of the emotions*, p. 93 and p. 97; Cole, *Mental diseases* [1913], pp. 49-50; S.S. Colvin, 'Education', in White and Jelliffe (eds), *The modern treatment of nervous and mental diseases*, pp. 56-99, p. 89.

<sup>59</sup> Darwin, *The expression of the emotions*, pp. 348-9.

<sup>60</sup> Coupland, 'Philosophy of mind', pp. 39-40.

<sup>61</sup> Colvin, 'Education', p. 87.

<sup>62</sup> McDougall, *Psychology*, p. 239; R.C. Temple, 'Administrative value of anthropology', *Nature* 92 (Sept. 1913-Feb. 1914), pp. 207-13, p. 208; Cole, *Mental diseases* [1913], p. 122.

*wholly inadequate or imaginary causes*'.<sup>63</sup> A mental state could not be both 'emotional' and a balanced reaction to a situation. In fact, emotion itself was part of hierarchy of affective states organised according to the degree cognition and volition entered into their constitution. At the lowest level was feeling, a reflex reaction to simple corporeal pleasure or pain. Although the next stage, emotion, was also 'reflexly and involuntarily aroused', the stimulus was 'a perception or idea' rather than mere sensation. The highest affective level was sentiment, differentiated from emotion primarily on the basis that in the former state, attention to an idea was voluntary. In effect, sentiments were 'intellectualised emotions' such as truth, justice, duty, conscience, and aesthetic taste, from which 'every vestige of personal reference' had been eliminated' so that feeling was attached 'to an object of pure intellect'.<sup>64</sup> The ideal development of emotion was therefore a movement further and further away from reflex, the body, and even the self, until the animal had been written out of its definition.

### **Will in the evolutionary model of mind**

As emotion was incrementally augmented by cognition and will, it was gradually civilised. The maintenance of will as the highest attribute of humanity conversely relied on the reinforcement of intelligence and suppression of emotion as its constituent elements. This was necessitated by the efforts of psychological medicine to recast will in naturalistic and evolutionary terms in the late nineteenth century.<sup>65</sup> The lengthiest and most elaborate rejection of metaphysical notions of will in this field was produced by Henry Maudsley (1835-1918), the most distinguished British alienist of the late nineteenth century. His *Body and will* (1883) argued over several hundred pages that will was no more than 'the conscious expression of the co-ordination of mental functions working to an end'.<sup>66</sup> Subsequent writers continued to define will as 'a complex of intellectual and affective states accompanied by certain forms of behaviour', and as 'composite in its nature' rather than 'a fundamental aspect of

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<sup>63</sup> *DPMI*, p. 432. My italics.

<sup>64</sup> Cole, *Mental diseases*, pp. 47-8 and pp. 53-4; Coupland, 'Philosophy of mind', pp. 39-40; Stoddart, *Mind and its disorders*, p. 59 and p. 93.

<sup>65</sup> L.J. Daston, 'The theory of will versus the science of mind', in W.R. Woodward and M.G. Ash (eds), *The problematic science: psychology in nineteenth-century thought* (New York: Praeger, 1982), pp. 88-115, p. 111.

<sup>66</sup> H. Maudsley, *Body and will* (London: Kegan Paul, Trench, & Co., 1883), p. 295.

consciousness, such as sensation or feeling'.<sup>67</sup> It was argued that as purposive action, instinct was incipient will, and that it was possible to 'construct a scale which, by minute steps of difference, would lead down from the most truly purposive actions of man, actions sustained and renewed through long years by a firm self-conscious resolution to achieve some clearly conceived end, to the actions of the simplest microscopic animalcule'.<sup>68</sup>

Although secular science gained in one direction by this schema, in another the concept of autonomous and unique human identity was weakened. The early Victorian period witnessed a shift away from the 'aggressive heroism' of the 'imperial will' to the 'controlled heroism' of self-control, perhaps exemplified by the popular self-help credo of Samuel Smiles.<sup>69</sup> Yet as the nineteenth century progressed, the notion of free human agency itself was undermined by a complex of scientific forces and social changes, from Darwinism in biology and entropy in physics through to the proliferation of statistics and social policies predicated on the basis that man was an isolated and helpless cog in a vast and unstoppable machine. The Edwardian period was 'pervaded by images of the ineffectiveness and devitalisation of ordinary individuals'.<sup>70</sup> The incorporation of will into the evolutionary scale of development was only one aspect of this process by which the comforting notion of human power was broken down. The attempt of psychological medicine to dig itself out of this hole merely succeeded in creating a hill which it had to climb when it emerged. In emphasising the animal origins of the will, psychiatric practitioners simultaneously undermined the potential of its reach and underlined the potency of the forces it had to contain.

It was emphasised that the crucial element which shaped instinct into volition was deliberation, which involved a considered intellectual judgment.<sup>71</sup> The direction of will required intelligence: the French psychologist Theodule Ribot (1839-1916) conceived the relation between these two faculties as 'the robust blind man carrying on his

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<sup>67</sup> Colvin, 'Education', p. 95.

<sup>68</sup> McDougall, *Psychology*, pp. 152-3; see also Stoddart, *Mind and its disorders*, p. 70; Cole, *Mental diseases* [1913], p. 55; Coupland, 'Philosophy of mind', pp. 41-2.

<sup>69</sup> J. Reed, *Victorian will* (Athens: Ohio University Press, 1989), pp. 9-10 and pp. 76-7.

<sup>70</sup> M. Wiener, *Reconstructing the criminal: culture, law and policy in England, 1830-1914* (Cambridge: C.U.P., 1990), pp. 159-171 and p. 184; see also C. Clausen, 'Sherlock Holmes, order, and the late-Victorian mind', *The Georgia Review* 38 (1984), pp. 104-23, pp. 116-20.

<sup>71</sup> Colvin, 'Education', p. 96; Stoddart, *Mind and its disorders*, p. 70; Coupland, 'Philosophy of mind', pp. 41-2; Cole, *Mental diseases* [1913], pp. 61-2; McDougall, *Psychology*, p. 154.



shoulders the paralytic who sees clearly'.<sup>72</sup> But the effect of constituting the 'educated will' as the key to 'human character' only served to emphasise its origins in 'the primitive instincts'.<sup>73</sup> The only difference between animal life, 'composed of a blind obedience to their organised nervous mechanism', was the education and training which brought instinct under the control of will as development proceeded.<sup>74</sup> The essence of human will might even be defined not as the power to do, 'but also to leave something undone'; the 'essential feature of a man with a strong and stable personality' was his 'complete control of his instincts', that he was able *not* to act in the appropriate circumstances.<sup>75</sup> Man was 'man indeed only because racially and personally he has grown into the habit of inhibiting himself from brutishness or at least from savagery'. In such formulations, man hung on to his human status by the skin of his (recognisably canine) teeth. The primacy awarded to inhibition only emphasised that man has '*much, complex and various, to inhibit*'.<sup>76</sup>

Will was therefore simultaneously linked to and divided from instinct. It developed out of instinct, but once constituted its aim was to police and contain it. The aim of human development was the suppression of instinct and emotion, and the measure of man was his capacity for such repression.<sup>77</sup> In the evolutionary model of mind, two different but overlapping conceptions of will, as volition (the power to initiate or inhibit action) and strength of will (a character trait revealed in assertion and self-control), became inextricably meshed.<sup>78</sup> Will was associated with nurture, adulthood, civilisation, and most of all a uniquely human identity. It was dependent not only on 'the cerebral cortex with which the individual has been endowed, but also upon his education and experience'; although 'Nature provides the iron, man makes the horseshoe for service'.<sup>79</sup> It was the essence of "character", the 'force in Nature in which consciousness reaches its acme', and the defining feature of full human identity: the 'unfortunate beings [...] incapable of genuine volition, can never arrive at the dignity

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<sup>72</sup> Ribot, *The psychology of the emotions*, p. 440.

<sup>73</sup> G. Rhodes, 'Mechanism of the will', in Rhodes (ed.), *The mind at work*, pp. 88-93, p. 188 and p. 191; see also Bain, *The emotions and the will*, p. 340.

<sup>74</sup> Cole, *Mental diseases* [1913], pp. 55-7.

<sup>75</sup> T. Ribot, 'Will, disorders of' in *DPM2*, pp. 1366-68, p. 1367; Stoddart, *Mind and its disorders*, p. 71.

<sup>76</sup> G. Van Ness Dearborn, 'Kinesthesia and the intelligent will', *American Journal of Psychology* 24:2 (April 1913), pp. 204-55, pp. 235-6: emphasis in the original.

<sup>77</sup> Bain, *The emotions and the will*, p. 404 and pp. 407-8.

<sup>78</sup> See Reed, *Victorian will*, p. ix for these and other uses of will in various contexts.

<sup>79</sup> Stoddart, *Mind and its disorders*, p. 71; Savage, 'An address on mental disorders', p. 1135; Coupland, 'Philosophy of mind', p. 42.

of personality'.<sup>80</sup> More than this, will was not only essential to the constitution of the adult mind, but 'necessary for civilisation itself'. If desires were allowed to pass into action without any restraining influence, anarchy would ensue.<sup>81</sup> In pre-war psychological medicine, the concepts of emotion and will played a crucial part in depicting civilisation as simultaneously threatened by a resurgence of the animal and a collapse of the human.

### **Emotion and will in mental disorder**

In the previous chapter, it was argued that hysteria and neurasthenia were perceived as diseases which were socially and politically dangerous. It will now be shown that these fears were intimately related to, and even enabled by, evolutionary understandings of mind and the particular attributes attached to emotion and will within this model. It followed on from the notion of mind as a unified structure, dependent on the balanced action of feeling, thought, and volition, that 'if one simple element fails, the whole is thrown out of gear'.<sup>82</sup> All these functions were implicated, and so it is difficult to describe mental disorders specifically as disabilities of will, thought or emotion. A loss of proportion in any direction, however, inevitably had an impact on the will as the highest faculty of mind. Therefore it was possible to describe the abnormal mind, whatever the precise cause of the disorder, as one which had been 'released from the vigilant control of the will'.<sup>83</sup> The heightened emphasis on will as the most important aspect of human identity is even perversely reflected in the late nineteenth century creation of aboulia, a disorder defined as the absence of will (and unsurprisingly deemed to be more common in women than men). This was thought to be rare in its purest forms, but it was an additional complication in hysteria, neurasthenia, and other 'psychiatrical' conditions.<sup>84</sup>

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<sup>80</sup> Cole, *Mental diseases* [1913], p. 56 and pp. 61-2; Colvin, 'Education', p. 99; E.J. Foley, 'Modes of consciousness' in Rhodes (ed.), *The mind at work*, pp. 67-101, p. 90; Reed, *Victorian will*, p. 130.

<sup>81</sup> E. Buttar, 'Physiology of the brain and nervous system', in Rhodes (ed.), *The mind at work*, pp. 28-43, pp. 31-2.

<sup>82</sup> Shaw, *Ex cathedra*, p. 24.

<sup>83</sup> Coupland, 'Philosophy of mind', p. 29.

<sup>84</sup> Ribot, 'Will, disorders of', pp. 1366-67; Van Ness Dearborn, 'Kinesthesia and the intelligent will', p. 227.

A lack of will was implicated in both hysteria and neurasthenia, but it was emphasised particularly in the latter disorder.<sup>85</sup> It was usually perceived as an adjunct of the nervous weakness which characterised neurasthenia, and left the ‘abnormally irritable’ organism ‘unduly facile in response to all extraneous influences’.<sup>86</sup> This receptiveness to external impressions was the cause of the weakness of the will, as it resulted in an inability to adequately process information and to make the reasoned judgments on which genuine volition depended. In turn, this fostered ‘emotional disturbance’ and the proliferation of phobias and groundless fears.<sup>87</sup> Arthur Brock, a general practitioner from Edinburgh, even characterised the disorder as a weakness of will caused by lack of use, and thereby an original fault of the neurasthenic rather than simply a symptom. In his hands, this became a social diagnosis: lack of effort was the defining characteristic and the pathology of the modern age.<sup>88</sup> Taking a similar line, David Ferrier (1843-1928), a specialist in physiology and neuropathology, argued that pharmaceutical remedies were comparatively useless in neurasthenia. The ‘real treatment’ consisted of ‘the cultivation of stoicism, self-control, and a reasoned disregard of the symptoms to which he has been attaching so much and such unnecessary importance’.<sup>89</sup>

Weakness of will was also conceived as a prominent feature of hysteria, although authors emphasised emotion to a far greater extent than in their accounts of neurasthenia. The symptoms ‘generally present to a greater or less degree in every hysteric subject’ were defective will-power and emotional instability.<sup>90</sup> The emphasis was usually on emotion, but this was achieved partly through a complete denial of will in the hysteric. A standard announcement was, ‘It is not that the patient will not, but that she cannot will’.<sup>91</sup> The absence of will in the hysteric was even utilised to excuse her of the charge of malingering. The hysteric was described as ‘an actress [who] does not know that she is acting’, and it was explained that ‘the will of the subject has no influence on these symptoms’; if a supposedly paralysed limb stirred in sleep, the

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<sup>85</sup> [Anon.], ‘Review: La neurasthénie rurale by Dr. Raymond Belbèze’, *Lancet* 1911 (2), p. 351.

<sup>86</sup> [Anon.], ‘Medical societies: Medical society of London’, p. 1543.

<sup>87</sup> Tredgold, ‘Neurasthenia and insanity’, p.86; Potts, *Nervous and mental diseases*, p. 410; [Anon.], ‘Review: La neurasthénie rurale’, *Lancet* 1911 (2), p. 351.

<sup>88</sup> A.J. Brock, ‘“Ergotherapy” in neurasthenia’, *EMJ* 6:5 (May 1911), pp. 430-4. See also chapter seven, where Brock’s views of neurasthenia in shell-shock are discussed.

<sup>89</sup> Ferrier, ‘Neurasthenia and drugs’, p. 14.

<sup>90</sup> See Nagel, *Nervous and mental diseases*, p. 166; Cole, *Mental diseases* [1913], p. 218; I.G. Cobb, ‘Neurasthenia – its causes and treatment’, *Practitioner* 95:2 (August 1915), pp. 224-44, p. 227.

<sup>91</sup> Ormerod, ‘Lumleian lectures. II’, p. 1236.

‘movements are volitional only in appearance [...] the conscious ego does not participate therein’.<sup>92</sup> This was a dubious pardon: it acted to further deny the hysteric an existential reality beyond her disease, and to negate her identity by confounding it with that of her parasite. Indeed, in Ribot’s account will had not simply been displaced in hysteria. It seemed rather that the will had never ‘constituted itself’, and in such cases it was therefore more appropriate to speak of ‘congenital atrophy’ than ‘disease of the will’. Hysterics suffered from a ‘constitutional impotency of the will’: ‘their prodigious instability, their caprices, which incessantly appear, keep them in a permanent condition of disequilibrium and of moral ataxy’, and it seemed that will was ‘unable to develop because the conditions necessary to its existence are wanting’.<sup>93</sup>

The hysterical personality was defined by abnormal will-power and emotionalism, but these were preconditions of the development of hysteria as much as its results. In British constructions of the disease will and emotion were equally important at both levels, not least because cause and effect were deeply entwined. The symbiosis of emotion and will was particularly underlined in Ormerod’s exposition of Janet’s theory of dissociation. Ormerod explained that a ‘secondary consciousness’ developed from the restriction of the field of personal consciousness, which prevented certain memories being integrated with perceptions of the present. The hysteric was both stunted and freed by this relationship to the past, ‘at once less checked and governed by past experiences than a normal person’. She was unable to take a ‘comprehensive view of facts and motives’, and therefore ‘reasoned volition becomes replaced by impulsiveness, and she is said to suffer from weakness of will’. Consequently emotion not only *caused* the pathological condition of hysteria, but was itself manifested pathologically *within* the disease. The hysterical patient was ‘not emotional, in the sense of readily responding with conscious emotion to the circumstances of the present’. Rather the ‘emotions she exhibits are really old ones, relating to circumstances of the past, which have become automatic – old tune [sic], played in her subconscious mind, as if on a barrel organ’.<sup>94</sup>

In this description, the emotion present in hysteria was figured as doubly lower, as regressive. The hysteric existed in a state of pure emotion – in that for medicine, her

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<sup>92</sup> Wilson, ‘Some modern French conceptions of hysteria’, p. 314 and p. 329.

<sup>93</sup> Ribot, ‘Will, disorders of’, p. 1368.

<sup>94</sup> Ormerod, ‘Two theories of hysteria’, pp. 272-3.

disease was utterly identified with her self – which was yet beyond emotion. Her symptoms were recrudescences of emotion, the frozen yet mutant remnants of a self which was both past and present, separate (dissociated) from the self which had continued to develop but which simultaneously blocked a healthy, normal type of development. Just as the insane in asylums were throwbacks to a past stage of evolution, the hysteric personality was a living survival of a past stage in the patient's own mental evolution. This idea of mental disorder as regression applied equally to descriptions of neurasthenia which stressed weakness of will, because the lower faculties were unleashed whenever the will was not in control. Will was the highest function of mind, and so the 'only true way to regard' any mental disturbance was as 'a devolution, either from what was the highest state of the individual, or from what we take to be the average type of his social scale'.<sup>95</sup>

The view of mental disorder as regression was predicated on the conception of man as an animal which had clawed its way to civilisation through the careful cultivation of the will. Yet the will grew out of instinct. It was the highest human development, but its very existence was perverse evidence of these animal origins. Man was 'a vertebrate animal with the instincts of the animal', who had 'attained a veneer of civilisation' only through 'the power of inhibition' and 'the influence of his environment'. In 'insanity these acquisitions of his progress are gradually dissociated and shed in the inverse order of their acquirement, until at last a man is left a wreck barely above the level of the animal'.<sup>96</sup> Weakness of the will, however, was inbuilt in the human condition. Like all recent mental acquirements, it was 'unstable and precarious'.<sup>97</sup> Even in the 'normal' person, mental states were 'in a continual oscillation between higher and lower'; a 'phonographic repetition of the day's sayings and a cinematographic representation of the day's doings would show many ups and downs in the levels of development'.<sup>98</sup> The 'instinct and capacities which regulate the lives of other animals, and which were employed by man in his primitive state' survived in the 'residual consciousness' of each individual.<sup>99</sup> The 'social defective or the weakling with want of control' was

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<sup>95</sup> Shaw, *Ex cathedra*, p. 94 and p. 107.

<sup>96</sup> R. [Armstrong-] Jones, 'An address on temperaments', pp. 5-6.

<sup>97</sup> Ribot, 'Will, disorders of', p. 1367.

<sup>98</sup> Shaw, *Ex cathedra*, p. 110.

<sup>99</sup> G. Rhodes, 'The unity of consciousness – subconscious zone', in Rhodes (ed.), *The mind at work*, pp. 194-206, pp. 194-5.

judged to be 'parallel to undeveloped man', but he was also 'human and very near most of us': he was marked off not by 'specific difference', but 'only variation'.<sup>100</sup>

## Conclusion

In early 1915, as the war was beginning to turn from awful novelty to the backdrop of life, Freud examined the causes of the disillusionment it had occasioned. He concluded that civilisation had made the fateful errors of believing its own propaganda and forgetting (or failing to realise) the foundations on which it was built. Within the mind of each individual, 'every earlier stage of development persists alongside the later stage which has arisen from it', and these primitive forces continually threatened to break free, 'as though all later developments had been annulled or undone'. Civilisation was a superimposition, a mere gloss, on the 'imperishable' primitive mind. The basis of civilisation was renunciation of instinctual satisfaction, a sacrifice which forced its members into ever 'greater estrangement from their instinctual disposition', and which was never complete. There was no escape from this tension. Each individual born into civilisation had to make the same forfeit, and civilisation itself could never be assured. War was not a departure from the progress of civilisation, but an expression of the instincts and impulses which always persisted beneath its surface.<sup>101</sup>

This paper was not Freud's proudest moment. He described it as 'a piece of topical chit-chat' written to satisfy the publisher.<sup>102</sup> It was certainly topical. In England too, the pens of respected writers and forgotten gutter journalists poured forth on the weighty consequences of the war for civilisation.<sup>103</sup> But the threat Freud identified was also a familiar feature of pre-war British intellectual and scientific discourse. The view that civilisation was built on the conquest of individual, anti-social desires was prominent throughout the nineteenth century. It is found in John Stuart Mill's 1836 essay on 'Civilisation', which argued that 'all combination' resulted from 'the sacrifice of some portion of individual will for a common purpose' and that willingness to make

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<sup>100</sup> Savage, 'An address on mental disorders', p. 1136.

<sup>101</sup> S. Freud, 'Thoughts for the times on war and death' (1915), *SE*, vol. 14, pp. 275-300, pp. 282-6.

<sup>102</sup> D. Pick, *War machine: the rationalisation of slaughter in the modern age* (New Haven and London: Yale University Press, 1993), p. 218.

<sup>103</sup> See Hynes, *A war imagined*, pp. 3-24.

this sacrifice separated the civilised man from the 'savage'.<sup>104</sup> However, it was only after 1859 that instinct, rather than mere desire, was identified as the offering received but never devoured on the altar of civilisation. The shift from desire to instinct trampled over meliorating dreams of progress. The animal within could only be policed, never destroyed. It was a necessary constituent of human identity, yet one that must be constantly rejected in order to maintain the human and civilisation.

To this extent Freud's paper recapitulated, although it also re-inflected, the discoveries which had been made throughout the late nineteenth century. The traditional boundaries of high and low which governed Western thought had been reconstituted as gateways, points of exchange between the categories they delineated. This process has been described here through reference to theories of speech, language and voice in anthropology, child psychology, the nascent discipline of speech therapy, and neurology. All these disciplines employed an evolutionary model of mind in which emotion and will were conceptualised as repositories, respectively, of the primitive and the civilised. The control of emotion by will was the cornerstone of human identity. These concepts continued to be imbued with evolutionary meaning in theories of shell-shock. The next chapter, which examines the ways in which the neuroses were gendered in pre-war and wartime psychological medicine, demonstrates that shell-shock was perceived as a threat to not only the masculine, but the human ideal of behaviour. The analysis of concepts of emotion and will in theories of the war neuroses in chapters six and seven further shows that evolutionary ideas underpinned the medical discourse on shell-shock.

Freud's 1915 paper has been brought into this conclusion to illustrate another point of relevance to future discussions. It has been argued throughout this chapter that late nineteenth-century thinkers across a variety of disciplines were preoccupied by the dangerous proximity of the human to the animal. This theme has been identified by other historians. Mathew Thomson, for example, has argued that anthropological expeditions which set out to confirm 'biologically based otherness and inequality'

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<sup>104</sup> J.S. Mill, 'Civilization', in J.B. Schneewind (ed.), *Mill's Essays on Literature and Society* (London and New York: Collier-Macmillan, 1965), pp. 148-82, p. 152; see also Reed, *Victorian will*, pp. 18-19 and pp. 65-7.

ended by revealing ‘the “savage” and “primitive” basis of the “civilised” mind’.<sup>105</sup> Jenny Bourne Taylor has shown that throughout nineteenth-century psychology the unconscious, the ‘obscure recesses’ of the mind, was overwhelmingly perceived as a repository of the primitive. Although ‘psychological debates played a crucial part in establishing what it is that makes a coherent and rational person’ by reinforcing dichotomies of the kind outlined here, ‘they also dwelt on the instability of these borderlines, continually wavering between the desire to explore the ‘hidden depths’ within the mind and to regulate and control them’.<sup>106</sup> In these final examples, the conceptual gateways built between high and low can also be seen to constitute a different, historical point of exchange, between the psychological medicine of the late nineteenth-century and the psychodynamic approaches to mind most identified in Britain with the infiltration of Freudian ideas in the post-war period.

Bourne Taylor has shown that the Freudian theory of the unconscious drew on, although it also transformed, ‘well-known theories of the pervasive influence of unconscious mental processes’.<sup>107</sup> Laura Otis has demonstrated that the idea of ‘organic memory’, a theory shown in this chapter to be a standard feature of anthropology, neurology, and psychology, permeated Freudian psychoanalysis. It was only because ontogeny recapitulated phylogeny that Freud ‘could view human history through the child and through the neurotic as well as through the unconscious of the “normal” individual’.<sup>108</sup> These interfaces warn against reading apparent traces of Freudianism in wartime theories as evidence only of this influence. This lesson is underlined by Thomson’s argument that it was above all the psychologists on the Torres Straits anthropological expedition of 1898 who refashioned ‘the dichotomy between the “primitive” and the “civilised” in terms of mind and culture’ and embedded this ‘at the very heart of their new psychology’.<sup>109</sup> Three of these psychologists, W.H.R. Rivers, William McDougall, and C.S. Myers, spent the war treating shell-shocked men. The theories each produced looked not only to the bodies and minds of individual soldiers,

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<sup>105</sup> M. Thomson, “‘Savage civilisation’: race, culture and mind in Britain, 1898-1939’ in W. Ernst and B. Harris (eds), *Race, science and medicine, 1700-1960* (London and New York: Routledge, 1999), pp. 235-58, p. 236. See also M. Thomson, ‘Psychology and the “consciousness of modernity” in early twentieth-century Britain’ in M. Daunt and B. Rieger (eds), *Meanings of modernity: Britain from the late-Victorian era to World War Two* (Oxford and New York: Berg, 2001), pp. 97-115, p. 100-5.

<sup>106</sup> Taylor, ‘Obscure recesses’, p. 143 and p. 157.

<sup>107</sup> *Ibid.*, p. 140.

<sup>108</sup> L. Otis, ‘Organic memory and psychoanalysis’, *History of Psychiatry* 4 (1993), pp. 349-72, p. 372

<sup>109</sup> Thomson, “‘Savage civilisation’”, pp. 236-7.



and the texts of neurology and psychology, but to the primitive peoples they had encountered in South-East Asia and then rediscovered at the centre of civilisation.

## Chapter 4

### Gendered diagnoses: from the traumatic neuroses to shell-shock

#### Introduction

In 1896, inspired by the 'heroic' attitude of the leader of a failed raid on the Transvaal, Rudyard Kipling (1865-1936) composed 'If –', a verse shopping list of components to build the ideal Victorian man.<sup>1</sup> Among these Kipling included the ability to

... force your heart and nerve and sinew  
To serve your turn long after they are gone,  
And so hold on when there is nothing in you  
Except the Will which says to them: 'Hold on!'

Historians have identified the keynotes of the Victorian masculine ideal as self-control, self-restraint, and will-power.<sup>2</sup> The cumulative tendency of recent scholarship has been to emphasise that in the years leading up to 1900 and beyond this model of masculinity was subject to internal redefinitions, generated powerful anxieties regarding male identity, and did not permeate the value structure of large swathes of the working classes.<sup>3</sup> Yet for all this, the war saw two and a half million men from the United Kingdom enlist in the armed forces without any form of legal compulsion. Social pressure, the temporary madness of 'war fever', youthful naivety, and even mere boredom or an apparent lack of attractive alternative career options doubtless played a part in swelling these numbers. Nevertheless, for many, duty, patriotism and loyalty were not simply rhetorical devices, but internalised values which retained their power

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<sup>1</sup> On Kipling and the Victorian male ideal see P. Kaarsholm, 'Kipling and masculinity' in R. Samuel (ed.), *Patriotism: the making and unmaking of British national identity. Volume 3: National fictions* (London: Routledge, 1989), pp. 215-26. For details of the Jameson raid, see L. James, *The rise and fall of the British Empire* (London: Abacus, 1995), pp. 264-5.

<sup>2</sup> The now classic statement of this 'masculine stereotype' is provided by G. Mosse, *The image of man: the creation of modern masculinity* (New York and Oxford: O.U.P., 1996).

<sup>3</sup> J. Tosh, *A man's place: masculinity and the middle-class home in Victorian England* (New Haven and London: Yale University Press, 1999); B. Shannon, 'ReFashioning men: fashion, masculinity, and the cultivation of the male consume in Britain, 1860-1914', *Victorian Studies* 46 (2004), pp. 597-630; L.A. Hall, *Hidden anxieties: male sexuality, 1900-1950* (Cambridge: Polity Press, 1991); A. Smith, *Victorian demons: medicine, masculinity and the gothic at the fin-de-siècle* (Manchester and New York: M.U.P., 2004); J. Springhall, 'Building character in the British boy: the attempt to extend Christian manliness to working-class adolescents, 1880-1914' in J.A. Mangan and J. Walvin (eds), *Manliness and morality: middle-class masculinity in Britain and America, 1800-1940* (Manchester: M.U.P., 1987), pp. 52-72; J. Tosh, 'Masculinities in an industrializing society: Britain, 1800-1914', *Journal of British Studies* 44 (2005), pp. 330-42.

as motivating forces throughout the war, although their objects may have shifted over the course of time.<sup>4</sup> One of the effects of the internal and external threats to the Victorian male ideal in the latter years of the century may even have been to reinforce its power. With more reason than most perhaps, Oscar Wilde's eldest son Cyril became convinced 'that, first and foremost, I must be a *man*. There was to be no cry of decadent artist, of effeminate aesthete, of weak-kneed degenerate'. He asked 'nothing better to end in honourable battle for my King and Country', a wish fulfilled when he was killed in action in the First World War.<sup>5</sup>

In one respect, the war therefore witnessed the triumph of the model of manliness set out in 'If –'.<sup>6</sup> But there were also those whose 'heart and nerve and sinew' failed despite themselves. In his 'Epitaphs of the Great War (1914-18)', Kipling memorialised 'The coward':

I could not look on Death, which being known,  
Men led me to him, blindfold and alone.

These lines can be read as a statement of individual failure to meet the standards of normative masculinity. The 'coward' of the title stands apart from the 'men' who lead him to death, a juxtaposition made more pointed by the placing of 'I' at the beginning of the first line and 'Men' at that of the second. Samuel Hynes interprets the couplet as evidence of a new imagining of war, in which the 'cast of characters' was no longer complete without the coward, the shell-shock victim, or the frightened boy as well as the hero.<sup>7</sup> The most recent analyses of the effects of shell-shock on concepts of masculinity have concluded that as fear became accepted as a natural and understandable response to battle, conventional standards of manliness were subjected to a rigorous reappraisal. Jessica Meyer argues that war experienced provided soldiers with 'a definition of masculinity that did not depend so heavily on self-control', and

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<sup>4</sup> See W.J. Reader, *At duty's call: a study in obsolete patriotism* (Manchester and New York: M.U.P., 1988); M. Eksteins, *Rites of spring: the Great War and the birth of the modern age* (London: Papermac, 2000), pp. 175-91.

<sup>5</sup> Quoted in A. Sinfield, *The Wilde century: effeminacy, Oscar Wilde and the queer movement* (Cassell: London, 1994), p. 126.

<sup>6</sup> Even in 1919, Kipling's writings could be presented as an accurate depiction of the attractions of army life. See J. Goodwin, 'An address on the Army Medical Service as a career', *Lancet* 1919 (2), pp. 631-33, p. 632 and p. 633.

<sup>7</sup> Hynes, *A war imagined*, pp. 214-5; see also C. Carrington, *Rudyard Kipling: his life and work* (Harmondsworth: Pelican, 1970), p. 548.

consequently they were 'able to define their military service not as an experience of emasculation, but rather as an episode that had made them men'.<sup>8</sup> The war can therefore be variously perceived as the logical outcome of the masculine ideal, a testament to its power and/or its failure, or the site of its renegotiation, and none of these readings are incompatible.

As an episode in which thousands of men who went to war inspired by the masculine ideal failed to meet its exacting standards, shell-shock would seem an irresistible temptation to the historian interested in exploring these issues. It is an historical event on which three areas of scholarship might fruitfully converge: analyses of the history of psychiatry inspired by feminism, which have developed alongside the modern discipline since the late 1960s;<sup>9</sup> studies devoted to uncovering the historical construction and socio-cultural impact of concepts of masculinity, which belatedly emerged as a subject of serious enquiry in the late 1980s;<sup>10</sup> and research which has examined how gender influenced experiences of the war, and informed the meanings attributed to it, a strand also prevalent in the field of cultural history of the war since the late 1980s.<sup>11</sup> The historiography of shell-shock and masculinity in Britain, however, remains dominated by an analysis first put forward by Elaine Showalter in 1985. Showalter argued that as an epidemic of male hysteria, shell-shock was perceived and experienced as emasculating and effeminising its subjects. At the same time, it was a 'disguised male protest' against both the war and the Victorian masculine ideal. The influence of this model of manliness was also evident in the differential application of diagnostic labels and treatments applied to ranking men and officers. The hysterical

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<sup>8</sup> J. Meyer, "'Gladder to be going out than afraid": shellshock and heroic masculinity in Britain, 1914-1919', in J. Macleod and P. Purseigle, *Uncovered fields: perspectives in First World War studies* (Leiden and Boston: Brill, 2004), pp. 195-210, p. 208; M. Roper, 'Between manliness and masculinity: the "war generation" and the psychology of fear in Britain, 1914-1950', *Journal of British Studies* 44 (2005), pp. 343-63.

<sup>9</sup> See N. Tomes, 'Feminist histories of psychiatry' in M. Micale and R. Porter (eds), *Discovering the history of psychiatry* (Oxford and New York: O.U.P., 1994), pp. 348-83.

<sup>10</sup> For comments, past and present, on the status of the history of masculinity, see J.E. Adams, E. Cohen, and M. Poovey, 'Review forum', *Victorian Studies* 36 (1993), pp. 206-226, and K. Harvey and A. Shepherd, 'What have historians done with masculinity? Reflections on five centuries of British history, circa 1500-1950', *Journal of British Studies* 44 (2005), pp. 274-80.

<sup>11</sup> For an early comment on this trend, see J. Winter, 'Catastrophe and culture: recent trends in the historiography of the First World War', *Journal of Modern History* 64 (September 1992), pp. 525-32, p. 526-28. Some notable publications in this field are M.R. Higonnet *et al* (eds), *Behind the lines: gender and the two world wars* (New Haven and London: Yale University Press, 1987); A. Caesar, *Taking it like a man: suffering, sexuality and the war poets* (Manchester and New York: M.U.P., 1993); J. Watson, *Fighting different wars: experience, memory and the First World War in Britain* (Cambridge: C.U.P., 2004); N.F. Gullace, *The blood of our sons: men, women, and the renegotiation of British citizenship during the Great War* (Basingstoke and New York: Palgrave Macmillan, 2002).

soldier was, like the hysterical woman, perceived as 'simple, emotional, unthinking, passive, suggestible, dependent, and weak', and was treated with harsh disciplinary therapies. The 'complex and overworked neurasthenic officer was much closer to an acceptable, even heroic male ideal', and so was treated with analytic therapies which stressed self-knowledge.<sup>12</sup>

When Showalter first published this examination, the history of psychiatry was still an emergent discipline with large swathes of ground, not least shell-shock itself, uncovered; masculinity was still treated by most as an unproblematic, if not self-evident, concept; and studies of gender in relation to the First World War were in their infancy. In this context she provided a brilliant, provocative, and original interpretation which showed the rich possibilities of using concepts of gender to analyse shell-shock. Its influence is imprinted on virtually every discussion of the war neuroses which makes reference to this aspect of the topic.<sup>13</sup> Nevertheless, its flaws are now evident to the critical student. In a recent essay, the only sustained critique of the analysis, Laurinda Stryker attacked Showalter's arguments on virtually every ground: the unacknowledged political framework of her interpretation, the intellectual coherence of her explanation of the causative mechanism(s) of the war neuroses, the lack of sufficient or suitable evidence for many of her claims, her division of treatment modalities into analytical and disciplinary, and the assertion that doctors stigmatised shell-shocked men as effeminate.<sup>14</sup> But perhaps of more importance than these defects is that so far as the history of shell-shock in Britain is concerned, historians have for the most part been content to adopt Showalter's conclusions rather than to move the topic on in accordance with recent scholarship in other relevant areas. Those discussions which have departed from the outline set up by Showalter are scattered and

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<sup>12</sup> Showalter, *The female malady*, pp. 167-194; see also Showalter, 'Rivers and Sassoon'; Showalter, 'Hysteria, feminism and gender'; E. Showalter, *Hystories: hysterical epidemics and modern culture* (London and Basingstoke: Picador, 1997), especially pp. 30-112.

<sup>13</sup> For examples, see J. Busfield, 'Class and gender in twentieth-century British psychiatry: shell-shock and psychopathic disorder', in J. Andrews and A. Digby (eds), *Sex and seclusion, class and custody: perspectives on gender and class in the history of British and Irish psychiatry* (Amsterdam and New York: Rodolphi, 2004), pp. 295-322; Bourke, *Dismembering the male*, p. 112; Barham, *Forgotten lunatics*, pp. 116-7 and pp. 161-4; Jones and Wessley, *Shell shock to PTSD*, p. 49; see also J. Rutherford, *Forever England: reflections on race, masculinity and empire* (London: Lawrence and Wishart, 1997), pp. 72-3

<sup>14</sup> L. Stryker, 'Mental cases: British shellshock and the politics of interpretation' in G. Braybon (ed.), *Evidence, history and the Great War: historians and the impact of 1914-18* (New York and Oxford: Berghahn Books, 2003), pp. 154-71.

have not yet had much impact on the wider historiography.<sup>15</sup> The potential which Showalter's analysis seemed to hold out has been stifled by the failure to build on it, and as a result the field has stultified.

This applies only to research, or lack of it, on the British context of shell-shock. Historians of the war neuroses in France and Germany have used Showalter's arguments as a springboard to investigate the gendering of these categories in specific national conditions. In late nineteenth-century France, Charcot's work normalised the concept of male hysteria, particularly as a result of traumatic accidents, and consequently there was 'a striking absence of commentary among doctors on the fact that the 1914-18 epidemic [of war neuroses] struck primarily a male population'.<sup>16</sup> In Germany, the concept of male hysteria emerged hand-in-hand with debates on the traumatic neuroses. The neurologist Hermann Oppenheim argued that the traumatic neuroses originated in material damage to the nervous system, but his critics countered that they were nothing more than hysteria. The question had important political implications: if the symptoms were caused by the pathological mental processes of the individual, then the state or employers were not liable to pay compensation to the victims of accidents. The association of hysteria with work therefore displaced its traditional gender identity, and made it a preferable diagnosis for employers and the state before, during, and after the war.<sup>17</sup> In both these countries, male hysteria was therefore associated with the modern industrial environment and the masculine world of work.

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<sup>15</sup> See above, footnote 8; Bourke, 'Effeminacy, ethnicity and the end of trauma'; J. Bourke, *An intimate history of killing: face-to-face killing in twentieth-century warfare* (London: Granta Books, 1999), pp. 242-67.

<sup>16</sup> M. Roudebush, 'A battle of nerves: hysteria and its treatments in France during World War I', in Micale and Lerner (eds), *Traumatic pasts*, pp. 253-79, pp. 254-5 and p. 263; M. Micale, 'Jean-Martin Charcot and *les névroses traumatiques*: from medicine to culture in French trauma theory of the late nineteenth century', in Micale and Lerner (eds), *Traumatic pasts*, pp. 115-39, pp. 119-122, and pp. 130-1; see also M. Roudebush, 'A patient fights back: neurology in the court of public opinion in France during the First World War', *Journal of Contemporary History* 35 (2000), pp. 29-38.

<sup>17</sup> P. Lerner, 'From traumatic neurosis to male hysteria: the decline and fall of Hermann Oppenheim, 1889-1919', in Micale and Lerner (eds), *Traumatic pasts*, pp. 140-71; P. Lerner, 'Psychiatry and casualties of war in Germany, 1914-18', *Journal of Contemporary History* 35 (2001), pp. 13-28, especially pp. 14-16; P. Lerner, 'Rationalizing the therapeutic arsenal: German neuropsychiatry in World War I', in M. Berg and G. Cocks (eds), *Medicine and modernity: public health and medical care in 19<sup>th</sup> and 20<sup>th</sup> century Germany* (Cambridge, New York and Melbourne: C.U.P., 1997), pp. 121-48, pp. 125-29; P. Lerner, *Hysterical men: war, psychiatry, and the politics of trauma in Germany, 1890-1930* (Ithaca and London: Cornell University Press, 2003), especially pp. 15-85 and pp. 124-62; see also D. Kaufmann, 'Science as cultural practice: psychiatry in the First World War and Weimar Germany', *Journal of Contemporary History* 34 (1999), pp. 125-44, pp. 129-34, and H-P. Schmiedebach, 'Post-traumatic neurosis in nineteenth-century Germany: a disease in political, juridical and professional context', *History of Psychiatry* 10 (1999), pp. 27-57.

These findings have particular significance for the understanding of gender norms and perceptions of shell-shock in Britain. Any consideration of this topic has to confront Showalter's analysis above all, because it has been the most influential. Although the perception that hysteria and neurasthenia were differently gendered formed part of her examination, it was underpinned by the notion that responses to shell-shock were conditioned by the appearance in men of hysteria, the archetypal female malady. But research on European countries has suggested that in the years before the war, a concept of male hysteria had been formulated, above all in relation to the traumatic neuroses, which undermined the primacy of this association with femininity and which influenced later observations on the war neuroses. This chapter shows that in Britain, debates on the traumatic neuroses created an atmosphere in which male hysteria (in certain contexts and certain forms) was unexceptional, and that this perception was carried over into understandings of the war neuroses.<sup>18</sup> In fact, contrary to Showalter's assertions, British doctors did not describe shell-shock as emasculating or effeminate behaviour. But the blanket silence maintained on the possible association of hysteria with female mental disorders does imply that at some level, shell-shock was perceived as a threat to the model of perfect manliness. Finally, however, it is argued that the comparisons doctors did choose to make are extremely important for understanding the framework within which the war neuroses were conceptualised. The behaviour of shell-shocked men was repeatedly described as child-like. This suggests that deviation from the masculine ideal was judged not simply as feminine, but against the whole complex set of alignments integral to the evolutionary model of mind.

### **Hysteria and neurasthenia as gendered diagnoses**

The conventional analysis of shell-shock in relation to concepts of masculinity has argued that in pre-war British medical discourse hysteria and neurasthenia were differently gendered, and that these attributes were carried over into differential diagnosis of the war neuroses. Early studies of neurasthenia in America concluded that

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<sup>18</sup> Although accounts of shell shock in Britain now routinely include some reference to pre-war concepts of the traumatic neuroses, the implications of these debates for understandings of shell shock as a gendered diagnosis have not been explored. See Leese, *Shell shock*, p. 39, p. 178; Shephard, 'Shell-shock', p. 36; W. Holden, *Shell shock* (London: Channel 4 Books, 2001), p. 17. Feudtner is a rare exception in stating that hysteria was 'a common malady, for both men and women', and that conceptions of traumatic hysteria undoubtedly influenced views of shell shock. Feudtner, "Minds the dead have ravished", p. 387.

it was 'a particularly useful label for men' because it was positively associated with causes such as over-work and over-civilisation, and it also escaped the pejorative connotations of hysteria and hypochondriasis.<sup>19</sup> The most recent research on neurasthenia in Britain suggests rather that it was distributed equally among the sexes, perhaps with a slight preponderance of men, and that it cannot be viewed as simply 'the male alternative to hysteria'.<sup>20</sup> The sexual distribution of the diagnosis was very rarely commented on in the medical literature of the immediately pre-war years.<sup>21</sup> In some cases, the strenuous insistence that examples of 'brawny muscularity' and eminent intellectuals could be found in the ranks of neurasthenics would imply that at least some doctors perceived it as a predominantly female, rather than male, disorder.<sup>22</sup> It seems clear that in Britain, neurasthenia was not identified as a particularly masculine complaint, although it may nevertheless have provided a more palatable diagnosis than hysteria in some cases.

But it is hysteria which is at the heart of the historiographical association between gender and the war neuroses. From the wandering womb in Hippocratic writings, through the witch craze of the early modern period, right up to and beyond Freud's hysterics, the history of hysteria has overwhelmingly been written as the history of female suffering, protest, and stigmatisation. Historically, hysteria is the archetypal female malady.<sup>23</sup> It is only in recent years that historians have begun to examine the medical construction of male hysteria.<sup>24</sup> The most sustained research in this area has been conducted by Mark Micale, who has established that in the last fifteen years of his life Charcot formulated an elaborate set of ideas about masculine hysteria and energetically campaigned for the

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<sup>19</sup> Sicherman, 'The uses of a diagnosis', p. 42; Wessely, 'Neurasthenia and fatigue syndromes', p. 513. But see also T. Lutz, 'Neurasthenia and fatigue syndromes: social section', in Berrios and Porter (eds), *A history of clinical psychiatry*, pp. 533-44, pp. 536-7, which argues (drawing mainly on American evidence) that neurasthenia was perceived as an 'effeminising' diagnosis.

<sup>20</sup> Sengoopta, "'A mob of incoherent symptoms'", p. 99; M. Thomson, 'Neurasthenia in Britain: an overview', in Gijswijt-Hofstra and Porter (eds), *Cultures of neurasthenia*, pp. 77-95, p. 81.

<sup>21</sup> One such example is Cole, *Mental diseases* [1913], p. 220, which claimed neurasthenia was more prevalent in men.

<sup>22</sup> Macnaughton-Jones, 'The relation of puberty and the menopause to neurasthenia'; Clarke, 'Neurasthenia and eyestrain', p. 25; see also Oldfield, 'Some pelvic disorders in relation to neurasthenia', p. 337.

<sup>23</sup> Helen King, for examples, discusses historical research on male hysteria but concludes that the 'label "hysteria", with its history of multiple resonances with the womb and with inferiority, simply will not stick to a male patient'. H. King, 'Conversion disorder and hysteria: social section', in Berrios and Porter (eds), *A history of clinical psychiatry*, pp. 442-50, pp. 445-6.

<sup>24</sup> In these comments, I am concerned only with the actual medical diagnosis of hysteria in the male, rather than the appearance of symptoms which seem hysterical but were diagnosed under a different label, whether it be organic disease, 'railway spine' or the traumatic neuroses. For research on hysteria in men, see Micale, 'Hysteria and its historiography', pp. 93-101.



acceptance of the theory. By the time he died, in 1893, the idea of male hysteria was widely accepted within the mainstream of European medicine.<sup>25</sup> Micale has demonstrated that Charcot's theories of male and female hysteria were 'complexly and selectively gendered', with each individual component of the concepts 'gendered in different ways and to different degrees'. Through a studied avoidance of stereotypical portrayals of male hysteria as limited to adolescent, effeminate or homosexual males in his published writings, even when it meant suppressing observations made in his private clinical notes, Charcot preserved traditional gender identities.<sup>26</sup> He described the symptoms of hysteria as more capricious, dramatic, and varied in women than in men, as well as emphasising its statistical prevalence in females and their role as the sole parental agents of its transmission. But ultimately, 'the Charcotian clinical constructions of the diagnosis of male and female hysteria were strikingly alike'.<sup>27</sup>

Micale has also conducted a brief survey of British perceptions of male hysteria, focussing on the period 1880-1900. He argues that in contrast to the widespread discussion of male hysteria in Europe, a 'long and studied silence' on the subject was maintained in Britain. Those sources which did mention male hysteria employed 'a range of interpretative devices that served to distance medical men from the reality and significance of widespread hysterical disorders in members of their own sex and country'. Authors established the reality but extreme rarity of hysteria in men, and would illustrate general discussions with female cases, using the female pronoun throughout their discussions. They also employed alternative diagnostic strategies for cases that almost certainly would have been labelled hysterical on the Continent, or speculatively re-diagnosed these cases along organic lines. Micale concludes that this lack of discussion reflects 'the social, cultural, and psychological attitudes of doctors' rather than the clinical reality of male hysteria, and that the strength of the ideology of separate

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<sup>25</sup> M. Micale, 'Charcot and the idea of hysteria in the male: gender, mental science, and medical diagnosis in late nineteenth-century France', *Medical History* 34 (1990), pp. 363-411, pp. 365-71.

<sup>26</sup> This reading is more nuanced and comprehensive than that made by Goldstein, who concludes that 'Charcot's male hysteria was a variant on a familiar nineteenth-century rhetorical theme: it conflated forms of otherness, linking the characteristics of women with those of the lower classes or, alternatively, with those of the Orient'. J. Goldstein, 'The uses of male hysteria: medical and literary discourse in nineteenth-century France', *Representations* 34 (1991), pp. 134-65, p. 154.

<sup>27</sup> M. Micale, 'Hysteria male/hysteria female: reflections on comparative gender construction in nineteenth-century France and Britain', in M. Benjamin (ed.), *Science and sensibility: gender and scientific enquiry, 1780-1945* (Oxford: Basil Blackwell, 1991), pp. 200-39; Micale, 'Charcot and the idea of hysteria in the male'.

spheres in Britain meant that the relativisation of gender identities implicit in the diagnosis of male hysteria was resisted by middle-class diagnosticians.<sup>28</sup>

The British medical literature from the pre-war years provides support for some of Micalé's conclusions, namely the complex gendering of the disorder in the male, but there is also evidence that at this later period the existence of male hysteria was widely accepted. As in Europe, Charcot appears to have been an important force in this process: his work was the first point of reference in discussions from the 1880s onwards.<sup>29</sup> Although textbooks of nervous and mental diseases stated that hysteria was more prevalent in women, it was acknowledged that it occurred in both sexes.<sup>30</sup> Joseph Nagel, the author of one such book, claimed that in recent years the disorder had been 'of very frequent occurrence among men and boys'.<sup>31</sup> The statistical increase in cases of male hysteria was also noted by the sexologist Havelock Ellis (1859-1939), although he argued it was chimerical: the impoverished men who contracted hysteria appeared in hospital records, while the many 'idle and well-to-do' women who made up the bulk of real numbers did not. It was 'more serious and obstinate' in men, while women frequently suffered a mild form which did not attract medical attention. In his view, these facts vitiated statistics, and although 'hysteria in men is more frequent than was once supposed, it is much more common in women'.<sup>32</sup>

There is some evidence that the manifestations of hysteria were perceived differently according to the sex of the patient. Thomas Glynn (1841-1931), professor of medicine at Liverpool University, maintained that in men the fragmentary, hysterical paroxysms – transient giddiness, dimness of sight, and confusion – were as valuable as indications of hysteria as were the more pronounced fits in women'.<sup>33</sup> There is also some support for Micalé's claim that hysterical cases were differentially diagnosed according to sex. Edwin Ash, house physician to St. Mary's Hospital, referred to two cases of neuroses he had cured using faradic electricity. The first was a young woman suffering from a hysterical contraction of the knee joint, and the second a young man who was subject to

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<sup>28</sup> Micalé, 'Hysteria male/hysteria female', pp. 215-26.

<sup>29</sup> Jacob, 'Remarks on functional aphemia'; Bastian, 'On different kinds of aphasia'; Wyllie, *The disorders of speech*, pp. 42-4; Wilson, 'Some modern French conceptions of hysteria', p. 294.

<sup>30</sup> Potts, *Nervous and mental diseases*, p. 414; Clarke, *Hysteria and neurasthenia*, pp. 127-32.

<sup>31</sup> Nagel, *Nervous and mental diseases*, p. 163.

<sup>32</sup> H. Ellis, *Man and woman: a study of human secondary sexual characters*, 5th edn (New York and Melbourne: Walter Scott Publishing Co., 1914), p. 384.

<sup>33</sup> Glynn, 'Abstract of the Bradshaw lecture', p. 1303.

'epileptiform convulsions'. Ash gave no reason why this second case should not be described as hysterical, and his willingness to employ 'psycho-electrical' treatment to restore the patient's 'self-confidence' implies that he did not view it as an organic disorder. His attribution of some further attacks a few years after treatment to 'overwork', typically associated with male neurasthenia (although Ash did not use this term), further suggests gender differentiation in his diagnosis.<sup>34</sup> There are also, however, accounts of male hysteria which make no comment at all on the peculiarity of the condition, or on any effeminate attributes of the patient.<sup>35</sup> As early as 1890, Ernest Jacob was surprised to find hysterical mutism 'in a strong Yorkshire miner, with a not very well-marked neurotic history', but he had no qualms in concluding that such cases were probably far more frequent than was commonly supposed.<sup>36</sup> By 1911 it was even possible to use the male pronoun throughout an article on hysteria, although this was the exception to the rule.<sup>37</sup>

It is clear that on the eve of the war the existence of male hysteria was widely accepted. This did not negate the traditionally feminine association of the disorder, as a discussion of the 'phylogenetic theory' formulated by the distinguished general physician and pathologist Frederick Parkes Weber (1863-1962) demonstrates. This theory, a strange amalgam of pre-Charcotian ideas of the effeminate male hysteric, Karl Ulrichs' third sex, and Darwinian sexual selection, was not typical or influential.<sup>38</sup> It does, however, illustrate the complex ways in which concepts of masculine and feminine attributes could be aligned and then disarranged in explanations of male hysteria. In Weber's definition, simulation (conscious or unwitting) was the essential feature of hysteria. He argued that this trait had been particularly useful to women in past ages, both as protection against the male and in order to manipulate him. It had therefore been developed in the female as a tertiary sex character (a character 'dependent on the nervous system, including both instincts' and mental attributes) through the action of natural selection. The existence of hysteria in men was therefore explained as 'the pathological exaggeration' of the female

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<sup>34</sup> Ash, 'The combined psycho-electrical treatment of neurasthenia', p. 131.

<sup>35</sup> Stewart, *The diagnosis of nervous diseases*, pp. 238-9.

<sup>36</sup> Jacob, 'Remarks on functional aphemia', p. 623.

<sup>37</sup> Wilson, 'Some modern French conceptions of hysteria'. The more common practice was to refer to the hysteric as 'she', but to sufferers from other nervous or mental disorders as 'he'. See for example H.C. Miller, 'Rest-cures in theory and practice', *Practitioner* 89:6 (December 1912), pp. 834-45.

<sup>38</sup> Havelock Ellis discussed the theory, but it does not appear to have influenced his views of male hysteria. H. Ellis, *Man and woman*, p. 21 and p. 23. On the relations between male hysteria and sexual inversion, see V.A. Rosario, *The erotic imagination: French histories of perversity* (New York and Oxford: O.U.P., 1997), pp. 69-111.

tertiary sex character of simulation. To this extent, Weber cast the hysterical male as essentially feminine. Yet he also attempted to displace this association. At the outset he excluded 'temporary "hysterical" conditions not rarely observed in the male as the result of violent emotions, starvation, and grave nutritive disturbance, or as forming a familiar part of the effect of certain toxic substances such as alcohol' from his analysis. At its close, he claimed that a certain class of simulation, 'such as to escape military duty in countries where conscription is practised', could not be classed as hysterical because it was a rational response to the situation. Finally, he argued that tertiary sex characters, like other instincts, might be released from the 'restraining' action of the mind by influences such as 'mental and physical overwork and shocks'.<sup>39</sup> In this instance, hysteria was less a female type of behaviour than one characteristic of a lower stage of human evolution.

The cumulative effect of these provisos was to undermine the significance of male hysteria. Although the association with femininity was essential to Weber's theory, he implicitly suggested that the majority of male cases were not really evidence of female mental characteristics, but had a separate and external cause, such as alcohol or accidents. The theory initially collapsed the difference between male and female hysteria, but ultimately Weber reinforced traditional gender identities. There are three aspects of his conception of male hysteria which are relevant to the current discussion. First, he constituted hysteria as rooted in the evolutionary inheritance, and a condition which could all too readily develop if higher control was loosened. Although for Weber hysteria was particularly a female legacy, this general evolutionary framework of explanation offered an alternative set of alignments (with savages, children, and animals) that would be exploited in theories of shell-shock. Secondly, his article suggests that although male hysteria had been normalised in the pre-war years (to the extent that its existence was acknowledged by virtually all authors), it had not been thoroughly masculinised. Finally, he specifically listed shock as an agent which facilitated the production of hysteria in men. In the early years of the twentieth century, this factor was persistently invoked in the context of debates on the traumatic neuroses, and acted (as in Weber's article) to mitigate, if not entirely dispel, the feminine associations of hysteria.

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<sup>39</sup> F.P. Weber, 'The association of hysteria with malingering: the phylogenetic aspect of hysteria as pathological exaggeration (or disorder) of tertiary (nervous) sex characters', *Lancet* 1911 (2), pp. 1542-43, p. 1543.

## Gender and the traumatic neuroses

The earliest reports of shell-shock in the British medical press particularly drew attention to the aetiological role of 'shock', and described the symptoms as analogous to those found in civilian traumatic neuroses following railway or industrial accidents.<sup>40</sup> The general models of hysteria and neurasthenia outlined above and in the previous chapter undoubtedly influenced doctors' conceptions of shell-shock, but their first point of reference was the traumatic neuroses. Any account of shell-shock as a gendered diagnosis must take full cognisance of how concepts of masculinity and femininity were deployed in the construction of the traumatic neuroses in the pre-war years. The debates on these disorders undermine the conventional historiographical analysis of shell-shock and gender in several respects, not least that part which is founded on the perception of hysteria and neurasthenia as distinct entities with different gendered attributes. The general tendency of discussions of the traumatic neuroses was to collapse the distinction between the two, via descriptions such as 'Traumatic Neurasthenia (Hysteria)' and 'hystero-neurasthenia', observations that symptoms of both were blended in most cases, and the proposal of a similar aetiology (shock, followed by suggestion and the development of a fixed idea) for all forms of the traumatic neuroses.<sup>41</sup>

More importantly however, the debates on the traumatic neuroses demonstrate that even before 1914 a link had been forged between hysteria, the public male environment, and the relations of the individual to the state. In Britain, the concept of the traumatic neuroses was first developed in the mid-Victorian period in relation to public fears about railway accidents. The railway accident became linked to the neuroses through the concept of 'railway spine', a condition initially deemed to result from actual organic injury to the spinal cord, but later judged to be a nervous disorder

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<sup>40</sup> See [Anon.], 'Nervous and mental shock among the wounded', *BMJ* 1914 (2), pp. 802-3; [Anon.], 'French wounded from some early actions', *BMJ* 1914 (2) [November 14 1914], pp. 853-4; [Anon.], 'The war and nervous breakdown'; Myers, 'A contribution to the study of shell shock'; [Anon.], 'Shell explosions and the special senses', *Lancet* 1915 (1), pp. 663-4.

<sup>41</sup> Cole, *Mental diseases* [1913], p. 94 and p. 217; F.S. Palmer, 'Traumatic neuroses and psychoses', *Practitioner* 86:6 (June 1911), pp. 808-20, pp. 811-2; [Anon.], 'Medical societies: Liverpool Medical Institution', p. 1001; W. Thorburn, 'Presidential address: the traumatic neuroses', neurological section, *PRSM* 7:2 (1913-14), pp. 1-14, p. 4 and pp. 7-8; J.W.G. Grant, 'The traumatic neuroses – some points in their aetiology, diagnosis, and medico-legal aspects', *Practitioner* 93:1 (July 1914), pp. 26-43, p. 40; [Anon.], 'Medical societies: Medical Society of London', p. 1471.

produced by the extreme shock and fear at the moment of the accident.<sup>42</sup> As an event which was simultaneously and perhaps singularly public, arbitrary, and violent, the railway accident 'acquired a subtext of metaphorical and implied meanings, becoming emblematic of the condition of modern humanity, subject both to the remorseless efficiency of an increasingly mechanised civilisation and the violent unpredictability of seemingly irrational and uncontrollable machines'.<sup>43</sup> The railway was one of the most potent symbols of the 'age of progress', but it was also the site of anxieties about the cost and consequences of modernity.

The concept of male hysteria in Britain was established not only in relation to railway, but also workplace, accidents. This connection was not emphasised in general discussions, but those cases of male hysteria provided by doctors were virtually always associated with traumatic injury. This perhaps explains the apparent prevalence of miners among male hysterics.<sup>44</sup> As part of his study of hysteria, Ormerod gave three examples of hysteria in which the 'fixed idea originated from an injury', which were all male. The cases he discussed in which the fixed idea was related to disease and to dreams were all female. Ormerod also gave the example of a sailor who had developed fits after being struck on the head by a piece of metal at an explosion which had occurred during gun-drill. It was initially thought that he had suffered a local injury to the brain, but the hysteria was revealed when he had a fit in which the whole scene of the gun-drill was re-enacted: 'He listened for the word of the commanding officer, made the proper reply, and finally, when the explosion happened, fell down unconscious'.<sup>45</sup> John Geary Grant, the author of an article on the traumatic neuroses, claimed that hysteria was 'formerly considered to belong almost exclusively to the gentler sex, but now it is quite frequently found as an "hysterical accident" in the male'.

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<sup>42</sup> R. Harrington, 'The railway accident: trains, trauma, and technological crises in nineteenth-century Britain', in Micale and Lerner (eds), *Traumatic pasts*, pp. 31-56, pp. 43-51.

<sup>43</sup> Harrington, 'The railway accident', p. 55; see also Pick, *War machine*, pp. 106-10 and 113-135; Schivelbusch, *The railway journey*, pp. 129-49. For a discussion of the ways in which Victorian fears regarding accidents other than railway or industrial reflected prevalent anxieties about the effects of modernity, see R. Cooter, 'The moment of the accident: culture, militarism and modernity in late-Victorian Britain', in R. Cooter and B. Luckin (eds), *Accidents in history: injuries, fatalities and social relations* (Amsterdam and Atlanta, GA: Editions Rodopi B.V., 1997), pp. 107-57.

<sup>44</sup> Jacob, 'Remarks on functional aphemia', p. 623; H.W. Gardner, 'A case of periodic paralysis', *Brain* 35:3 (February 1913), pp. 243-53, p. 243; [Anon.], 'Medical societies: Edinburgh Medico-Chirurgical Society', *Lancet* 1910 (1), pp. 27-8.

<sup>45</sup> Ormerod, 'Two theories of hysteria', p. 274 and p. 277.

His own case histories documented traumatic hysteria in a number of 'sturdy workmen', including colliers, dock labourers, and plumbers.<sup>46</sup>

The association of male hysteria with the workplace was made explicit in discussions of the traumatic neuroses. From the turn of the century, an additional factor was added to the debates: the negative influence of compensation claims in producing and maintaining traumatic disorders. This issue was also linked with railway accidents, but the tendency was increasingly to stress rather the complex of relations between employer, employed and state in industrial accidents.<sup>47</sup> The physician Frederick Palmer (1847-1926), for example, considered 'the requirements of modern life, the desire for speed, and the enormous increase of mechanically propelled vehicles' as 'strongly contributory' to the increase in the traumatic neuroses. But he believed that the cause of the most recent influx of cases could be attributed overwhelmingly to four pieces of legislation: the Employer's Liability Act of 1890, and the Workmen's Compensation Acts of 1897, 1900, and 1906.<sup>48</sup> In this connection, doctors also began to comment on the prevalence of men among the traumatised. In 1912, Alexander James, physician to the Edinburgh Medical Infirmary, provided the statistics for men and women treated for hysteria and neurasthenia at that institution in the fifteen years between 1894 and 1909. He identified the most marked feature of these figures as the disproportionate increase in the number of men given these diagnoses: in the second half of the period, three times as many men had been seen for these disorders as in the earlier years. In his view, this spread of the neuroses in men could only be attributed to the effects of the Workmen's Compensation Acts.<sup>49</sup>

The most interesting analysis of the effects of state intervention on the traumatic neuroses in relation to gender was made by William Thorburn, president of the neurological section of the Royal Society of Medicine. He argued that hysteria tended to be produced by severe shocks, often involving several people, with 'dramatic associations'. As the majority of slight workplace accidents did not fit this template, 'the hysterical type is rarely met with in cases coming under the Workmen's

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<sup>46</sup> Grant, 'The traumatic neuroses', p. 30 and p. 38.

<sup>47</sup> See A.J. Hall, 'How far is trauma a possible factor in the production of disease', *Practitioner* 88:6 (June 1912), pp. 831-44, p. 832.

<sup>48</sup> Palmer, 'Traumatic neuroses and psychoses', p. 818.

<sup>49</sup> A. James, 'Trauma as a factor in disease. II', *EMJ* 8:4 (April 1912), pp. 312-23, p. 313.

Compensation Act'. This legislation rather caused an increase in cases of traumatic neurasthenia. The attitudes of both workmen and employers had changed because of the new law: the former became worried that a return to employment would destroy his claim to compensation, and the latter reluctant to re-employ a disabled man for whom he handed over responsibility to the insurance company. In the legal conflict which ensued, psychological injuries which previously would have been easily resolved by the return to work were aggravated. Consequently there had developed 'a neurasthenia of a type less commonly seen in the last century, less acute in onset, far more insidious, gradually increasing and becoming so intensified with time and repeated applications to an arbitrator that it often prevents the unfortunate victim from ever again returning to a useful life'.<sup>50</sup>

Thorburn claimed that the apparent increase in male nervous disorders caused by the Workmen's Compensation Act was, to a certain extent, illusory. The prevalence of men simply reflected the fact that men were over-represented in those cases which went to court, because the male 'financial position is more complicated, the stake is greater, and the negotiations more prolonged'. The Acts had, however, produced an actual increase of traumatic neuroses in women. Under common law, females had rarely developed traumatic neurasthenia, as their claims for compensation were relatively small and therefore rapidly settled, but this had changed since 1897.<sup>51</sup> In this account, it appears that the traumatic neuroses were perceived as an unsettling effect of modernity on established social relations. The interference of the state in the relations of employer and employed, loosening the traditional bonds of deference, trust, and responsibility, not only caused nervous disorder, but a new and more widespread form of this affliction. The particular effects claimed for the recent legislation on women seems part of the same complex of fears. Their entry into the workplace had changed the nature of that environment, and perhaps it was only to be expected that they would be visited with pathological symptoms. As they encroached further into the male world, women also became more prone to peculiarly male stresses, such as financial anxieties. This process of gender relativisation disrupted old certainties even to the degree that it was women who were deemed to be most affected by the *Workmen's* Compensation Act.

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<sup>50</sup> Thorburn, 'Presidential address', pp. 12-13.

<sup>51</sup> *Ibid.*, p. 11 and pp. 13-14.



It has been argued that because male hysteria was perceived as the outcome of a traumatic event, it served to reinforce the traditional gender identity of the disorder; that whereas female hysteria was produced from within the individual, male hysteria required the external intervention of some kind of accident.<sup>52</sup> Thorburn's analysis, which emphasised the pathological effects of modernity on both sexes, suggests that this interpretation does not fit the British case exactly. The notion that male traumatic hysteria simply re-inscribed traditional gender distinctions is also undermined by another, more important aspect of British constructions. Although male hysteria was most discussed as a manifestation of the traumatic neuroses, several factors served to align traumatic hysteria with the general model, where the aetiological emphasis was on the internal constitution (mental and/or nervous) of the individual, rather than the precipitating event.

Firstly, the traumatic neuroses were overwhelmingly explained as the result of emotional, rather than physical, shock. The initial theory of 'railway spine' put forward in the 1880s had suggested that traumatic symptoms resulted from actual physical concussion. But by at least the early 1900s although physical factors were not discounted entirely, it was widely accepted that the most significant factor in the development of the traumatic neuroses was emotional shock generally, and fear in particular.<sup>53</sup> Geary Grant stated that in most cases of traumatic neuroses, 'the trauma is a psychic one, and those accidents, such as explosions underground, railway disasters, and the like, in which there are accompanying sights and sounds and elements of horror, are peculiarly efficient'.<sup>54</sup> Thorburn thought that increased newspaper attention to traumatic accidents had 'created a lurid mental picture of the injured, and indirectly affected the general public in such a way as to prepare a fertile soil for nervous disturbance in those who might themselves be injured at a later date'.<sup>55</sup> Thorburn's comments imply that the traumatic hysteric was emotional and suggestible even before the shock of the accident. Emotionality and suggestibility were described as prominent symptoms of the traumatic neuroses, but in this way were implicitly attributed to the individual rather than the pathological effects of

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<sup>52</sup> See U. Link-Heer, "'Male hysteria': a discourse analysis", *Cultural Critique* 15 (1990), pp. 191-220, p. 214.

<sup>53</sup> [Anon.], 'The British Medical Association seventy-ninth annual meeting in Birmingham: section of neurology and psychological medicine', *Lancet* 1911 (2), pp. 450-1; Hall, 'How far is trauma a possible factor in the production of disease', pp. 839-40.

<sup>54</sup> Grant, 'The traumatic neuroses', p. 27; Palmer, 'Traumatic neuroses and psychoses', p. 810 and p. 812-3; Thorburn, 'Presidential address', p. 4.

<sup>55</sup> Thorburn, 'Presidential address: the traumatic neuroses', p. 1 and pp. 9-10.

the accident.<sup>56</sup> It is therefore unsurprising to find some authors claiming that ‘the more ignorant and uneducated’ sections of the population most frequently developed traumatic neurosis, although some also suggested men and those under work pressure were equally often found among the sufferers.<sup>57</sup> The dual role ascribed to emotion and suggestion provided a strong link to the general theories of hysteria and neurasthenia.

Theories of the traumatic neuroses were also aligned with the general model of hysteria and neurasthenia through the medical insistence that predisposed subjects were more likely to develop a traumatic injury as a response to accidents. Again and again authors invoked the importance of the hereditary make-up of the individual, a family or personal history of nervous disorder, and the existence of an inherited or acquired ‘neuropathic tendency’.<sup>58</sup> It was claimed that one of the major questions which had to be decided in compensation cases was ‘to what extent the traumatic shock is a causative factor in the aetiology of the disorder, or whether it simply plays the part of a revealing agent, acting on a brain endowed with a latent morbidity’.<sup>59</sup> There was no straightforward answer to this question, but solutions were based on the attempt to measure the severity of the external causative agent against the severity of the symptoms. Geary Grant, for example, thought that ‘psychic shock’ was a potent cause of the traumatic neuroses in ‘suitable’ subjects, and even ‘normal’ ones, but he also distinguished a particular class of case in which a trivial injury was followed by a serious neurosis. In these cases, ‘it is the mind of the subject (or his want of mind) which is the cause of the condition, and the accident can only be considered as the *agent provocateur*’. He claimed that where hysteria was the ‘direct result of severe injury or intense psychic shock’, it should be seen as genuine and as the result of the accident. However, where either the injury or the psychic shock did not seem sufficient to produce the symptoms, the hysteria should be ‘regarded as due to conditions unconnected with the accident, and should not be allowed as the basis of a claim for damages or compensation’.<sup>60</sup>

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<sup>56</sup> Palmer, ‘Traumatic neuroses and psychoses’, p. 813; Grant, ‘The traumatic neuroses’, p. 40.

<sup>57</sup> Thorburn, ‘Presidential address’, p. 11; Palmer, ‘Traumatic neuroses and psychoses’, p. 811.

<sup>58</sup> Thorburn, ‘Presidential address’, p. 11; Hall, ‘How far is trauma a possible factor in the production of disease’, p. 844; [Anon.], ‘Medical societies: Liverpool Medical Institution’, p. 1001; Grant, ‘The traumatic neuroses’, p. 37; Palmer, ‘Traumatic neuroses and psychoses’, p. 811; Russell, ‘The treatment of neurasthenia’, p. 1453.

<sup>59</sup> H. Littlejohn and J.H.H. Pirie, ‘Medical jurisprudence: mental disturbances following traumatism’, *EMJ* 7:1 (July 1911), pp. 88-9, p. 88.

<sup>60</sup> Grant, ‘The traumatic neuroses’, pp. 40-3.

These were issues which were debated again and again as doctors attempted to uncover the exact causes of the war neuroses, and as politicians attempted to settle the vexed question of whether pensions should be awarded for wartime traumatic injury. But the importance so far as this discussion is concerned is that wartime doctors were able to draw on a pre-existing body of knowledge on traumatic hysteria in the male, and moreover, one in which the industrial environment could easily be extended to include the modern battlefield. In the years before the war, male hysteria had gained widespread acceptance in Britain, partly as a result of Charcot's work on the subject, but also because of discussions of traumatic neuroses arising from railway accidents or workplace injuries. A complexly gendered theory of male hysteria had been developed alongside that of female hysteria. This stressed the development of hysteria in men as a result of accidents in the modern and male environments, but the traumatic neuroses were equally deemed to be produced ultimately by an unstable nervous predisposition and an excess of emotion. In these ways, male hysteria was both separated from and aligned to its manifestation in women. Although theories of male hysteria had been formulated and its existence accepted, their essential similarity to the general model could imply that they embodied the same set of gender assumptions. This still, however, leaves an important factor out of the equation: the evolutionary framework within which the traumatic neuroses, and then shell-shock, were conceptualised. The remainder of this chapter will demonstrate that although the war neuroses raised anxieties regarding male identity, these were not limited, or even explicitly expressed in relation to, a putative association with femininity. Shell-shock was seen as a failure of not only the masculine ideal, but of the highest developments of humanity itself.

### **Shell-shock and the failure of the masculine ideal**

In early 1916, Frederick Mott chose to end his lengthy Lettsomian lectures on shell-shock with a quotation from a now forgotten wartime novel called *Aunt Sarah and the War*. The relevant passage was a letter from the front written by Captain Tudor, in which he contrasted the insignificant problems of the home front with the experiences of men in the trenches. Tudor claimed, and Mott repeated, 'Lord, if they could listen to the unceasing shells that drive some men deaf, some men blind, some men dumb, and other men crazy, and these all of them MEN, with a newly earned meaning in the word; for there's a new meaning now in many an old word. We shall want a brand-new

Dictionary, and its deuced hard work on old Murray, that just at the end of his great work he shall need to begin it all again'.<sup>61</sup> Mott's emphatic defence of the manliness of shell-shocked men achieves the opposite of its aim: rather than reassuring, it highlights the extent to which the masculine ideal was threatened by the experience of the war neuroses. But the menace does not end there. The suggestion that the dictionary will need to be re-written to accommodate the new meanings of masculinity, although intended to convey that this new definition will have to encompass the new levels of heroism that have been achieved, also demonstrates anxiety at the extent to which the war had disrupted all the old certainties. In this conclusion, Mott implied that the war not only threatened masculinity, but the established structure of civilised life.

The assertion that doctors described shell-shock as effeminising or emasculating men finds little support in the wartime medical literature. A thorough combing of articles on the war neuroses for such references yields few results. Harry Campbell (1860-1938), physician to the West End Hospital for Nervous Diseases, observing that soldiers often manifested anxiety during thunderstorms, noted that women were also usually scared of thunder.<sup>62</sup> In his discussion of occupational therapy, Edwin Fearnside warned that nervous soldiers should not be encouraged in 'feminine' pursuits such as needle-work, mat-making, wood-carving, and jigsaw puzzles.<sup>63</sup> It is even rare to find the war neuroses explicitly described as disrupting masculine identity. Rawdon Veale (1873-1954), a lieutenant-colonel serving with the RAMC in France, described the effects of severe functional disease as 'the conversion of what was once a "man" into a mere body without guiding control', and cited one patient's opinion that 'all his manliness had been rubbed out of him' by massage, but his comments are atypical.<sup>64</sup> For the most part, doctors preferred to leave these conclusions implicit in their accounts of symptoms and therapies. In the British literature, it was rare to find impotence cited as a common symptom, or homosexuality listed as a predisposing factor in the development of a war neurosis. The physicians who even mentioned either were almost

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<sup>61</sup> F.W. Mott, 'The Lettsomian lectures on the effects of high explosives on the central nervous system. III', *Lancet* 1916 (1), pp. 545-53, p. 553.

<sup>62</sup> H. Campbell, 'War neuroses', *Practitioner* 96:5 (May 1916), pp. 501-9, pp. 502-3.

<sup>63</sup> Fearnside, 'Essentials of treatment', p. 46.

<sup>64</sup> R.A. Veale, 'Some cases of so-called functional paresis arising out of the war and their treatment', *Journal of the RAMC* 29:5 (November 1917), pp. 607-14, p. 608 and p. 613.

without exception those who directly employed or were favourable to psychoanalysis.<sup>65</sup> The only exceptions were Sir George Savage, a distinguished alienist who did not actually treat shell-shocked soldiers, and Mott, who referenced the claim that impotence was a common symptom to the psychoanalytically-inclined John MacCurdy, and supported it with a few lines of Shakespeare.<sup>66</sup> In other writings Mott argued that, in contrast to their civilian counterparts, sexual factors played little part in the development of the war neuroses.<sup>67</sup>

The existence of medical anxieties regarding the implications of shell-shock for masculine identity is far more powerfully expressed through the lack of direct comparisons to female behaviour than these few and scattered references. Although the traumatic neuroses had helped to normalise the idea of male hysteria in certain contexts, there was still a long cultural and medical tradition associating the disorder with femininity. This heritage appears to have been deliberately jettisoned by shell-shock doctors. The silence is conspicuous. For example, in July 1916 Edward Milligan, an Australian surgeon working at a Casualty Clearing Station in France, published a description of 'chloroform hypnosis', which he described as a 'well-known method of treatment for hysteria'.<sup>68</sup> In fact, there does not appear to be any evidence that this method had ever been used to treat hysteria before the war. As a gynaecologist who wrote to the *British Medical Journal* in response to this article pointed out, chloroform was most often used during labour. He used it not only for pain relief, but to induce a mental state in which the patient would respond to suggestion to 'bear down and so assist natural expulsion'.<sup>69</sup> Although this use was not common among gynaecologists, the introduction of chloroform in the late 1840s had anticipated the inflection of fears surrounding hypnosis in later decades, particularly the possibilities of sexual

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<sup>65</sup> Forsyth, 'Functional nerve disease', p. 1401; Read, 'A survey of war neuro-psychiatry', p. 376; Chambers, 'Mental wards', p. 166; C. McDowall, 'The genesis of delusions: clinical notes', *JMS* 65: 270 (July 1919), pp. 187-94, pp. 189-90. See also Stryker, 'Mental cases', pp. 157-8.

<sup>66</sup> G.H. Savage, 'Mental disabilities for war service', *JMS* 62:259 (October 1916), pp. 653-7, p. 655; F.W. Mott, 'Two addresses on war psycho-neurosis: (II). The psychology of soldier's dreams', *Lancet* 1918 (1), pp. 169-72, p. 169.

<sup>67</sup> F.W. Mott, 'Two addresses on war psycho-neurosis. (I) Neurasthenia: the disorders and disabilities of fear', *Lancet* 1918 (1), pp. 127-9, p. 128; see also Burton-Fanning, 'Neurasthenia in soldiers', p. 910.

<sup>68</sup> E.T.C. Milligan, 'A method of treatment of "shell shock"', *BMJ* 1916 (2), pp. 73-4, p. 73. The method was also taken up by Myers, on Milligan's suggestion. Myers, 'Contributions to the study of shell shock (IV)', p. 463.

<sup>69</sup> P.R. Cooper, 'Correspondence: treatment of "shell shock"', *BMJ* 1916 (2), p. 201.

exploitation when women lay helpless and will-less under male control.<sup>70</sup> It is impossible that Milligan was not aware of the strong association between chloroform and childbirth, but he preferred to describe it as a method for treating hysteria rather than compare the soldier to women engaged in the most female of all acts.

Doctors did occasionally confront the similarities between shell-shock and the female neuroses, but always insisted that these were only superficial. Grafton Elliot Smith and Thomas Pear, authors of the well-received *Shell shock and its lessons* (1917), argued that the 'intelligent, highly moral, over-worked business man must not be given the same treatment as the society lady suffering from lack of honest labour'.<sup>71</sup> Arthur Hurst (1879-1944) consultant to the British forces in Salonkia, neurologist to the Royal Victoria Hospital, Netley, and then commanding officer of the Seale Hayne Military Hospital at Newton Abbot, was a strong advocate of hypnosis. He acknowledged the objection that hypnotism treated the symptoms 'without dealing with the underlying abnormal condition of the nervous system', but he claimed that these symptoms arose in soldiers only after some quite exceptional incident. The soldier might be suffering from nervous exhaustion, but this was 'a very different condition to the quite abnormal nervous system of the young woman'.<sup>72</sup> He had no qualms about acknowledging the existence of hysteria in men, but the direction of his work was to minimise its significance, even if this was at the expense of expanding the feminine empire of hysteria: for example, his conclusion that the persistent vomiting experienced by soldiers after gassing was hysterical was used to argue that sickness in pregnancy must be of the same nature.<sup>73</sup>

These attempts to separate shell-shock from the female neuroses continued even in the post-war period. In his *Instinct and the unconscious* (1920), Rivers explained the frequency of female hysteria in civil life by arguing that there was an essential difference between civilian and war psychoneuroses. The instinctive tendencies which manifested in the psychoneuroses fell into two classes: the first consisted of those 'which in a state of nature would promote the happiness of the individual or the crude

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<sup>70</sup> On the chloroform debates in the mid-nineteenth century, see M. Poovey, *Uneven developments: the ideological work of gender in mid-Victorian England* (London: Virago, 1989), pp. 24-50.

<sup>71</sup> G.E. Smith and T.H. Pear, *Shell shock and its lessons*, 2nd edn (Manchester: M.U.P., 1918), p. 102; see also pp. 31-4.

<sup>72</sup> A.F. Hurst, *Medical diseases of the war*, 2nd edn (London: Edward Arnold, 1918), pp. 33-4.

<sup>73</sup> A.F. Hurst, 'Hysteria in the light of the experience of war', *ANP* 2 (1919), pp. 562-72, p. 566-7.

necessities of the race, but are in conflict with the traditional standards of thought and conduct of the society to which the individual belongs'; the second group were distinguished by their 'protective character', and their function was to 'produce immediate pain or unpleasant affect as a means of warning against and avoiding danger'. The war neuroses stemmed from this second group. However, the psychoneuroses of civil life were caused mainly by disturbances of the sexual instinct, and were therefore associated with the first class. He attributed the greater prevalence of hysteria in women to the particular dangers they associated with sex, such as childbirth or unwanted pregnancy.<sup>74</sup> Therefore although female hysteria was also explained as a result of an untenable demand on the danger instincts, it was also conceptually separated twice over from the male war neuroses: once by its relation to the particularly civil and *civilised* repression of the sexual instinct, and again by its relation to biological functions peculiar to the female.

Both the tendency to silence on the similarities between female and war neuroses, and their attempts to reinstate differences between these forms, suggests that doctors were anxious to deny that the masculine ideal was threatened by shell-shock. These fears may have been encouraged by claims in the civilian sphere that women were also liable to war neuroses, an assertion which further blurred the distinction between the soldier and the nervous woman.<sup>75</sup> For obvious reasons, references to war neuroses among women are few and far between. Those which can be found, however, support the notion that the war encouraged a democratisation of suffering, in which women's pain was validated through comparison to that of soldiers. The banner at the head of a 1917 advertisement for Sanatogen read 'War Neuroses in Women'. The text below claimed, 'If it is true that prolonged strain, fear, and worry, are conducive to psychasthenias, exhaustion neuroses, and other abnormalities, the woman at home is certainly a victim of these conditions. Brooding in loneliness over the empty places that may never be filled again – dreading each letter, each paper lest unwelcome news is there – will disturb the equilibrium of even the best balanced nervous system, and sometimes create

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<sup>74</sup> W.H.R. Rivers, *Instinct and the unconscious: a contribution to a biological theory of the psychoneuroses* (Cambridge: C.U.P., 1920), pp. 136-8.

<sup>75</sup> The argument was also, although infrequently, made that by opening up a greater variety of occupations to women, the war might decrease the incidence of female nervous disorders. See [Anon.], 'Scotland', *BMJ* 1917 (1) [February 24 1917], pp. 277-8, p. 277; L.A. Weatherly, 'The war and neurasthenia, psychasthenia and mild mental disorders. I', *TMW* 11 (July-Dec 1918), p. 217; Ross, 'Shell shock', p. 55; see also S.M. Gilbert, 'Soldier's heart: literary men, literary women, and the Great War' in Higgonet *et al* (eds), *Behind the lines*, pp. 197-226.

both neural and endocrine manifestations'.<sup>76</sup> This perhaps testifies above all to the readiness of peddlers of quack remedies to infuse their old appeal to the nerves with wartime concerns; the 'nerve-shattered soldier' was targeted by Bovril and Ovaltine, while 'shell-shock serums' were also available on the commercial market.<sup>77</sup> But physicians also diagnosed war neuroses in women. Wilfred Harris (1869-1960), a neurologist and captain in the RAMC, referred to 'patients who have developed neurasthenia through the war', either through 'stress of fighting' or 'through dread of injury to relatives or husbands fighting abroad'.<sup>78</sup> In the course of a discussion on the effect of air raids, Islay Muirhead, surgeon to the Stoke Newington Invalid Asylum, even claimed that women were more prone to 'the war neuroses' than men, because of their 'more obvious instability and smaller control of feeling by intellect'.<sup>79</sup>

Muirhead, a civilian practitioner, reinforced traditional gender distinctions when he discussed war neuroses in women. The diagnosis was put to different use by a woman who could, with much justification, claim to have served and to have suffered. In the aftermath of the war, Vera Brittain (1893-1970) developed an obsession that her face was undergoing a sinister transformation, and she waged an 'exhausting battle against nervous breakdown' for eighteen months. Nothing, she said, made her 'realise more clearly the thinness of the barrier between normality and insanity than the persistent growth, like an obscene, overshadowing fungus, of these dark hallucinations throughout 1920'.<sup>80</sup> This account, published in 1933, echoes the blueprint of the internal struggle established in post-war memoirs written by officers: the litany of events which could make any man break down, followed by glimpses of the fearful world beyond reason, and eventually the fulfilment of duty which pulled the shattered hero back from the edge. Like many women of her class, Brittain was motivated by the same model of social duty that is popularly identified with the officer class. During the war, she strove for the equality of sacrifice by swapping Oxford University for nursing work, the most obvious form of service for a woman of her background. In its wake, now strongly tied to pacifist ideals, she claimed a communality of suffering not only

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<sup>76</sup> *TMW* 11 (July-December 1918), p. 215.

<sup>77</sup> See *TMW* 11 (July-December 1918), p. 290, and the back pages of the *Practitioner*, all issues from 1916-18.

<sup>78</sup> W. Harris, *Nerve injuries and shock* (London: O.U.P., 1915), pp. 101-2.

<sup>79</sup> I.B. Muirhead, 'The mental factor', *TMW* 11 (July-December 1918), pp. 170-2; see also I.B. Muirhead, "'Shock" psychology', *TMW* 9 (July-December 1917), pp. 309-10, p. 309.

<sup>80</sup> V. Brittain, *Testament of youth: an autobiographical study of the years 1900-1925* (London: Virago Press Limited, 1978), pp. 496-7.



through her experience of death, but by her voyage to the brink of madness and back again.<sup>81</sup>

### **Men, women and children in the hierarchy of evolutionary development**

All the evidence points to the conclusion that shell-shock was perceived as a threat to the masculine ideal. However, this danger was not constituted in the way described in the conventional historiography. It is not through explicit reference to the effeminising or emasculating effects of the war neuroses that medical anxieties regarding male identity are revealed, but through the lack of such comparisons and attempts to differentiate between civilian (female) and military (male) nervous disorders. Moreover, the appearance of hysteria in men was not unbelievable or even surprising to doctors. Its existence had been established before the war, and through the debates on the traumatic neuroses, linked to the kind of modern, industrial, and male environment which the battlefields of the war perversely epitomised. But the particular fears expressed in explanations of the traumatic neuroses provide another link to those invoked by shell-shock. In these pre-war discussions, the relativisation of gender roles was only one symptom of the pathological effects of modernity, which disrupted traditional social relations and patterns of life in their entirety. In shell-shock, the complex of fears also embraced the whole network of relations which composed the modern world and the civilised mind.<sup>82</sup>

This is demonstrated most strikingly by the comparisons which shell-shock doctors did choose to make. Again and again the neurotic soldier was described as like a child.<sup>83</sup>

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<sup>81</sup> This interpretation is directly influenced by the discussion of the service ideal among female nursing volunteers, and Brittain's wartime adherence to this, in Watson, *Fighting different wars*, pp. 59-104 and pp. 247-59, although Watson does not discuss Brittain's 'war neurosis'. For an account which stresses Brittain's individualism rather than her class-based notion of duty, see L. Layton, 'Vera Brittain's Testament(s)', in Higgonet *et al* (eds), *Behind the lines*, pp. 70-83.

<sup>82</sup> It should perhaps also be noted in this connection that other historians have identified self-restraint as central not so much to the masculine ideal as to the rise of 'civilised' societies; see N. Elias, *The civilizing process: sociogenetic and psychogenetic investigations*, rev edn (Oxford: Blackwell Publishers, 2000), especially pp. 363-447. In Foucault's argument, the internalisation of discipline was central to the creation of the characteristic modern European state and its techniques for maintaining a docile workforce; see M. Foucault, *Discipline and punish: the birth of the prison* (London: Penguin, 1991), especially pp. 135-228. The persuasiveness of these particular theories may be disputed, but it is beyond doubt that the relation to masculinity is only one part of the history of the role of concepts of self-control in the creation of modern societies.

<sup>83</sup> Regression (to adolescence, rather than childhood) was also the theme of one of the earliest novels written about a shell-shocked soldier, Rebecca West's *The return of the soldier* (1918).

Smith and Pear's book is littered with such references. The behaviour of the nerve-shattered soldier 'presents considerable resemblance to that of a child'; he met problems in a 'childish way'; the attitude of the physician should be that 'which the sensible mother exhibits towards a child who exhibits sudden and unreasonable fear, anger, or any socially undesirable emotion'.<sup>84</sup> John Collie, a pre-war expert on malingering and a Ministry of Pensions official, also claimed that the mentality of sufferers was 'reduced more or less to the level of young children with their small powers of self-control, tendency to impulsive display of emotion, and marked suggestibility'.<sup>85</sup> Veale emphasised that these men 'have become as little children and as little children they must be re-educated [...] as children they respond to encouragement, to censure, to praise or blame rightly bestowed'.<sup>86</sup> Charles Stanford Read, the officer in charge of 'D' Block, Netley, one of the centres where all nervous soldiers were sent on their arrival in England, highlighted a form of hysteria he called 'mental puerilism', in which the main symptom was 'childishness in speech and behaviour'.<sup>87</sup> Mott had seen similar cases, in which men emerging from stupor 'behave just as children do; they look at picture books, and they not only use the words which young children use, but the voice is modulated on the same juvenile standard'.<sup>88</sup> These comparisons could be multiplied endlessly: the hysterical fits suffered by soldiers were like the tantrum fits of a child; the dreams of one man regressed further backwards, until he was fighting the Indians of his boyish nightmares rather than the Germans of his adult reality; another had amnesia so severe that he 'did not even know what his arms and legs were for, and had to be re-educated as you would teach a small baby'.<sup>89</sup>

Shell-shock was described as a regression from the male ideal, rather than configured as a type of feminine behaviour. In the evolutionary model of mind, there was a conceptual alignment between the behaviour of women and children. But emotion and lack of volition, the hallmarks of hysteria, were also perceived as characteristics of children, primitive races, and animals. There was no simplistic binary opposition of male and

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<sup>84</sup> Smith and Pear, *Shell shock and its lessons*, pp. 71-2, p. 92 and p. 99.

<sup>85</sup> Collie, 'Neurasthenia', p. 530.

<sup>86</sup> Veale, 'Some cases of so-called functional paresis', p. 613.

<sup>87</sup> Read, 'A survey of war neuro-psychiatry', pp. 369-70.

<sup>88</sup> F.W. Mott, 'War psychoses and psychoneuroses', *JMS* 64:265 (April 1918), pp. 230-4, pp. 232-3. He included extended accounts of such cases in F.W. Mott, *War neuroses and shell shock* (London: Hodder and Stoughton, 1919), pp. 80-4.

<sup>89</sup> Examples are taken from J.T. MacCurdy, *War neuroses*, p. 28 and p. 44, and A.F. Hurst in *RWOCESS*, p. 25. See also Myers, *Shell shock in France, 1914-1918*, p. 55; L.R. Yealland, *Hysterical disorders of warfare* (London: Macmillan, 1918), p. 24; Ross, 'Anxiety neuroses of war', pp. 153-4 and p. 158.

female. It is even arguable that within this evolutionary model of mind, the female was the least relevant point of reference for understanding the male mind. The civilised child recapitulated racial development, but at puberty the sexes took different developmental paths. The female stopped short of the level of evolution achieved by the male, but also developed a distinctive set of sexual characteristics which were entirely her own. At various stages of his development, man was animal, savage, and child, but he was never woman. The lack of direct comparisons between shell-shocked soldiers and women then assumes a different significance. The war neuroses not only undermined the masculine, but the human, ideal. The civilised masculine mind was perceived as the apex of a scale of development. Each individual male mind was conceived as recapitulating a process of racial evolutionary development, and so contained elements of the mental characteristics of all these other groups. The shell-shocked soldier had not simply fallen short of the male ideal, but the standard of humanity itself. The patient was not only like a child, but he was also dangerously close to the animal and the primitive. The epidemic of male hysteria therefore threatened not only the concept of heroic masculinity, but could be perceived as a fracture in civilisation itself.

## **Conclusion**

This chapter has argued that although shell-shock disrupted ideals of masculinity, it was not perceived as a feminine type of behaviour. Historiographical interpretations of shell-shock in Britain, although also invoking the division of hysteria and neurasthenia discussed in the second chapter, have relied particularly on the view that as the archetypal female malady, hysteria was perceived as effeminising men. Historians of the war neuroses in France and Germany have argued that the particular discourses which developed around hysteria in these countries neutralised to a certain extent the traditional connotations of the disorder. Here, it has been shown that a similar process occurred in Britain. Through debates on the traumatic neuroses in the late-nineteenth and early-twentieth centuries, the idea of hysteria in men was normalised and associated with modern, public, and industrial environments. Male hysteria continued to be complexly gendered, but it was not immediately (at least superficially) associated with femininity. When the First World War broke out, and soldiers began to develop hysterical disorders, doctors drew on their knowledge of the traumatic neuroses. Shell-shock was therefore also complexly gendered. In their attempts to disassociate the war neuroses absolutely

from female hysteria, physicians unintentionally revealed how these disorders rebelled against standard notions of masculine behaviour. They also, however, explicitly compared shell-shocked men to children. This demonstrated that the nervous and mental disorders of war were perceived as a regression, not only from the ideal of male behaviour, but the highest acquisitions of human identity. This theme of regression will be more fully developed in chapter seven, which examines physiological and biological theories of the war neuroses, and shows that shell-shock was also perceived in terms of its effects on the animal body.

As the close of this chapter marks the end of the first half of this thesis, it is an appropriate place to draw together themes previously discussed. The first chapter set out the basis for this intellectual and medical history of shell-shock. It argued that in order to recreate a sense of the contemporary meanings of the war neuroses, it is necessary to appreciate how doctors incorporated pre-war understandings of mental disorder into their theories of shell-shock. The analysis of hysteria and neurasthenia in the second chapter, and of the traumatic neuroses in the present chapter, were part of this project. These chapters showed that historiographical arguments relating to social class and gender in the diagnosis of shell-shock have been based on an insufficiently nuanced reading of categories in pre-war psychological medicine. In the process, they have also demonstrated that theories of body-mind relations before the war were more complex than historians of shell-shock have suggested. This raises questions regarding the extent to which shell-shock forced a transition to psychological understandings of mental disorder. The next chapter, which examines the prevalence and persistence of physical theories of causation among shell-shock doctors, further develops this strand. It argues that a rigid division into physical and psychological theories is not the most productive, or even necessarily accurate, way of analysing contemporary views of shell-shock. The final three chapters show that on the contrary, apparently diverse theories were formulated within the evolutionary framework of understanding set out in chapter three; and it was through their infusion with evolutionary meaning that the war neuroses were perceived as a social threat with far greater repercussions than a loss of fighting efficiency.

## Chapter 5

### Shock, concussion, and commotion: the prevalence and persistence of physical theories of causation

#### Introduction

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.<sup>1</sup>

The above outline of the development of medical views on the causation of shell-shock, penned by W.H.R. Rivers in July 1918, has become a narrative staple of the historiography of the war neuroses. The story told, again and again, is that when soldiers first began to manifest strange nervous and mental behaviour, perplexed doctors schooled in the organic psychiatry of the late-Victorian and Edwardian era immediately ascribed these symptoms to the mysterious physical effects of shell explosions on the central nervous system. Only as the war proceeded did it gradually become apparent that these were psychological disorders, and psychotherapeutic techniques were successfully employed to heal the mental wounds of broken veterans. The chronology of this transition from physical to psychological explanations of shell-shock varies from historian to historian, but the basic elements of the story never alter.<sup>2</sup> Accordingly, shell-shock is ascribed a major role in the emergence of psychodynamic approaches in more general accounts of British psychiatry and psychology.<sup>3</sup> Insofar as

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<sup>1</sup> W.H.R. Rivers, 'Preface' in MacCurdy, *War neuroses*, pp. v-ix, p. vi.

<sup>2</sup> See, for example, Merskey, 'Shell-shock', p. 250 and p. 258; Feudtner, "Minds the dead have ravished", pp. 384-7; G.L. Mosse, 'Shell-shock as a social disease', *Journal of Contemporary History* 35 (2000), pp. 101-108, p. 103; J. Bourke, 'Shell-shock, psychiatry and the Irish soldier during the First World War', in A. Gregory and S. Pařeta (eds), *Ireland and the Great War: 'a war to unite us all?'* (Manchester and New York: Manchester University Press, 2002), pp. 155-70, p. 160.

<sup>3</sup> Stone, 'Shellshock and the psychologists', especially pp. 251-3; R.D. Hinshelwood, 'Psychodynamic psychiatry before World War I', in G.E. Berrios and H. Freeman (eds), *150 years of British psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 197-205, p. 203; M. Pines, 'The development of the psychodynamic movement', in G.E. Berrios and H. Freeman (eds), *150 years of British psychiatry, 1841-1991* (London: Gaskell, 1991), pp. 206-31, p. 206 and p. 213-15; J.L. Crammer, 'Training and education in British psychiatry 1770-1970', in H. Freeman and G.E. Berrios (eds), *150 years of British psychiatry, volume 2: the aftermath* (London and New Jersey: Athlone, 1996), pp. 209-42, p. 225-6.

the intellectual history of shell-shock has been written, the focus has been on a handful of psychological theories developed in the later years of the war.

This chapter explores the other, neglected side of the story: the quantitative and qualitative role of theories of physical causation in the medical literature on shell-shock. It demonstrates that such theories were both less prevalent and more persistent than the conventional historiography would suggest. Perhaps most strikingly, over the entire course of the war not a single doctor argued that the physical effects of shell explosions could account for all cases of 'shell-shock'. The first reports on nervous and mental symptoms in soldiers readily compared these to the traumatic neuroses, and listed a range of 'physical' and 'psychological' causes which contributed to the development of these disorders. As in the pre-war use of 'functional' to describe the neuroses, the language of these accounts broke down the putative distinction between body and mind. The prevailing trend in the first two years of the war was to emphasise the interrelation of physical and psychological causes and effects. However, even at this very early date some physicians put forward relatively sophisticated psychological theories. Although the employment of such explanations would become more frequent and more prominent as the war progressed, their appearance constituted a development of one strand of thought which had always been present in discussions of shell-shock rather than a sea-change in medical opinion.

The historiographical insistence on the transition from physical to psychological theories has obscured three alternative shifts in medical thinking which became apparent from 1916 onwards. The first was that until this point, accounts had stressed that whatever the exact mechanism of causation, ultimately these disorders were all the outcome of the war. The fact of service temporarily outweighed all other considerations. But as conscription was introduced and Britons became more aware that they were in for a long and bitter struggle, the blame for shell-shock was displaced from the war onto the soldier. This was achieved through either a renewed emphasis on the aetiological role of heredity, or a new tendency to view psychological breakdown as the outcome of the entire life history of the individual. The second shift was the increasing invocation of emotion as an important aetiological factor. This aspect will be discussed fully in the next two chapters, but it should be noted here that emotion could be portrayed as primarily a physiological, as well as a psychological, experience. The

third development was the emergence of elaborate theories of physical causation, at precisely the point when some historians have argued that these were finally discredited.

This last event can be traced above all to the entry of Frederick Mott, the physician historically and historiographically most associated with physical theories, into the debates on shell-shock. The detailed examination of Mott's views on the war neuroses made here impacts on the conventional narrative of transition to psychological understanding in several ways. Although he has been correctly identified as the leading proponent of physical theories, the fact that Mott did not publish on the subject until December 1915 undermines the argument that such explanations were most prevalent in the early years of the war. In fact, from the outset he acknowledged the importance of emotional and psychological elements in the causation of shell-shock, and this was entirely consonant with his pre-war writings on alcoholism, syphilis, insanity and the traumatic neuroses. The consistent strand running through his work before, during, and after the war was an emphasis on the importance of heredity in mental disorder, and the experience of shell-shock did not alter his views in this respect. Finally, Mott maintained that purely physical causes accounted for a small proportion of cases of 'true' shell-shock until his death. He was not alone in this belief. A diminishing minority of physicians continued to invoke physical theories of causation well into the 1940s. The degree to which shell-shock occasioned changes in British psychiatric thought on the causation of mental disorder, and the ways in which it acted to do so, must be re-examined.

### **Early medical responses to the nervous and mental disorders of war, 1914-16**

The very earliest reports on the nervous and mental disorders of war in the British medical press, in November 1914, made no reference to the physical effects of bursting shells. Instead, cases of 'nervous or mental shock' were explained as the result of 'exposure and the severe strain and tension of the fighting line', coupled with 'the depressing effect of the horrible sights and sounds of modern battlefields', or straightforwardly described as examples of 'traumatic hysteria'.<sup>4</sup> As this last example

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<sup>4</sup> [Anon], 'Mental and nervous shock among the wounded', p. 802; [Anon.], 'French wounded from some early actions', p. 854.

suggests, doctors immediately noted the similarity of these symptoms to those following industrial and railway accidents.<sup>5</sup> Although these disorders were immediately assimilated to pre-war debates on the traumatic neuroses, doctors also struggled to understand the particular role of the environment of war in producing these symptoms. These two factors, the framework of explanation inherited from pre-war psychological medicine and the attempt to comprehend the particular influence of industrial warfare in producing neuroses, shaped medical responses to shell-shock in the first eighteen months of war. Both militated against the ascription of a purely physical aetiology, assumed in most historical accounts to be the standard medical line in the early months of the war, to these nervous and mental disorders. The categories which had been developed before the war to understand similar symptoms were too ambiguous to allow such explanations to be uniformly implemented, while the essential novelty of this war meant that features beyond the physical effects of shell explosions had to be explored.

The hallmark of these early accounts is aetiological ambiguity. Reports referred to 'men who came back from the front with nerves shattered', or 'the dumb and the deaf, the paralysed, and the insane from shell explosions and shock', or 'military cases of hysteria, hysterio-traumatism, traumatic neurosis, and nervous troubles due to suggestion'.<sup>6</sup> The text of the bill put forward in the House of Commons to facilitate the early treatment of mental disorders among soldiers precisely, if inelegantly, expressed its object as to deal with those 'suffering from mental disorder of recent origin arising from wounds, shock, disease, stress, exhaustion, or any other cause'.<sup>7</sup> Another piece described the 'series of homecoming 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 over-reaction, defects of mental synthesis, mental instability or disequilibrium, even paramnesia and hallucinations'.<sup>8</sup> This varied list of symptoms could have been easily

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<sup>5</sup> Elliott, 'Transient paraplegia', p. 1005; [Anon.], 'The war and nervous breakdown', p. 189; Farquhar Buzzard in 'Discussion: the psychology of traumatic amblyopia following explosion of shells', neurological section, *PRSM* 8:2 (1914-1915), pp. 65-8, p. 66; [Anon.], 'Shell explosions and the special senses', p. 663; Harris, *Nerve injuries and shock*, p. 51 and p. 123.

<sup>6</sup> [Anon.], 'Medical notes in Parliament: the Naval and Military War Pensions Bill', *BMJ* 1915 (2), pp. 106-7, p. 107; W. Osler, 'An address on science and war', *Lancet* 1915 (2), pp. 795-801, p. 798; [Anon.], 'The neurology of war', *BMJ* 1915 (2), p. 264.

<sup>7</sup> [Anon.], 'Medical notes in Parliament: early treatment of mental disorder', *BMJ* 1915 (1), p. 777.

<sup>8</sup> [Anon.], 'Lord Knutsford's special hospitals for officers', p. 1201.



divided among categories established within pre-war psychological medicine, but because their appearance in soldiers was perceived as more significant than any other aspect of their manifestation, the imposition of definite categories was resisted. This interpretation is further supported by a report on ‘the commotional syndrome in war’ which ignored the aetiological implications of this designation and concluded, almost in despair, that it was ‘as suitable as another’ to describe the diverse cases of ‘nervous shock under a single heading’.<sup>9</sup> It also provides a partial explanation of the appeal of ‘shell-shock’, which bracketed disorders together under a label with clear overtones of war.

At this point, war service conferred a privilege on patients, and the communality of righteous suffering was emphasised above all else. The nervous and mental disorders found in soldiers were portrayed as the outcome of the totality of war experience, which might impinge more on mind than body in some cases, or vice versa, but always with a reciprocity of influence. So, for example, a typical list of predisposing factors included anxiety, fatigue, and lack of food alongside ‘the horrors of the battlefield’, concussion, strain and tension, and ‘the sight of blood, of suffering, and of death’.<sup>10</sup> It was universally acknowledged that the conditions of trench warfare affected soldiers in diverse ways, all of which were conducive to nervous and mental breakdown.<sup>11</sup> The initial emphasis on the war as supreme causative agent militated against purely physical theories, and encouraged doctors to consider possible psychological pressures. As an anonymous author explained, the important point was not whether the symptoms resulted from ‘psychical or physical traumata’, but that ‘they are the product of modern warfare under modern conditions’.<sup>12</sup> Although the exact aetiologies of these disorders were a matter of concern for doctors attempting to formulate theories and devise treatments, at this very early stage there was also a distinct effort to emphasise their shared origin above their different manifestations.

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<sup>9</sup> [Anon.], ‘The commotional syndrome in war’, *BMJ* 1915 (2), pp. 185-6, p. 186.

<sup>10</sup> [Anon.], ‘The war and nervous breakdown’, p. 189; [Anon.], ‘Insanity and the war’, *Lancet* 1915 (2), pp. 553-4, p. 553; see also H.S. Pemberton, ‘The psychology of traumatic amblyopia following the explosion of shells’, *Lancet* 1915 (1), p. 967; Turner, ‘Remarks on cases of nervous and mental shock’, p. 835.

<sup>11</sup> See, for example, A. Feiling, ‘Loss of personality from “shell shock”’, *Lancet* 1915 (2), pp. 63-6, p. 63; [Anon.], ‘Mental and nervous shock among the wounded’, *BMJ* 1914 (2), pp. 802-3, p. 802.

<sup>12</sup> [Anon.], ‘Lord Knutsford’s special hospitals for officers’, p. 1201.

Although the facts of war service and the manifold effects of the modern battlefield were one reason doctors resisted pigeonholing disorders as ‘physical’ or ‘psychological’, such rigid distinctions were also alien to the conceptual framework of pre-war medicine. The theory of psycho-physical parallelism enabled mental disorder to be explained as the result of either psychological or somatic processes, and allowed for a considerable degree of latitude in ascribing ultimate causes. The four main terms used to describe disorders in soldiers in the early months of the war – ‘traumatic’, ‘nerves’, ‘shock’, and ‘functional’ – reflected this theoretical ambiguity or neutrality. All these designations were open to interpretation and had shifting connotations in pre-war medical discourse. The previous chapter discussed the particular resonances of ‘trauma’. ‘Nerves’ was an equally imprecise concept: although medicine might be expected to be the last bastion of a specifically anatomical usage, the context of discussions of ‘nervous’ symptoms in soldiers suggests that the psychological implications increasingly prevalent in the term in the pre-war years had infiltrated even this sphere.<sup>13</sup> ‘Shock’ also embraced the psychological and the physiological. In his 1892 account of ‘shock from fright’, Herbert Page denied that shock produced a ‘molecular disturbance of the cerebro-spinal centres’, but nevertheless it acted through and upon the body to produce a ‘purely dynamical nervous derangement’.<sup>14</sup> In 1917, Jasper Wilson, a captain in the RAMC, refused to use the term because of its ‘varied significance’. Not only were there several different types of shock - ‘surgical shock, psychical shock, apoplectic shock, commotio cerebri, diaschisis’ - but even ‘in its best recognised form, surgical shock, the physiological mechanism which has been interfered with to produce the symptoms is unknown’.<sup>15</sup>

It is uses of the term ‘functional’, however, which best reflect the continuity with pre-war thought, and undermine simplistic readings of early theories of the nervous and mental disorders of war. In the opening months of the war, the point when the conventional historiographical outline leads us to believe that they were most rife, overtly physical explanations for the war neuroses were rarely employed. But where such theories were put forward, it was in the context of widespread acceptance of the functional nature of most cases. The two most detailed expositions of physical theories

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<sup>13</sup> See G.S. Rousseau, *Nervous acts: essays on literature, culture and sensibility* (Basingstoke: Palgrave Macmillan, 2004), p.65-6, on the psychological dimensions of ‘nerves’ in the early twentieth century.

<sup>14</sup> H.W. Page, ‘Shock from fright’, in *DPM2*, pp. 1157-60, p. 1158.

<sup>15</sup> J.G. Wilson, ‘The effects of high explosives on the ear’, *BMJ* 1917 (1), pp. 353-5, p. 353.

made before 1916 were by the physiologist Thomas Elliott (1877-1961), and the ophthalmologist John Evans. The rhetorical strategy of these authors is more telling than their employment of physical theories. Both argued that although the majority of cases were undoubtedly functional, it was nevertheless possible that some resulted from actual organic lesions. Their articles were put forward as an attempt to highlight this alternative, and to provide aids for differential diagnosis.<sup>16</sup> It appears that at this stage, symptoms were readily diagnosed as functional, and organic origin was only considered after this possibility had been apparently ruled out. This was certainly the case for Arthur Hertz (later Hurst), who only questioned whether an 'obviously hysterical' man might have incurred organic damage after suggestion had failed to effect a cure.<sup>17</sup> Authors were still warning that the possibility of organic causation should not be excluded in apparently functional cases well into 1916, although voices were now also heard arguing that the real danger was misdiagnosis of psychological disorders as organic.<sup>18</sup>

However, as argued in chapter three, 'functional' did not automatically imply 'psychological'. A report on 'the pathology of shell concussion' in August 1915 argued that cases of instantaneous death were caused by rapid and dramatic changes in atmospheric conditions produced by explosions. The author suggested that cases of 'acute neurasthenia', a recognised 'functional' disorder, might be the result of similar although less extensive damage to the nervous system.<sup>19</sup> Other authors saw the problem as determining where physical injury ended and functional disturbance began.<sup>20</sup> The strategy of coupling an essentially psychological explanation with nominal allegiance to the existence of an underlying physical pathology also continued into the war. For example, John Herbert Parsons (1868-1957), ophthalmic consultant to the home troops, proposed to regard traumatic amblyopia as 'wounds of consciousness' because there was 'no demonstrable organic lesion'. He added the cautious proviso that 'this does not imply that there is no neural lesion to account for the psychological disorder, but

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<sup>16</sup> Elliott, 'Transient paraplegia'; J.J. Evans, 'Organic lesions from shell concussion', *BMJ* 1915 (2), p. 848.

<sup>17</sup> A. Hertz [Hurst], 'Paresis and involuntary movements following concussion caused by a high explosive shell', neurological section, *PRSM* 8:2 (1914-1915), pp. 83-4, p. 84.

<sup>18</sup> [Anon.], 'Medical societies: Brighton and Sussex Medico-Chirurgical Society', *Lancet* 1916 (1), p. 1042; M. Culpin, 'Practical notes on functional disorders', *BMJ* 1916 (2), pp. 548-9.

<sup>19</sup> [Anon.], 'The pathology of shell concussion', *BMJ* 1915 (2), pp. 264-5, p. 265.

<sup>20</sup> This is a recurrent theme in Harris, *Nerve injuries and shock*: see p. 5, p. 31, p. 50, p. 93 and p. 98.

merely that it has hitherto escaped observation'.<sup>21</sup> This was not mere rhetoric designed to appease thoroughgoing materialists. The entire mode of medical thought tended to break down the distinction between physical and psychological damage, stressing the interchange between these different types of disorder. Some authors held that an initially functional disturbance might become 'structural and permanent'; others that, as physical damage healed, the symptoms maintained were purely functional; still others that there might remain an organic basis on which apparently hysterical symptoms, such as transient paraplegia, might be grafted.<sup>22</sup> In all these explanations, and elsewhere, the tendency was to suggest that physical and psychological damage co-existed in most cases.<sup>23</sup>

The possible physical causes of wartime functional disorders were debated, but these were not perceived as limited to the effects of bursting shells. The laryngological section of the Royal Society of Medicine, for example, regularly put forward cases of 'functional' aphonia in soldiers for members to comment on. These discussions reveal the level of disagreement among doctors even on individual cases: at meetings throughout 1915 and 1916, some diagnosed 'pure' functional disorder, others pointed to the co-existence of a functional element with anatomical irregularities, and still others touted the possibility of incipient or developed tubercular disease.<sup>24</sup> In these meetings, the possibility that concussion or commotion (the theory that the dynamic force exerted by explosions caused decompression within the organism)<sup>25</sup> had produced

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<sup>21</sup> J.H. Parsons, 'The psychology of traumatic amblyopia following explosion of shells', neurological section, *PRSM* 8:2 (1914-1915), pp. 55-65, pp. 56-7; see also [Anon.], 'The war and nervous breakdown', p. 189.

<sup>22</sup> [Anon.], 'The disabled soldier in France', *BMJ* 1916 (2), p. 499; W.H. Jessop in 'Special discussion on shell shock without visible signs of injury', sections of psychiatry and neurology (combined meeting), *PRSM* 9:3 (1915-1916), pp. i-xliv, p. xxxvi; Turner, 'Remarks on cases of nervous and mental shock', p. 835; [Anon.], 'Shell explosions and the special senses', p. 663.

<sup>23</sup> [Anon.], 'Special hospitals for officers', p. 1157; Collie, 'Neurasthenia', p. 526; T.E. Harwood, 'A preliminary note on the nature and treatment of concussion', *BMJ* 1916 (1), p. 551; T.E. Harwood, 'Three cases illustrating the functional consequences of head-injuries', *Lancet* 1916 (2), p. 431.

<sup>24</sup> See, for example, C. Potter, 'Case of gunshot wound of the neck with laryngeal symptoms for diagnosis and opinions as to treatment', laryngological section, *PRSM* 8:2 (1914-1915), p. 116; 'Discussion on functional cases', laryngological section, *PRSM* 8:2 (1914-1915), pp. 117-20; W. Milligan, 'A note on treatment of "functional aphonia" in soldiers from the Front', laryngological section, *PRSM* 9:2 (1915-1916), pp. 83-5; C. Potter, 'Case of aphonia in a soldier', laryngological section, *PRSM* 9:2 (1915-1916), pp. 90-2; L.H. Pegler, 'Case of (?) nervous or functional aphonia', laryngological section, *PRSM* 9:2 (1915-1916), pp. 118-20. The same arguments were still being made in 1918: see 'Discussion: war neuroses', section of laryngology, *PRSM* 11 (parts 1 and 2) (1917-1918), pp. 185-200.

<sup>25</sup> Although authors on shell-shock did not explicitly make this link, a variant of this theory was put forward to explain altitude sickness or 'aerosthenia' in pilots. See [Anon.], 'The influence of altitude on the nervous system', *Lancet* 1916 (1), pp. 36-7; [Anon.], 'The physiology of flying', *BMJ* 1917 (2), p.

the symptoms was not even raised. Inevitably, as the most dramatic feature of modern warfare was the enormous quantity of high explosives used, authors lingered on their possible effects. But actual damage to the nervous system was only one of these results; even at a very early stage, authors pointed out that often the shell explosion was only the final straw which precipitated breakdown in an already run-down man.<sup>26</sup> Another popular theory was that the cumulative effect of prolonged shelling was a sensory overload which inhibited the function of the special senses.<sup>27</sup> In one account, the functional deafness produced by the auditory effects of shells was compared to that found in 'boilermakers, riveters, blacksmiths, and people working on railways'.<sup>28</sup> The battlefield was here configured as a gross extension of the pathological modern industrial environment.

It is clear that purely physical theories of causation did not dominate the field in the opening years of the war. Furthermore, evidence of relatively sophisticated psychological theories can also be found at a very early date. In March 1915, the neurological section of the Royal Society of Medicine held a discussion on traumatic amblyopia. No participants referred to commotion or concussion. One stated that the disturbance was 'purely mental and belonged to the region of ideas'; another explained this 'mental condition' in a case he had seen as a result of the man's anxiety about the welfare of his wife and children; and the final respondent, Hugh Crichton Miller (1877-1959) expounded the theory of 'defence' and 'anxiety' mechanisms produced by intolerable mental conflict.<sup>29</sup> A few months later Adolphe Abrahams attributed a case of hysterical paraplegia to the patient's 'anxiety-neurosis that the burden on a cripple

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662. The concept of commotion had a much older history: it was defined in a French medical text of 1834 as 'the shock experienced by certain parts of the body on the occasion of falls or when being stricken'. It was sometimes used to describe the effects of railway accidents, including symptoms such as memory loss which would now be understood as psychological. See Schivelbusch, *The railway journey*, p. 137.

<sup>26</sup> Turner, 'Remarks on cases of nervous and mental shock'; [Anon.], 'Special hospitals for officers', p. 1155; W. Milligan and F.H. Westmacott, 'Warfare injuries and neuroses: introductory paper', laryngological section, *PRSM* 8:2 (1914-1915), pp. 109-14, p. 113; Campbell, 'War neuroses', p. 501.

<sup>27</sup> Inhibition of function, rather than a disturbance caused by an actual lesion, was often the explanation for disturbances of the special senses, although sometimes it was only implicitly related to shell explosions. See Milligan and Westmacott, 'Warfare injuries and neuroses', p. 114; Parsons, 'The psychology of traumatic amblyopia', pp. 62-3; Harris, *Nerve injuries and shock*, p. 109 and p. 121; [Anon.], 'Lord Knutsford's special hospitals for officers', p. 1201.

<sup>28</sup> [Anon.], 'Shell explosions and the special senses', p. 663.

<sup>29</sup> Farquhar Buzzard, Leslie Paton, and Crichton Miller in 'Discussion: the psychology of traumatic amblyopia following explosion of shells'. After serving with the RAMC in Egypt, and as consultant neurologist to the 4th London General Hospital, Crichton Miller founded the Tavistock Clinic in 1920.

should not be laid to his charge'.<sup>30</sup> Although the terminology of these examples is unusual, authors who adhered to a physical theory of causation for certain cases might also display sensitivity to the importance of terrifying 'psychical experiences' and anxiety over the performance of duty in other cases.<sup>31</sup> The more elaborate psychological theories formulated over the next few years were not new discoveries, but an evolution.

### **1916: a turning point, but in which direction?**

In 1916, debates on the war neuroses moved into a new gear. Twenty-three signed articles on the nervous and mental disorders of war were published in medical journals, nearly three times the number for the previous year, and the volume of work on the subject would continue to expand for the remainder of the war. There was a new seriousness to these discussions, a more widespread commitment to grappling with shell-shock as a scientific problem. No doubt this change in tone partially reflected the simple fact that doctors had by this point seen large numbers of cases, and collectively and individually devoted attention to the nervous and mental disorders of war for several months. Consequently, they were now in a position to develop more sustained arguments and to formulate conclusions rather than merely raise questions. There was also acceptance that Britain was now in the war for the long haul, and that the number of these cases showed no signs of abating. The inability to deal with shell-shock in the individual not only posed dangers for the fighting unit in the field, but, given the apparent intractability of some cases, the possibility of a manpower crisis loomed. From January 1916, 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', the medical community displayed a new engagement with the mental health of the army and its consequences for the fighting strength of the nation in both military and civilian spheres.

One manifestation of this more serious approach was increasing criticism of 'shell-shock' as a viable diagnostic label. It had initially appealed at least partly because, as in Myers' original article, it was non-committal as to the physical or psychological origins

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<sup>30</sup> Abrahams, 'A case of hysterical paraplegia', p. 179.

<sup>31</sup> Turner, 'Remarks on cases of nervous and mental shock', p. 833 and p. 835.

of the disorders it described.<sup>32</sup> But it rapidly became apparent that, precisely because of its ability to skate over such differences, ‘shell-shock’ was useless for practical purposes. Less than a year after its first appearance in print, Henry Head impatiently complained that ‘shell-shock’ did not exist: the term only bracketed together ‘a heterogeneous collection of different nervous affects from concussion to sheer funk, which have merely this much in common that nervous control has at last given way’. The effort to subsume all these disorders under one heading was comparable to an attempt ‘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’.<sup>33</sup> The rejection of terminologies which tried to embrace symptomatic manifestations linked only by their appearance in combatants proceeded alongside – and was a logical necessity imposed by – the more vigorous attempt to discriminate between types of mental and nervous disorders of war.<sup>34</sup>

The exploratory tone of pre-1916 accounts, which attempted to blend physical and psychological causes and symptoms, was not overturned completely or immediately. The tendency to invoke emotion, defined variously and sometimes simultaneously as physiological or psychological experience, as a significant aetiological factor in certain respects continued this trend of commingling elements across the mind-body divide (this aspect will be discussed more fully in the next two chapters). But the trend towards differentiation had two important consequences, neither of which tally entirely with the conventional historiographical narrative of a transition to psychological understanding. The first, which will be examined presently, was the emergence of sustained and elaborate theories of physical causation. This event has been obscured by the focus on more explicit psychological theorising in 1916.<sup>35</sup> These developments

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<sup>32</sup> Myers, ‘A contribution to the study of shell shock’, p. 320.

<sup>33</sup> [Anon.], ‘A discussion on shell shock’, *Lancet* 1916 (1), pp. 306-7, p. 306.

<sup>34</sup> One of the features of discussions in 1916 was a more vigorous attempt to differentiate between types of war nervous and mental disorders. Campbell, ‘War neuroses’; W.A. Turner, ‘Arrangements for the care of cases of nervous and mental shock coming from overseas’, *Lancet* 1916 (1), pp. 1073-75, p. 1073; W. Garton, ‘Shell shock and its treatment by cerebro-spinal galvanism’, *BMJ* 1916 (2), pp. 584-6; Buzzard, ‘Warfare on the brain’, p. 1096; [Anon.], ‘The mental factor in modern war: shell shock and nervous injuries’, in *The Times History of the War* (London, The Times, 1916), pp. 313-48, p. 320.

<sup>35</sup> M.D. Eder, ‘An address on the psycho-pathology of the war neuroses’, *Lancet* 1916 (2), pp. 264-8; C.S. Myers, ‘Contributions to the study of shell shock (II): being an account of certain cases treated by hypnosis’, *Lancet* 1916 (1), pp. 65-9; C.S. Myers, ‘Contributions to the study of shell shock (III): being an account of certain disorders of cutaneous sensibility’, *Lancet* 1916 (1), pp. 608-13; Myers, ‘Contributions to the study of shell shock (IV)’, *Lancet* 1916 (1), pp. 608-13; Myers, ‘Contributions to the study of shell shock (IV)’, *BMJ* 1916 (1), pp. 441-3; G.E. Smith, ‘Shock and the soldier. I’; G.E. Smith, ‘Shock and the soldier. II’, *Lancet* 1916 (1), pp. 853-7.

were two sides of the same coin: psychological explanations could not be defined *in opposition to* physical theories until the latter had been formulated in detail. The second trend was the tendency to displace responsibility for mental breakdown from the war to the material it worked on, the individual soldier. As with the formulation of physical theories of causation, this was part of the movement towards increasing differentiation of the nervous and mental disorders of war.

The attempt to exculpate the war proceeded in two directions. The first, found almost exclusively among the 'psychological' theorists, explained symptoms by recourse to events in the patient's past life history. Although they did not discount entirely the role of war experience, a variety of such commentators argued that the origins of the symptom, or of the breakdown itself, were to be found in the previous experiences of the individual and his unique mental 'make-up' rather than simply the distressing occurrences of the war itself. The war might cause even the strongest individual to break down, but equally or more often it had simply set the spark to the flammable material in the patient's own psyche.<sup>36</sup> In the other direction, several authors argued that it was mainly those who possessed an inherently unstable nervous system who developed mental and nervous disorders.<sup>37</sup> There was no clear-cut dividing line between these two explanations: most authors maintained that both heredity and life experience were important factors, although giving more weight to one than the other.<sup>38</sup> Nevertheless, the trend towards absolving the war of ultimate responsibility for breakdown is beyond question. By 1916 the war was becoming part of the fabric of life rather than an extraordinary intrusion, but it was also the year conscription was introduced, the year of the Somme, the year in which the crisis was visibly deepening and the unity of the war effort became ever more important. In this context, it seems most significant that across the board doctors, whether biased towards psychological or

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<sup>36</sup> Myers, 'Contributions to the study of shell shock (III)', pp. 610-11; Myers, 'Contributions to the study of shell shock (IV)', p. 466; Rows, 'Mental conditions following strain and nerve shock'; Smith, 'Shock and the soldier. I', pp. 814-5; William Brown in 'Special discussion on shell shock', pp. xxvii-xxx.

<sup>37</sup> Campbell, 'War neuroses', pp. 501-3; J.M. Clarke, 'Some neuroses of the war', *Bristol Medico-Chirurgical Journal* 34:130 (July 1916), pp. 49-72, p. 59; Savage, 'Mental disabilities for war service', p. 653; 'Discussion: mental disabilities for war service', *JMS* 62:259 (October 1916), pp. 815-20; [Anon.], 'Reports of societies: mental disabilities for war service', *BMJ* 1916 (2), pp. 179-80; see the contributions of Stansfield and Fearnside to 'Special discussion on shell shock', p. xxx and p. xxxix.

<sup>38</sup> See, for example, Smith and Pear's denial of Robert Armstrong-Jones' assertion that they were 'out-and-out environmentalists'. Armstrong-Jones, 'The pathology of the barbed wire', pp. 1-2; G.E. Smith and T.H. Pear, 'Letters to the editor: shell shock and its lessons', *Nature* 100 (Sept. 1917-Feb. 1918), pp. 64-6, p. 65; see also G.E. Smith, 'Correspondence: "the psychoneuroses of war"', *BMJ* 1917 (2) [September 22 1917], p. 402; Rivers, 'War-neurosis and military training', fn 1, p. 18.



physical explanations, began to argue that the pathology of the war neuroses was to be found in the individual rather than in the environment of war.

There is particular significance to the invocation of heredity as an important aetiological factor in shell-shock. In the early months of the war it was rare for authors to even hint that existing nervous instability might account for symptoms in soldiers.<sup>39</sup> For the most part, the conditions of war alone were judged sufficient to account for at least less severe breakdowns. As a report in the *British Medical Journal* argued, although usually insanity developed in individuals with 'some antecedent peculiarities', not only were combatants subject to a rigorous selection procedure, but the 'terrible stresses' of trench life meant that breakdowns occurred 'in circumstances very different from those of ordinary life'. Nervous soldiers should 'be regarded and spoken of as mentally war wounded; they are verily instances of trauma'.<sup>40</sup> This was a complete revolution from the dominant position of pre-war psychological medicine. The temporary retreat of heredity as a viable explanation, rather than speculation on the effects of high explosives, was the most surprising aspect of discussions on the war neuroses until the end of 1915. This withdrawal, however, was short-lived.

The resurgence of heredity as an explanatory factor in theories of the war neuroses also has an impact on the historiographical thesis of a transition to psychological understanding. One part of this argument is that the reliance of pre-war medicine on notions of hereditary degeneration was undermined by the experience of shell-shock.<sup>41</sup> In the final years of the war and beyond, it was still common to find authors commenting on the prevalence of 'neuropathic or psychopathic disposition', or 'hereditary taint' among soldiers suffering from mental or nervous disorders.<sup>42</sup> Even where statistics were collected which appeared to show that there was no personal or

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<sup>39</sup> See, however, Myers, 'A contribution to the study of shell shock', p. 317; [Anon.], 'The war and nervous breakdown', p. 189; [Anon.], 'Special hospitals for officers', pp. 1155-56.

<sup>40</sup> [Anon.], 'The Mental Treatment Bill', *BMJ* 1915 (1), pp. 771-2, p. 772; see also [Anon.], 'Insanity and the war', *Lancet* 1915 (2) [September 4 1915], pp. 553-4, p. 553.

<sup>41</sup> Stone, 'Shellshock and the psychologists', p. 245; Feudtner, "'Minds the dead have ravished'", p. 410.

<sup>42</sup> See, for example, Adrian and Yealland, 'The treatment of some common war neuroses', p. 868; [Anon.], 'Reports of societies: shell shock', *BMJ* 1917 (2), p. 81; Hotchkis, 'Renfrew District Asylum as a War Hospital', p. 246; Burton-Fanning, 'Neurasthenia in soldiers', p. 907; R.H. Steen in 'Discussion: functional gastric disturbance in the soldier', *JMS* 63:260 (January 1917), pp. 144-8, p. 144; Turner, 'The Bradshaw lecture', p. 613; Weatherly, 'The war and neurasthenia, psychasthenia and mild mental disorders. I', p. 217; McDowall, 'The genesis of delusions', pp. 187-8; Eager, 'A record of admissions', p. 277, p. 280, p. 284, p. 290; summary of findings, *RWOCESS*, pp. 95-6; J.P. Stewart, 'The treatment of war neuroses', *ANP* 1:1 (January 1919), pp. 14-24, p. 15.

family history of nervous or mental instability, the importance of these results was minimised by arguing that the methods of investigation were unreliable and that the actual incidence of predisposition must be higher.<sup>43</sup> Attempts to investigate the validity of theories of degeneration might reach surprising conclusions. In 1919 H. Laing Gordon, physician to the Lancaster Clinic of Psychotherapy, conducted a survey of shell-shocked soldiers in order to discover whether dark eye colour and abnormal palate, popularly believed to be degenerative stigmata, were prevalent. He found that a high proportion of nervous soldiers bore these features, but nevertheless ended his article by suggesting that estimations of susceptibility to nervous disorders would probably 'be reached more readily through psychopathology than through somatic pathology'.<sup>44</sup>

Although heredity continued to play a large part in many accounts of shell-shock, it was not uniformly emphasised. Tooth, for example, believed that given the manifold stresses 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'.<sup>45</sup> It was also often acknowledged that although hereditary predisposition increased the likelihood of breakdown and might be an operative factor in a large number of cases, even 'the strongest nervous system' might be 'shattered' by the experience of trench warfare.<sup>46</sup> The doctrine of heredity therefore appears to have been undermined to some extent by the experience of war, but the limits of this process should not be ignored. The conclusions of the Committee of Enquiry are a good guide in this respect: it was argued there that 'predisposition plays an immense part in the incidence of shell shock', but listed the 'dominant factors concerned in [...] the pre-disposition to mental and nervous disorders' as heredity, environment, training, and education in childhood.<sup>47</sup> The definition of 'predisposition' was widened, but heredity was not entirely discounted. Even Charles Myers' *Shell shock in France* (1940) stated its aim as to convince the

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<sup>43</sup> R. Eager, 'War psychoses occurring in cases with a definite history of shell shock', *BMJ* 1918 (1) [April 13 1918], pp. 422-5; O.P.N. Pearn, 'Psychoses in the Expeditionary Forces', *JMS* 65:269 (April 1919), pp.101-8, pp. 101-2; an exception is Gordon, 'War neuroses', pp. 363-4.

<sup>44</sup> H.L. Gordon, 'Eye-colour and the abnormal palate in neuroses and psychoses', *Lancet* 1919 (2), pp. 9-10.

<sup>45</sup> Tooth, 'Neurasthenia and psychasthenia', p. 339.

<sup>46</sup> J.S. Bury, 'Remarks on the pathology of the war neuroses', *Lancet* 1918 (2), pp. 97-9, p. 98; Grimbley, 'Neuroses and psycho-neuroses of the sea', p. 244; summary of findings, *RWOCESS*, p. 144; Macpherson *et al* (eds), W.P. Herringham, T.R. Elliot and A. Balfour (eds), *History of the Great War*, p. 14.

<sup>47</sup> Summary of findings, *RWOCESS*, p. 148.

reader 'how dependent [the disorder] is 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*'.<sup>48</sup>

### **Frederick Mott and the historiography of shell-shock**

One doctor whose views on the importance of heredity in the causation of nervous and mental disorders were not changed one iota by the war was Frederick Mott (1856-1926). Mott is usually portrayed as an unreconstructed Victorian (with all that popular understanding of that epithet implies), unprepared for the experience of shell-shock by his pre-war post as pathologist to the London County Council Asylums, out of his depth with living patients, and unable to comprehend psychological thinking, particularly because his wartime experience was confined to the home front.<sup>49</sup> There are elements of truth in this composite picture, but it is not the whole story. Sixty-three when the war broke out, Mott was always more comfortable with brains fixed in formaldehyde than the philosophy of mind, and his explanations of human behaviour were more likely to draw on his classical education than the latest psychological research.<sup>50</sup> But he was not antagonistic to such ideas. He would happily quote Jung in the same breath as the rabidly anti-psychoanalytic alienist Charles Mercier when he thought both were speaking common sense.<sup>51</sup> Ernest Jones (1879-1958), a pioneer of psychoanalysis in Britain, recalled that in 1910 Mott had written 'congratulating [him] on "spreading the knowledge of Freud's valuable work"', although he conceded that the correspondent had 'little psychological aptitude'.<sup>52</sup> This shortcoming did not result from lack of contact with living patients, either before or during the war. Although Mott's focus was on pathological research, he retained the post of consulting physician to the Charing Cross Hospital from the 1890s until his retirement in 1923, believing it

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<sup>48</sup> Myers, *Shell shock in France 1914-18*, p. ix; see also Hurst, *Medical diseases of war* [1944], p. 1 and p. 3.

<sup>49</sup> Shephard, *A war of nerves*, p. 6, p. 17, p. 30, p. 76, p. 88 and p. 111-2; Jones and Wessely, *Shell shock to PTSD*, pp. 23-4.

<sup>50</sup> See particularly F.W. Mott, 'The study of character by the dramatists and novelists', *JMS* 61:254 (July 1915), pp. 339-44.

<sup>51</sup> However, he did believe that only the most exceptional physicians had the necessary 'experience, knowledge of technique, high moral principles, tact, and delicacy of feeling' to carry out psychoanalysis successfully. F.W. Mott, 'A British Medical Association lecture on psychology and medicine', *BMJ* 1923 (1), pp. 403-8, p. 404 and p. 407.

<sup>52</sup> Jones, *Free associations*, p. 123.

essential to keep 'in contact with general medicine and clinical neurology'.<sup>53</sup> The grainy photographs of stained cell slides littered among his writings on shell-shock are no more prominent than his discussions of the war experiences, dreams, and life histories of individual patients.

One the eve of the war, Mott was best known for his pathological researches, and particularly his establishment of general paralysis as a late stage of syphilis rather than an independent mental disorder.<sup>54</sup> He was also an active campaigner for reforms which would put psychiatry on a more sound professional footing. The institution of the pathological laboratory at Claybury, as well as his founding of the *Archives of Neurology* in 1900 as a platform for the researches conducted there, was one aspect of these efforts towards a scientific psychiatry. He started a course of instruction for students taking the Cambridge Psychological Diploma, and in 1919 contributed to setting up a similar diploma for the University of London. In 1907 he put forward a plea for the establishment of a centre for research into and treatment of mental disorder in its early stages, a wish granted when Henry Maudsley stepped forward with the necessary funds. Mott was actively involved in the planning of this centre, and the Maudsley Hospital opened under his supervision in 1916.<sup>55</sup> All these efforts were driven by his conviction that the apparent increase in the insane was one of the most pressing social issues of the day. His earlier researches had explored the effects of syphilis and alcohol, two of the great Victorian evils, on the central nervous system. In the years immediately before the war his interest turned to the problem of the causation of insanity.<sup>56</sup> Mott's involvement with shell-shock during the war should be viewed as

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<sup>53</sup> C. von Monakow, 'Sir Frederick Mott, K.B.E.: his life and work' in J.R. Lord (ed.), *Contributions to psychiatry, neurology and sociology dedicated to the late Sir Frederick Mott, K.B.E.* (London: H.K. Lewis, 1929), pp. 383-89, p. 383. Mott also provided a vivid account of the patient pool at the Charing Cross Hospital in F.W. Mott, 'Alcohol and its relations to problems in mental disorders', in E.H. Starling, *The action of alcohol on man* (London: Longmans, Green, and Co., 1923), pp. 183-212, p. 187.

<sup>54</sup> C. Quézel, *History of syphilis* (Cambridge: Polity Press, 1990), pp. 162-4; see also *MR4*, pp. 358-9; G.H. Savage, 'Syphilis and insanity', *Practitioner* 92:5 (May 1914), pp. 601-11, p. 601; Cole, *Mental diseases* [1913], p. 182.

<sup>55</sup> Mott, 'Preface', pp. iii-vii; [Anon.], 'The Maudsley Hospital', *BMJ* 1917 (1), p. 51; F.W. Mott, 'The second Maudsley lecture', *JMS* 67:278 (July 1921), pp. 319-39, pp. 319-325; [Anon.], 'The Maudsley Hospital', *JMS* 69:285 (April 1923), pp. 151-55; [Anon.], 'Occasional notes: the London County Council and Sir Frederick Mott, K.B.E., F.R.S.', *JMS* 69:285 (April 1923), pp. 220-4; [Anon.], 'Obituary: Sir Frederick Mott', *Lancet* 1926 (1), pp. 1228-30; [Anon.], 'Obituary: Sir Frederick Mott', *BMJ* 1916 (1), pp. 1063-66.

<sup>56</sup> These interests are demonstrated in the chronological bibliography of Mott's work in Lord (ed.), *Contributions to psychiatry, neurology and sociology*, pp. 391-401. For his comments on the growth of insanity as a pressing social problem, see F.W. Mott, 'Sanity and insanity', *Journal of the Royal Sanitary*

an outgrowth of this sincere interest in using medical knowledge to solve the problems facing modern society rather than the bumbling intrusion of a pathologist into an unfamiliar and uncongenial sphere.

Mott is an important figure for the student of shell-shock for many reasons. He entered the debates on shell-shock in 1916, and by the end of the war had published ten articles on the subject, more than any other single author. Historiographically, Mott is the doctor associated above all with physical theories of causation.<sup>57</sup> That Mott was the foremost proponent of such theories is not in doubt. From 1916 until the end of the war and beyond, he doggedly insisted on the 'commotional' origin of some cases of war neuroses. Nevertheless, Mott has also been misrepresented. He always acknowledged the influence of a range of aetiological factors, and never once argued that all cases of mental and nervous disorders had a physical basis. Historians have failed to recognise the particulate and differentiated nature of Mott's theories, apparently assuming that he had an overarching theory of the war neuroses which was firmly rooted in physical causation.<sup>58</sup> The fact that even the arch-advocate of organic pathology allowed a place in his theories for psychological factors underlines the complexity of views on the war neuroses, while his stubborn adherence to physical theories throughout and after the war is representative of a small, but not insignificant body of opinion. The diminishing proportion of cases he attributed to such changes is also typical of a more general shift in attitudes. An examination of Mott's writings suggests that although psychological thinking gained some ground during the war, the chronology, context, and extent of this progress differs significantly from that set out in most histories of shell-shock.

To a certain extent, Mott's work can be used as a litmus test of the validity of the thesis that shell-shock forced a transition to psychological understanding of mental disorders. This can be illustrated by an examination of Ben Shephard's argument in *A war of nerves*, rapidly becoming the standard history of shell-shock. Mott is pivotal to his account. Shephard attributes the (assumed) predominance of organic theories in the first two years of the war to Mott's influence, and uses Mott's statement in February

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*Institute* 33 (1912-1913), pp. 228-51, p. 228; F.W. Mott, 'A study of the neuropathic inheritance', *American Journal of Insanity* 69 (1912-1913), pp. 907-38.

<sup>57</sup> See Leese, *Shell shock*, p. 52 and p. 70; Holden, *Shell shock*, p. 18 and p. 33; Bogacz, 'War neurosis and cultural change in England, 1914-22', p. 238; Bourke, *Dismembering the male*, p. 115.

<sup>58</sup> See for examples Shephard, 'Shell-shock', p. 34; Merskey, 'Shell-shock', p. 252; Jones and Wessely, *Shell shock to PTSD*, p. 23.

1916 that even the strongest man could break down under the influence of trench warfare as evidence that the tide of opinion was turning in favour of psychological theories. The publication of a survey of cases by Harold Wiltshire, a captain in the RAMC working at a base hospital in France, which purported to show that physical damage to the nervous system had no influence on symptoms, is seen as the final nail in the coffin of physical theories, which Shepard argues were 'dead and discredited' by the end of the year.<sup>59</sup> The use of Wiltshire's article is misjudged. Although he devoted considerable space to possible 'psychic causes', as had several other authors until this point, Wiltshire also repeatedly invoked 'neuropathic disposition' or 'taint' as a significant factor in the development of war neurosis.<sup>60</sup> There is also no evidence that this article had any real impact on medical opinion. It was rarely cited during the war, and those doctors who referred to it rarely agreed with all its conclusions.<sup>61</sup>

More important for current purposes is the role attributed to Mott in this account. In his earliest article which referred to the war neuroses, published in December 1915, Mott argued that mutism was caused by emotional shock and maintained by 'depressing emotional conditions'.<sup>62</sup> The claim three months later that even the 'strongest nervous system' might shatter under the onslaught of trench warfare is therefore not adequate proof that his opinions were shifting in favour of a psychological explanation.<sup>63</sup> The relatively late date of this first publication also belies Shepard's assertion that Mott was 'the dominant voice in London' for the first two years of the war. No sources are produced in support of this statement, and there are no references to Mott in the contemporary literature on the war neuroses before 1916 which would provide a clue to his beliefs before his first publications.<sup>64</sup> There is, however, plenty of evidence for

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<sup>59</sup> Shepard, *A war of nerves*, pp. 30-1.

<sup>60</sup> H. Wiltshire, 'A contribution to the etiology of shell shock', *Lancet* 1916 (1), pp. 1207-12, especially p. 1209-10.

<sup>61</sup> Hurst, *Medical diseases of the war* [1917], p. 5, and Turner, 'The Bradshaw lecture', p. 615, both referred to Wiltshire's article but maintained that certain cases resulted from physical injury. Only Smith and Pear referenced it without reservations. Smith and Pear, *Shell shock and its lessons*, 2nd edn, p. 5 and p. 10.

<sup>62</sup> F.W. Mott, 'The psychic mechanism of the voice in relation to the emotions', *BMJ* 1915 (2), pp. 845-7, p. 846.

<sup>63</sup> Mott, 'Lettsomian lectures. II', p. 448.

<sup>64</sup> In 1940, Myers claimed that in May 1915 Mott was attempting to show that shell-shock had a physical basis. It seems likely that the two were in contact at some point during the year, as in February 1916 Mott referred to notes written by Myers on a case of 'spinal concussion' which he had seen. Nevertheless, a comment made twenty-years after the event by someone who was in France at the time is not the best guide to medical opinion in London during the first two years of the war. Myers, *Shell shock in France 1914-1918*, p. 12; Mott, 'Lettsomian lectures. II', p. 442.

Mott's influence from 1916 onwards. This suggests that his championship of physical theories played a vital part in convincing others of their validity. Although such theories were tentatively touted from the beginning of the war, it was only from 1916 that authors began to argue surely and strongly for their plausibility, most often citing Mott in support.<sup>65</sup> It was also only at this point that other authors began to make a sustained case against the physical basis of shell-shock.<sup>66</sup> On this reading, the mid-point of the war did not witness the triumphal march of psychology so much as the emergence of distinct groups from within the welter of medical opinion.

### **Frederick Mott, shell-shock, and physical theories of causation**

In a series of lectures delivered in February and March 1916, Mott differentiated between three types of cases in which high explosives had an effect on the central nervous system. The first were immediately fatal cases, including those in which death occurred without visible injury. The second were cases of non-fatal wounds and injuries of the body. He concluded that as this group did not exhibit functional disturbances, there must be 'other factors at work in the production of nervous symptoms besides the aerial forces generated by the explosive'. The third group were cases of injury to the central nervous system without visible effects. He included 'functional neuroses and psychoses' in this category, explaining that although 'there may be no discoverable lesion in a "psychic trauma"', because 'every effect owns a cause' alterations in function 'must imply a physical or chemical change and a break in the links of the chains of neurons which subserve a particular function'.<sup>67</sup> This was a conventional restatement of the theory that because mind and body were interdependent, psychological disturbance must have a physical counterpart, even if it

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<sup>65</sup> For arguments in support of the theory of commotion published in 1916 by other authors, see Campbell, 'War neuroses'; Turner, 'Arrangements for the care of cases of nervous and mental shock', p. 1073; [Anon.], 'The war: nervous and mental shock', *BMJ* 1916 (1), pp. 830-2; Clarke, 'Some neuroses of the war', pp. 49-50; Garton, 'Shell shock and its treatment by cerebro-spinal galvanism'. One report on Mott's February 1916 lectures focussed on the physical theories he put forward at the expense of other aspects of his discussion, perhaps further suggesting that this was the most novel part of his argument. See [Anon.], 'Effects of high explosives on the nervous system: lecture by Major F.W. Mott, M.D.', *TMW* 6 (Jan-June 1916), p. 169.

<sup>66</sup> See Myers, 'Contributions to the study of shell shock (IV)', p. 464 (although Myers only explicitly rejected the theory of physical causation in relation to mutism here); Wiltshire, 'A contribution to the etiology of shell shock', pp. 1208-9; Buzzard, 'Warfare on the brain', pp. 1097-98.

<sup>67</sup> F.W. Mott, 'The Lettsomian lectures on the effects of high explosives upon the central nervous system. I', *Lancet* 1916 (1), pp. 331-8, p. 331.

was undiscoverable.<sup>68</sup> Although the direct effects of high explosives on the central nervous system accounted for some of these cases, Mott also included in his third group functional disorders which were attributed to the same causes invoked in civilian life.

The interdependence of physical and psychological factors in the causation of certain cases of war neurosis is a prominent theme running through Mott's writings. In his pre-war work on alcohol and insanity, he insisted that the effects of alcohol were not dependent only on 'the quantity and quality of the liquor taken', but all the 'physical and mental characteristics' which made up 'the personality of the individual'.<sup>69</sup> Even in his account of syphilis, a disease with a charted organic pathology, he had argued that 'the psychical trauma, the effect on the mind of a sensitive person in whom the moral sense has received a profound shock by the acquirement of what he knows is a loathsome, and believes to be an incurable disease', contrived with pathological changes to produce a state of nervous weakness.<sup>70</sup> This emphasis on the interrelation of mental and physical effects continued through his work on shell-shock. For example, when he suggested that certain cases of shell-shock might be caused by the noxious gases released when shells exploded, he also claimed that the excitable, the over-anxious, or those with a nervous predisposition would be more affected by the gas. In these cases and in those of physical shock, the emotional effect of the precipitating event was deemed to play an important part in the production of symptoms.<sup>71</sup> He believed that emotion set up a cycle of psychological and physiological reaction, as when a violent emotion caused a drop in blood pressure which restricted the supply of oxygen to the cortical cells.<sup>72</sup>

These examples demonstrate that Mott did not reject the influence of psychological elements even where he posited a predominantly physical aetiology for the development of symptoms. But from the first, he also differentiated between 'physical' and 'psychological' types of shell-shock, although this distinction emerged much more

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<sup>68</sup> See Veale, 'Some cases of so-called functional paresis', p. 607, and Bury, 'Remarks on the pathology of war neuroses', for equally conventional restatements of the possible physical basis of functional disorders.

<sup>69</sup> F.W. Mott, 'On alcohol and insanity', *BMJ* 1907 (2), pp. 797-803, p. 797.

<sup>70</sup> F.W. Mott, *Syphilis of the nervous system* (London: Henry Frowde and Hodder and Stoughton, 1910), p. 11 and pp. 193-8.

<sup>71</sup> Mott, 'Lettsomian lectures. II', p. 441; Mott, 'Lettsomian lectures. I', *Lancet* 1916 (1), pp. 331-338, p. 336; see also F.W. Mott, 'Punctiform haemorrhages of the brain in gas poisoning', *BMJ* 1917 (1), pp. 637-41.

<sup>72</sup> Mott, 'Lettsomian lectures. I', p. 336.



clearly in his later writings. His inconsistent use of 'shell-shock' is responsible for some of the historiographical confusion. In his opening address to the meeting on 'shell-shock without visible injury' in January 1916, he defined it as 'a term applied to a group of varying signs and symptoms indicative of loss of functions or disorder of functions of the central nervous system, arising from exposure to forces generated by high explosives'.<sup>73</sup> Throughout the piece, however, he actually used 'shell-shock' in a much more general sense, as an umbrella term which described the most significant identified event in the case histories of all sufferers, rather than a label which also explained the ways in which that event acted to cause the symptoms. In one place, he commented that in 'severe cases of "commotio cerebri," especially where there is concussion as well as psychic trauma', symptoms of psychosis might develop.<sup>74</sup> This statement presupposes that some cases proceed entirely from 'psychic trauma', and aims to point out an effect which might result when concussion is superadded. A further example of his belief in a purely or predominantly psychological category of shell-shock is the description of a case in which organic paraplegia had been diagnosed by another physician. Mott found no signs of organic disease, and convinced the man that he could walk if only he tried. A month later the man was apparently quite well.<sup>75</sup> This was perceived as a straightforward case of functional disorder.

There was a distinction in Mott's work between functional disorders which were perceived to have a predominantly psychological causation, and disorders which resulted from the direct (although invisible) physical effects of shell explosions on the central nervous system. This distinction was not absolute, and it could be difficult to determine into which group a particular case fell, but it nevertheless existed. The same piece from January 1916 described one soldier as suffering from 'shell shock and psychic trauma from witnessing death of comrades; psychic trauma maintained by terrifying experiences and dreams; nervous predisposition', and another simply as 'shell shock, without visible injury, from a 17-in. gun, affecting a gunner of fifteen years' service'. The term shell-shock was applied to both, but in the former Mott placed great weight on psychological factors, whereas in the latter he argued that 'functional disturbance due to emotional shock is not the sole cause of the symptoms'.<sup>76</sup> At the

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<sup>73</sup> Mott, 'Opening paper', p.i.

<sup>74</sup> Ibid., p. vi. My italics.

<sup>75</sup> Ibid., pp. xxii-xxiii.

<sup>76</sup> Ibid., pp. xxi-xxii and p. xiii.

close of the meeting Mott agreed with Henry Head that 'shell-shock' was an incorrect term as 'it covers a number of factors in the production of functional neuroses and psychoses observed in soldiers', and in his later work avoided the term without the use of qualifying statements.<sup>77</sup>

By mid-1917 Mott had clearly identified a class of 'true' or 'real' shell-shock, defined as cases in which there had been 'either concussion with loss of consciousness, or cerebral commotion with loss of consciousness, or inhalation of poisonous gas', and distinguished from functional disturbances occurring in 'neuropathic' individuals.<sup>78</sup> This distinction was further solidified in the title of his *War neuroses and shell shock* (1919) where he claimed that 'shell-shock' was 'a useful term if it is limited to cases where there is definite evidence of a shell or bomb bursting near enough to knock the man down, or blow him up in the air and cause a temporary loss of consciousness'. Even at this later stage he insisted that the dividing line was not absolute: although undoubtedly 'the vast majority of non-fatal cases of shell-shock are more emotional in origin than commotional [...] the two conditions may be associated'.<sup>79</sup> Mott never attempted to explain all cases of shell-shock as the result of actual physical damage to the nervous system, and his views of the interchange between mental and bodily events were more complex than has been assumed by the conventional historiography.

Nevertheless, Mott's opinions on the prevalence of commotional shell-shock did change over the course of the war. In his earlier writings, he did not cite any statistics, but in 1919 he admitted that at the beginning of the war he had been inclined to attribute a far larger percentage of cases to physical causes.<sup>80</sup> The year before, he had estimated that for every case of 'true' shell-shock, there were ten emotional cases.<sup>81</sup> In the post-war era the proportion of cases he assigned to commotion diminished even further, as he adopted the Committee of Enquiry's conclusion that no more than five

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<sup>77</sup> Ibid., p. xli.

<sup>78</sup> F.W. Mott, 'The Chadwick lecture on mental hygiene and shell shock during and after the war', *BMJ* 1917 (2), pp. 39-42, p. 41; F.W. Mott, 'The microscopic examination of the brains of two men dead of commotio cerebri (shell shock) without visible injury', *Journal of the RAMC* 29:6 (December 1917), pp. 662-78, p. 671.

<sup>79</sup> Mott, *War neuroses and shell shock*, p. 2, p. 22, p. 30 and p. 35.

<sup>80</sup> Ibid., p. 35.

<sup>81</sup> Mott in 'Discussion: war psychoses and psychoneuroses', *JMS* 64:265 (April 1918), pp. 234-8, p. 237.

per cent of cases were solely due to commotion.<sup>82</sup> But although Mott was forced to reconsider his initial views on the frequency of physical causation in shell-shock over the course of the war, there was no corresponding shift to a more sophisticated psychological understanding in his work. His therapeutic techniques never progressed far beyond his 1916 advice to, 'Be cheerful and look cheerful'. Hypnosis or psychoanalysis were unnecessary: common sense, rest, diversion from their distressing memories, and crude suggestion would cure neurotic patients.<sup>83</sup> The method Mott devised for rooting out malingerers is illustrative of his approach. When he suspected that a patient was consciously prolonging his disability, he would tell the ward sister in a stage whisper that, "This man must be kept in bed on a No. 1 diet, and when he can ask loud enough for you to hear he can have a bottle of stout and a mutton chop". He claimed to have had great success with this method.<sup>84</sup> At the end of the war, he remained wedded to psycho-physical parallelism. He 'fully admitted the importance of looking at the whole matter from the mental side as well as the physical' but emphasised that all 'psychical processes were subordinate to physiological processes', and there could 'not be mind without memory, or memory without body'.<sup>85</sup>

### **Frederick Mott, shell-shock, and heredity**

It is arguable that in his theories of shell-shock, Mott assigned most importance not to physical damage to the nervous system, but to the heredity of the individual. In his Lettsomian lectures Mott argued that the totality of the conditions of trench warfare, including wet, cold, hunger, and fear, combined to lower the nervous resistance of the individual, so that a shell explosion could act as the final straw leading to breakdown. The acknowledgement that these circumstances, might 'exhaust and eventually even shatter the strongest nervous system' in some respects marks a retreat from his pre-war emphasis on hereditary predisposition.<sup>86</sup> Before 1914 he had consistently argued that heredity was the single most significant determinant of mental disorder, claiming that there were 'individuals born of sound stocks that no acquired conditions – e.g. drink,

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<sup>82</sup> F.W. Mott, 'The neuroses and psychoses in relation to conscription and eugenics', *Eugenics Review* 14:1 (April 1922), pp. 13-22, p. 13.

<sup>83</sup> Mott, 'Lettsomian lectures. III', *Lancet* 1916 (1), pp. 545-53, p. 553; see also F.W. Mott, 'Mental hygiene in relation to insanity and its treatment', *Lancet* 1922 (2), pp. 793-5, p. 795.

<sup>84</sup> Mott, 'The Chadwick lecture', pp. 41-2.

<sup>85</sup> [Anon.], 'Notes and news: the pathology of dementia praecox', *JMS* 67:277 (April 1921), pp. 252-5, p. 254.

<sup>86</sup> Mott, 'Lettsomian lectures. I', p. 331.

poisons engendered from the body or taken from without, head injuries, emotional shock, distress, and even profound misery and destitution combined – can render insane'.<sup>87</sup> He never entirely negated the influence of environmental agencies, such as 'toxaemic conditions ... mental shock, grief, or other emotional moral causes' in his pre-war work, but believed that such apparent 'causes' were at best only 'a coefficient, and often merely serve as the spark which falls into the explosive matter'.<sup>88</sup>

This example demonstrates that the invocation of psychological factors as contributory elements in the production of the war neuroses was not a significant departure for Mott, although the widened sphere of influence they were allowed did constitute a shift from his pre-1914 writings. In 1911, he had argued that it was not insanity which was transmitted, but rather 'a predisposition or tendency, and some other factor than the inborn is required to produce the disease'. This might be syphilis, alcoholism, or tuberculosis, but it could equally be 'the strife of city life with its feverish pursuit of gain and pleasure, competitive competitions, the constantly increasing departure from simple modes of life, the unphysiological conditions of sexual life, and the extension of more refined physical and mental enjoyments, bringing with them desires and emotions previously unknown'.<sup>89</sup> In his accounts of shell-shock, the pathological environment of war took the place of civilised society, but for the most part this was again perceived only to act on the inherent nervousness of the individual rather than to actually cause the disorder. Although Mott acknowledged that in theory any man *could* break down under the stresses of war, this conclusion was continually undermined throughout his writings. As a consequence, the view that 'psychic trauma' was an adequate explanation for symptoms was also eroded, but via the insistence on nervous predisposition rather than the physical effects of shell explosions.<sup>90</sup>

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<sup>87</sup> Mott, *Nature and nurture in mental development*, pp. 64-5.

<sup>88</sup> Mott, 'Preface', pp. iii-iv; see also [Anon.], 'The British Medical Association seventy-ninth annual meeting', pp. 450-51; F.W. Mott, 'Heredity and insanity', *Eugenics Review* 2:4 (January 1911), pp. 257-81, p. 258.

<sup>89</sup> F.W. Mott, 'The inborn factors of nervous and mental disease', *Brain* 34:2 and 3 (November 1911), pp. 73-101, p. 90 and p. 101. Mott also described syphilis as a disease of civilisation, the incidence of which increased ever 'since the development of the railway in England'. F.W. Mott, 'Opening address, with special reference to the relation of the disease to public health, including congenital syphilis', in H. Morris, N. Moore, D. Power, and F.W. Mott, *Syphilis, with special reference to (a) its prevalence and intensity in the past and at the present days, (b), its relation to public health, (c) the treatment of the disease* (London: Longmans, Green, and Co., 1912), pp. 50-86, p. 50.

<sup>90</sup> At least one obituarist did not even mention Mott's support for commotional theories, but identified as his key finding that the war neuroses usually occurred in those of a 'constitutionally neuropathic disposition'. [Anon.], 'Obituary: Sir Frederick Mott', *Lancet*, p. 1229.

This was achieved in a number of ways. Most subtly, Mott consistently suggested that emotion and other 'psychological' factors operated to a far greater degree in the production of shell-shock in men with an inherent nervous weakness. In effect, he often judged whether an individual was 'neuro-potentially sound' according to the length of time he had served before developing a disorder, and the severity and persistence of symptoms.<sup>91</sup> Throughout his writings on the war neuroses he claimed to be 'convinced that an individual with a timorous disposition is more likely to suffer from a rapid breakdown than others', and that a 'considerable number of the cases of shell shock without visible injury' occurred 'in individuals of a neuropathic or psychopathic predisposition, or of a timorous and nervous disposition'.<sup>92</sup> Despite his acknowledgement of the various aspects of trench warfare which conduced to nervous breakdown, he maintained that 'the most important factor in connection with insanity is the inborn tendency of the individual'.<sup>93</sup> In 1918 he even gathered statistical evidence of this fact, to match his pre-war collection of asylum pedigrees, when he instigated an investigation into the family and personal history of patients at the Maudsley. The subordinate set to this task discovered that there was 'a family history of neurotic or psychopathic stigmata' in seventy-four per cent of 'psycho-neurotic cases'. This statistic was, of course, frequently appealed to in Mott's future writings.<sup>94</sup> There is little evidence that Mott's thought on the nervous and mental disorders of war evolved towards a psychological understanding as the war progressed. Heredity, the keynote of his pre-war researches into the origins of insanity, remained the central pillar of his argument until the very last lecture he gave, only months before his death.<sup>95</sup>

If anything, the experience of shell-shock only served to strengthen Mott's belief in the importance of heredity. His wartime writings displayed a brisk but sympathetic attitude to the sufferings of soldiers, but in the post-war period he focused on the inadequacies of the conscript army. It was not until the patriotic fervour surrounding shell-shock had faded that he publicly stated that the war had 'shown that a very considerable

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<sup>91</sup> Mott, 'Opening paper', pp. xxi-xxii and pp. xlii-xliii; Mott, 'The Chadwick lecture', p. 41.

<sup>92</sup> Mott, 'Opening paper', pp. iii-v; Mott, 'Lettsomian lectures. II', p. 448; Mott, 'The Chadwick lecture', p. 40.

<sup>93</sup> Mott, 'War psychoses and psychoneuroses', p. 234.

<sup>94</sup> J.M. Wolfsohn, 'The predisposing factors of war psycho-neuroses', *Lancet* 1918 (1), pp. 177-80, p. 180; Mott, 'Two addresses on war psycho-neurosis. (I)', p. 127; Mott, 'Alcohol and its relations to problems in mental disorders', p. 207.

<sup>95</sup> F.W. Mott, 'Heredity in relation to mental disease and mental deficiency', *BMJ* 1926 (1), pp. 1023-26.

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'.<sup>96</sup> He lamented the sad consequences of treating these 'neuropaths'; not only a crippling pensions bill, but that they 'were not therefore killed off to anything like the degree that the A1 physically and mentally sound men were'. The war had 'not had the purifying effect that it had in ancient times when in the struggle for existence the mentally and physically strong alone could survive'.<sup>97</sup> This crude and repugnant social Darwinism was a far cry from the Mott who had ended his Lettsomian lectures with a rhetorical flourish on the undiminished masculinity of shell-shocked soldiers. In Mott's case, the war did not foster greater psychological understanding. It merely hardened his existing prejudices, and convinced him that civilisation was in the throes of decline.

### **The persistence of physical theories of causation**

Mott remained an unrepentant advocate of theories of physical causation until his death, insisting that despite its comparative rarity and the recent tendency 'almost to decry its existence', commotional shock was nevertheless a genuine and proved disorder.<sup>98</sup> Although undoubtedly the stoutest defender of such theories, he was not alone. From 1917 onwards, the majority of articles focussed on the emotional and psychological origins of the war neuroses. The place of physical theories is captured well in a report from December 1918, which claimed that the 'term "shell shock" has hindered the acceptance of a purely psychological explanation of the war psycho-neuroses, and its gradual disuse signifies the growth of belief that the continuation of symptoms is not, save in a small proportion of cases, due to the physical effects of concussion or burial'.<sup>99</sup> The assertion that some cases resulted from invisible injury to the central nervous system continued to be made in a variety of signed articles,<sup>100</sup>

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<sup>96</sup> F.W. Mott, 'The psychopathology of puberty and adolescence', *JMS* 67:278 (July 1921), pp. 279-381, p. 301; [Anon.], 'British Medical Association special clinical meeting, section of medicine: war neuroses', *Lancet* 1919 (1), pp. 709-11, p. 709; F.W. Mott, 'Body and mind: the origin of dualism', *Lancet* 1922 (1), pp. 1-5, p. 4.

<sup>97</sup> Mott, 'The psychopathology of puberty and adolescence', p. 302; Mott, 'The neuroses and psychoses in relation to conscription and eugenics', p. 16.

<sup>98</sup> F.W. Mott, 'The neurological aspects of shock', *Lancet* 1921 (1), pp. 519-522, p. 520.

<sup>99</sup> [Anon.], 'The treatment of war psycho-neuroses', *BMJ* 1918 (2), p. 634.

<sup>100</sup> Tooth, 'Neurasthenia and psychasthenia', p. 339 and p. 340; Wilson, 'The effects of high explosives on the ear'; J.G. Wilson, 'Further report on the effects of high explosives on the ear', *BMJ* 1917 (1), pp. 578-9; Armstrong-Jones, 'The psychology of fear', p. 369 and pp. 372-3; Hurst, 'Observations on the etiology and treatment of war neuroses', p. 413; Eager, 'A record of admissions', pp. 287-8; J. Collie, 'The management of neurasthenia and allied disorders contracted in the army', *Journal of State Medicine*

unsigned pieces,<sup>101</sup> books,<sup>102</sup> correspondence to the medical press,<sup>103</sup> and at meetings of medical societies<sup>104</sup> until the end of the war and beyond. Many of these authors concluded that 'true' shell-shock accounted for only a minority of cases, and preferred to focus their attention on 'emotional' disorders. The important point is that although swamped by alternative explanations, physical theories retained their claim to a place in the medical literature.

It was not even until 1919 that a defence of physical theories to rival that of Mott was made. In that year, Alfred Carver, a captain in the RAMC, published the results of his experiments into commotional shock. Carver had observed the effects of high explosives on fish, rats and mice, and (for obvious reasons, to less rigorous scientific standards) on humans. The aim of the research was 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'.<sup>105</sup> Carver concluded that 'physical or "commotional" factors' were operative in a number of cases, although the important point was 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'. Although one or the other might be the primary cause in any given case, 'the individual, once sensitised by either, remains for a long time, perhaps always, hypersensitive to both forms of stimulation, and a vicious circle is thus established'.<sup>106</sup> It does not appear that Carver's researches made much of an impact. The only known response is a letter to the *Lancet*, which noted that the experiments had only been carried out on perch, and

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26:1 (January 1918), pp. 2-17, pp. 2-3; E.W. White, 'Observations on shell shock and neurasthenia in the hospitals in the Western Command', *BMJ* 1918 (1), pp. 421-2, p. 422; Bury, 'Remarks on the pathology of war neuroses', p. 97; Turner, 'The Bradshaw lecture', pp. 614-5; Johnson, 'Hysterical tremor'; Grimby, 'Neuroses and psycho-neuroses of the sea', p. 248; Hale-White, 'An address', p. 229; H. Davy, 'An address on some war diseases', *BMJ* 1919 (2), pp. 837-840, p. 837.

<sup>101</sup> [Anon.], 'Shell shock, gas poisoning, and war neuroses', p. 656; [Anon.], 'The management of neurasthenia and allied disorders in the army', *TMW* 8 (Jan-June 1917), pp. 642-3; [Anon.], 'Reviews: Malingering', *BMJ* 1917 (2), pp. 117-8.

<sup>102</sup> Hurst, *Medical diseases of the war* [1917], pp. 3-6; Hurst, *Medical diseases of the war* [1918], pp. 44-59; Marr, *Psychoses of the war*, p. 49 and pp. 110-119.

<sup>103</sup> J.L. Thomas, 'Correspondence: death from high explosives without wounds', *BMJ* 1917 (1), p. 599; L. Hill, 'Correspondence: death from high explosives without wounds', *BMJ* 1917 (1), p. 665.

<sup>104</sup> [Anon.], 'Reports of societies: shell shock', p. 81; [Anon.], 'British Medical Association special clinical meeting'

<sup>105</sup> A. Carver and A. Dinsley, 'Some biological effects due to high explosives', section of neurology, *PRSM* 12 (parts 1 and 2) (1918-1919), pp. 36-51, p. 51.

<sup>106</sup> *Ibid.*, p. 36; A. Carver, 'Some observations bearing upon the commotional factor in the aetiology of shell shock', *Lancet* 1919 (2), pp. 193-6, pp. 195-6.

offered some observations on the effects of high explosives on fishes with swim-bladders.<sup>107</sup> But neither was he perceived as a crank: one of his papers was presented to the neurological section of the Royal Society of Medicine, and reprinted in *Brain*, while a second article appeared in the eminently respectable *Lancet*.

In the post-war period, physical theories retained a toehold in the literature. Several witnesses to the War Office Committee of Enquiry on Shell-shock maintained that commotion or concussion accounted for a class of 'true' shell-shock, while the final report devoted several pages to these theories and concluded that five per cent of cases were of 'commotional' origin.<sup>108</sup> A year later the official medical history of the war claimed that only half this amount 'showed evidence of a possible lesion of the nervous system', and cited this as proof that 'nearly all the case of war psycho-neuroses' resulted from emotional causes – but nevertheless, not all.<sup>109</sup> Even in 1944, Arthur Hurst lamented the inaccurate application of the term 'shell-shock' in the previous war but maintained there would have been no objection had it been reserved for cases in which actual nervous damage had been sustained following 'exposure to the forces generated by the explosion of powerful shells or bombs'.<sup>110</sup> Lord Moran's *The anatomy of courage* (1945) strongly asserted that some 'men of stout heart' had broken down through 'the blast of a shell which damaged their brains'. These men 'had not been defeated by their thoughts', but were 'hurt as men with broken limbs are hurt', though they may not have sustained even a scratch. He argued that commotional and emotional shock 'can be kept apart and it is vital to keep them so, for when a man is hit he deserves more consideration than when he is frightened'.<sup>111</sup> As the Allies drove German forces from France for the second time that century, and Londoners gritted their teeth in the face of V-2 rockets driven by technology undreamt of in the First World War, still a tiny section of the medical community clung to the theory of commotion.

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<sup>107</sup> L.J. Kidd, 'Correspondence: shell shock in fishes', *Lancet* 1919 (2), p. 266.

<sup>108</sup> Statistic given in summary of findings, *RWOCESS*, p. 112; see pp. 100-19 for summary of evidence on concussion and commotion shock.

<sup>109</sup> Macpherson *et al* (eds), *History of the Great War*, pp. 18-9.

<sup>110</sup> Hurst, *Medical diseases of war* [1944], pp. 121-30.

<sup>111</sup> Lord Moran, *The anatomy of courage* (London: Sphere Books, 1968), p. 35-7.



## Therapeutic conservatism in approaches to shell-shock

It has been demonstrated here that physical theories were both less prevalent and more persistent than the traditional historiographical narrative has suggested, but this is only part of the story. The continued adherence of some doctors to physical theories of causation would be of little importance if the broad sweep of the medical literature had been towards sophisticated psychological explanations, but this was not the case. For most of the war, continuity was the order of the day. This was manifested sometimes in the continued insistence that the boundaries of the organic and functional were nebulous and interchangeable, a testament to the refusal to consider the mind and body entirely separable entities.<sup>112</sup> It was most often, however, demonstrated by therapeutic conservatism. One report on a case of ‘emotional mutism’ concluded that ‘hard manual work is the best remedy for such functional incapacities of traumatic origin’.<sup>113</sup> Some doctors treated functional disorders simply by causing the patient ‘some novel and unexpected emotional or physical shock’: in arcane technical jargon, the method ‘known as “taking the patient by surprise”’.<sup>114</sup> Even when psychological theories became more widespread, the response was sometimes blank incomprehension. Lionel Weatherly, a long-time advocate of reform to lunacy laws who did not work with soldiers, noted the space devoted to hypnosis and psychoanalysis in recent books on shell-shock, and therefore considered his discussion of useful medicinal remedies to be breaking new ground.<sup>115</sup>

In other circles, incomprehension proceeded alongside the attempt to assimilate new theories into familiar frameworks. Armstrong-Jones noted that one of the effects of the war had been an emphasis on ‘psychic’ theories. He claimed that in almost every issue of the *Lancet*, there were references to ‘the raising of the “threshold of consciousness”’, but assumed that ‘his hearers had all been doing that from the moment they qualified; it only meant the importance of making it more easy to impress the personality of the

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<sup>112</sup> T.E. Harwood, ‘Functional conditions in the light of head injuries’, *Journal of the RAMC* 28:6 (June 1917), pp. 699-707, p. 700 and pp. 705-6; A.F. Hurst and J.L.M. Symns, ‘The hysterical element in organic disease and injury of the central nervous system’, section of neurology, *PRSM* 12 (parts 1 and 2) (1918-1919), pp. 21-9.

<sup>113</sup> [Anon.], ‘The war: notes from south-eastern France’, *BMJ* 1916 (1), pp. 768-9, p. 768.

<sup>114</sup> Leonard Guthrie in ‘Special discussion on shell shock’, p. xli.

<sup>115</sup> L.A. Weatherly, ‘The war and neurasthenia, psychasthenia and mild mental disorders. II’, *TMW* 11 (July-Dec 1918), pp. 265-6. Conventional medicines were recommended elsewhere. See P.C.C. Fenwick, ‘Entero-spasm following shell shock’, *Practitioner* 98:4 (April 1917), p. 391.

medical man upon his patient'.<sup>116</sup> The terminology of psychology often merely glossed highly conventional views on mental disorder. William Chambers confidently diagnosed a young officer as suffering from an 'oedipus-complex': his treatment extended no further than sending the man back to his unit 'to look for his manhood once more'.<sup>117</sup> Meanwhile, Paul Bousfield, physician to the Lancaster Clinic of Psychotherapy, nonchalantly introduced examples of 'an abnormal erotic condition', 'infantile fixations', and 'a strong "father complex"' into his argument that variations in blood-pressure were key to understanding and treating the war neuroses.<sup>118</sup> This approach is exemplified by the second edition of Cole's textbook of nervous and mental disorders, published in 1919, which was scattered with new references to Freud. But these involved no more than a sentence or two inserted into the existing text. Cole did not revise his overall framework of explanation as a result of increased exposure to Freudian and other psychological theories.<sup>119</sup>

Even where there was greater understanding of the precepts of psychology, their application was limited. In 1918 Laughton Scott, a physician at the newly-founded Lancaster Clinic of Psychotherapy published a detailed account of his treatment of hysteria by suggestion.<sup>120</sup> Only a year later, his attention had turned to 'the part that a detailed mental analysis may play in the treatment of those psychoses in which anxiety is the predominant feature'. He had not altered his views on the value of suggestion in hysteria, but thought that 'confession' was of more use for 'the anxiety state'.<sup>121</sup> A technique Scott himself described as 'primitive' nestled happily next to one derived from Freud in his therapeutic armoury: in this respect, his articles are almost a microcosm of the medical literature at the end of the war. Colin McDowall, an asylum doctor who joined the staff at Maghull, gave a thoughtful and sensitive account of the emotional origins of mutism, but nevertheless took a 'simple, common-sense' approach

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<sup>116</sup> R. Armstrong-Jones in 'Discussion: observations on the Rolandic area in a series of cases of insanity', *JMS* 64:267 (October 1918), pp. 363-5, p. 363.

<sup>117</sup> Chambers, 'Mental wards', p. 171.

<sup>118</sup> Bousfield, 'The relation of blood-pressure to the psycho-neuroses', p. 270.

<sup>119</sup> Cole, *Mental diseases*, [1919], p. 31 (p. 28), p. 220 (p. 216), p. 225 (p. 221). Page numbers in brackets refer to corresponding passages in the 1913 edition.

<sup>120</sup> L. Scott, 'Hysterical "paralysis" of long standing', *Practitioner* 101:2 (August 1918), pp. 97-9, p. 99.

<sup>121</sup> L. Scott, 'The anxiety state – an aspect of treatment', *Practitioner* 102:4 (April 1919), pp. 222-4, p. 222 and p. 224.

to treating these disorders through breathing exercises.<sup>122</sup> It was not uncommon for doctors to admit the potential of psychoanalysis, but to argue that there was no need to bring 'to light the hidden psychical trauma and its buried complexes' in war cases, where the symptoms were so obviously the result of recent experience.<sup>123</sup> Even David Eder, who had joined the cause long before the war, took this approach and only treated five patients in a series of a hundred cases using psychoanalysis.<sup>124</sup>

The situation at the close of the war can be illustrated by some reactions to the theory of repression of war experience as the most significant factor in the development of the war neuroses. One respondent to W.H.R. River's paper on this topic in December 1917 recounted his experience with 'a young officer invalided home for shell shock without a wound', who 'did nothing but talk of his experiences'. The officer told him that he thought of nothing else; he was eventually 'put right' by a course of trout-fishing.<sup>125</sup> A few weeks later, a correspondent asserted in the *British Medical Journal* that most often the 'difficulty lies in rendering such means of distraction available to a patient whose one preoccupation is his illness and all that has led up to it'.<sup>126</sup> In the later years of the war, it was not uncommon for the acknowledgement that fear and anxiety were the mainsprings of the war neuroses to be followed by the recommendation that the keynote of treatment was 'to induce "self-forgetfulness"', and that the patient must be taught *not* to think about his war experiences.<sup>127</sup> In 1919, Millais Culpin (1874-1952), a surgical specialist who had given up this work in favour of 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 the context was a

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<sup>122</sup> McDowall, 'Mutism in the soldier', pp. 63-4; such conventional treatments were also propounded in C. MacMahon, 'Shell shock stammering and other affections of voice and speech', *Practitioner* 98:5 (May 1917), pp. 427-35.

<sup>123</sup> Harris, *Nerve injuries and shock*, p. 106; Stewart, 'The treatment of war neuroses', p. 16 and p. 24; Collie, 'The management of neurasthenia', p. 10; Ballard, 'The psychoneurotic temperament', pp. 374-5; Eager, 'A record of admissions', pp. 294-5; R. Eager, 'The early treatment of mental disorders', *Lancet* 1919 (2), pp. 558-63, p. 559.

<sup>124</sup> Eder, 'An address on the psycho-pathology of the war neuroses', p. 268.

<sup>125</sup> C.M. Tuke in 'Discussion: the repression of war experience', p. 20.

<sup>126</sup> J.E. Middlemiss, 'Correspondence: the treatment of war psycho-neuroses', *BMJ* 1918 (2), p. 700; see also [Anon.], 'The treatment of war psycho-neuroses', p. 634.

<sup>127</sup> Forster, 'The management of neurasthenia', pp. 86-8; R.T. Williamson, 'Remarks on the treatment of neurasthenia and psychasthenia following shell shock', *BMJ* 1917 (2), pp. 713-5, p. 715; see also White, 'Observations on shell shock and neurasthenia', p. 422; Hale-White, 'An address on some applications of experience', p. 229.

complaint that at a recent meeting on the war neuroses, the only allusion to this subject had been his own comments minutes before its end.<sup>128</sup>

This comment highlights that although psychological theories had been given a new impetus by shell-shock, their influence had definite boundaries. This does not undermine those advances which were made; the radicalism of certain texts is even heightened once they are placed against this background of widespread incomprehension and piecemeal assimilation. The ragged and uneven development of psychological approaches, however, must be underlined, as must the context in which they were put forward. Rivers' article on the repression of war experience is familiar to all historians of shell-shock, but the bizarre and creative explanations of the war neuroses which were published in the same year are never mentioned alongside it. One such article argued that shell-shock was caused by disruption to the atomic organisation of the brain, and set out a detailed 'Periodic Law of Corpuscles' by which the disturbance could be measured.<sup>129</sup> The theory that the disorder resulted from 'electrical nerve leaks' was still taken seriously enough to warrant sustained rebuttal.<sup>130</sup> In contrast to the exaggerated scientific veneer of these theories, a cure achieved by the miraculous intervention of a praying apparition was reported in the medical press as a news item, without any reference to delusions or hallucinations.<sup>131</sup> The acceptance of psychological approaches was by no means uniform or assured by the end of the war. At its close, two items appeared addressing 'the birth of psycho-therapy' and lauding modern attitudes to mind. The pioneers named? The heroes of late eighteenth century moral management: Philippe Pinel (1745-1826) and William Tuke (1732-1822).<sup>132</sup>

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<sup>128</sup> M. Culpin, 'Correspondence: the discussion on war neuroses', *BMJ* 1919 (1), p. 501.

<sup>129</sup> A. Churchward, 'The cause of the physiological and abnormal conditions in "shell shock" and other allied symptoms', *TMW* 9 (July-December 1917), pp. 149-50.

<sup>130</sup> W.M. Bayliss, 'On the origin of electric currents led off from the human body, especially in relation to "nerve-leaks"', *BMJ* 1917 (1), pp. 387-8, p. 387. Bayliss argued against this theory, but its currency is supported by the mention in Armstrong-Jones, 'Mental and nervous states in connection with the war and their mechanism', p. 335.

<sup>131</sup> [Anon.], 'Speech and hearing restored: soldier's remarkable recovery', *TMW* 9 (July-December 1917), p. 173.

<sup>132</sup> L.W., 'The birth of psycho-therapy', *TMW* 11 (July-Dec 1918), p. 27; B. Pierce, 'Psychiatry a hundred years ago, with some comments on the problems of to-day', *Lancet* 1919 (2), pp. 211-2, p. 212.

## Conclusion

The persistence of physical theories into the post-war era is one demonstration that the reach of psychological explanations of the war neuroses remained limited. It is still arguable, however, that scattered comments on commotion prove little more than the conservative views of a few individuals. It is far more important to realise, as has been shown in the opening pages of this chapter, that the contrast between 'physical' and 'psychological' theories was never as stark as some historians have suggested. The immediate medical response to shell-shock was not a uniform appeal to the mysterious effects of shell explosions, but a broad-ranging consideration of the possible aetiological factors thrown up by trench warfare. These discussions on the whole did not display sophisticated psychological understanding, but nor did they consist of a relentless stream of materialist posturing. A rigid distinction between physical and psychological causes and effects was alien to the conceptual framework of pre-war psychological medicine, and did not spontaneously manifest on the outbreak of war. The historiographical imposition of such a divide has obscured other trends, most notably the ways in which 1916 marked a turning point. The temporary disappearance of heredity as an aetiological factor was the real novelty of the first two years of the war, but it re-emerged in 1916 as part of a general move to displace the pathology of shell-shock from the war to the individual soldier. At the same point, there was an increase in psychological explanations, but this was matched by the first appearance of detailed and elaborate physical theories of causation. There was not a paradigm shift, but rather the emergence of two schools of thought at least partly in opposition to each other.

The aim of this chapter has been to convey, through a focus on the role of physical theories of causation, some of the richness and complexity of medical debates on the war neuroses. The detailed examination of the work of Frederick Mott has highlighted that even physical theories resist simplistic readings. It has also shown once more the importance of linking wartime theories to pre-war views on mental disorder. Before, during, and after the war, Mott allowed a role for psychological factors in his theories. Perhaps above all, this chapter has argued that individual articles must be placed in the context of the entire wartime literature. A bird's-eye view of theories of shell-shock in the British medical press reveals that physical theories were not as prevalent as has

been supposed in the earlier years of the war, and that psychological explanations did not hold the field in the later years. The following chapter, which explores physiological and biological theories, demonstrates that in fact, the physical/psychological divide makes little sense when applied to the wartime literature on shell-shock. It is one possible way of reading theories, but it involves the imposition of a mode of thought foreign to contemporaries. It consequently shuts off other avenues of interpretation and clouds the diversity of approaches to shell-shock among doctors. It also obscures areas of convergence between the vast range of theories of the war neuroses. As the final chapters will show, from the emphasis on physical theories in the work of Frederick Mott to the psychoanalytic theories of David Eder, shell-shock was always conceptualised as regression: and for this reason, it was not only an individual tragedy, but an epidemic with implications not only for the health of the army or the nation, but civilisation itself.

## Chapter 6

### Animal bodies: emotion and instinct in theories of the war neuroses

#### Introduction

In February 1918, a short item news item appeared in the *Lancet* under the intriguing heading 'Shell shock in cows'. This was a short comment on the recent trial of a milk dealer accused of selling milk which was 'not of orthodox purity'. The defendant claimed that his crime had been committed unwittingly: 'the milk reached the consumer exactly as it came from the cows, but it was drawn at a time when there was an air raid and the animals were suffering from shell shock'. The bench did not accept this defence, and the dealer was fined. However, the *Lancet*'s commentator thought that 'such a defence might well be valid'. It was well known that 'restlessness or nervousness' could affect both the quantity and quality of milk a cow produced; indeed, the same phenomenon was sometimes found in women 'affected by mental strain, anxiety, or fright'. If 'normal metabolism and nutrition' was disturbed by such influences, 'the normality of the action of the secretion of the mammary glands is interfered with'. His only objection to the plea of the milk dealer was that 'a valid defence would also require evidence that the shock had occurred, and that there had been no tampering with the fluid'.<sup>1</sup>

This item is more than the amusing curiosity it appears at first glance. It revolts against the modern conception of shell-shock as psychological disturbance: cows should not have any place in a genealogy of trauma. However, the author believed that cows could suffer from shell-shock because he defined the disorder as a physiological malfunction. In the latter years of the war, the physiology of emotion was incorporated into the mainstream of medical thought on the war neuroses. The conventional historiography has disregarded or downplayed this aspect, but it is vital to reconstructing the contemporary framing of shell-shock. Historians usually divide theories into those which argued that symptoms were caused by the physical effects of bursting shells, and those which argued that the disorder was an emotional or psychological response to war experience. The physiology of emotion breaks down this neat distinction, not only

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<sup>1</sup> [Anon.], 'Shell shock in cows', *Lancet* 1918 (2), pp. 187-8.

through the conception of emotion as a bodily instead of or as well as a psychological event, but through the range of ways and contexts in which such theories were employed. However, the physiology of emotion was comfortably accommodated within the wide-ranging conceptualisation of the war neuroses as a conflict of emotion and will.

The wartime interest in physiological theories of emotion was spurred by the publication of Walter Cannon's *Bodily changes in pain, hunger, fear and rage* in 1915. This book, which examined the deep bodily responses to fear, provided a plausible explanation of the all-encompassing effects of emotion on mind and body. But it also proved attractive to shell-shock doctors because it painted a portrait similar to that current in psychological medicine, in which fear was associated with the body, the animal, and instinct and operated against the rule of the will. This enabled physiological theories to be incorporated into discussions of shell-shock with remarkable ease. Alongside this interest in physiology, many doctors also began to award a central place to instinct in their theories. From the most physiologically-minded of doctors, seduced by Cannon's account of the instinct of self-preservation as the origin of bodily responses to fear, to those who drew on psychoanalytic theories and constructed the unconscious as a storehouse of instinctual tendencies and their emotional accompaniments, the same hierarchy of high and low, human and animal, was imposed on theories of the war psycho-neuroses. All these authors were led to the conclusion that shell-shock constituted a regression, either to an earlier stage of the development of the individual, or more frequently, to that of the race.

Both the physiology of emotion and the psycho-biology of instinct demonstrate that although individual doctors chose to tackle different sides of the equation, theories of shell-shock depended on the view of mind and body as complexly and irreducibly connected. There was no straightforward transition to a psychological understanding of the war neuroses: psychology, physiology, and biology were all, and inseparably, blended in these theories. This fact is demonstrated perhaps above all, given its author's historiographical status as the paragon of psychological thought, by W.H.R. Rivers' *Instinct and the unconscious* (1920). Although Rivers helped to normalise Freud for a British audience, this strange and fascinating book also drew on neurology, physiology, and anthropology in the attempt to explicate the biological basis of the war neuroses.



Although the theory of regression was worked out in more detail here than anywhere else, *Instinct and the unconscious* was in many respects the culmination of a trend in wartime thought rather than a departure from it. The physiological and instinctual theories of the war neuroses detailed in this chapter were dependent on an evolutionary framework of explanation. This mode of understanding underlined the perilous survival of its animal origins within civilisation, but also raised anxieties regarding the ultimate effects of civilised 'progress', a theme which will be explored in the final chapters of this thesis.

### **Walter Bradford Cannon and the physiology of the emotions**

In 1915, the Harvard-based physiologist Walter Bradford Cannon (1871-1945) published his *Bodily changes in pain, hunger, fear and rage*. The book drew together and interpreted a series of researches on the deep bodily responses to the major emotions conducted by Cannon and published in a series of articles from 1909-14.<sup>2</sup> The starting point of Cannon's research, explicitly founded on the precepts of Darwinian evolutionary theory, was that human behaviour was motivated not by reason or conscience, but instinct and emotion. The major emotions of fear, rage, pain, and hunger were all 'primitive experiences which human beings share with the lower animals'. The emotions and their expressions were to a large degree innate, as shown by the observation of children and widely distinct races, and were 'best explained as the retention in human beings of responses which are similar in character in lower animals'. The bodily responses to emotion were therefore of 'fundamental importance' in the interpretation of human behaviour.<sup>3</sup> The main thrust of Cannon's researches was to demonstrate that the effects of intense emotion were to equip the organism for fight or flight. In times of extreme stress, a substance called adrenin (later adrenalin) was secreted which increased the level of sugar in the blood, improved the efficiency of the circulation of blood to the essential organs, reduced the effects of muscular fatigue, and aided blood coagulation. Cannon argued that these bodily responses were evolutionary

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<sup>2</sup> For a list of these articles, see W.B. Cannon, *Bodily changes in pain, hunger, fear and rage: an account of recent researches into the function of emotional excitement* (D. Appleton and Company: New York and London, 1920) [reprint of 1915 edition], pp. 302-3.

<sup>3</sup> *Ibid*, p. vii and pp. 1-3.

adaptations which enabled the organism to respond to actual or anticipated dangers, by fight or flight, with maximum efficiency.<sup>4</sup>

All other potentialities of the organism bowed before these bodily changes because they were grounded in the instinct of self-preservation. As responses of a reflex character, they could not be reproduced even by the most 'supreme act of volition', and indeed were often 'distressingly beyond the control of the will'.<sup>5</sup> Not only was conscious control in vain, but these responses to emotion also ran riot over the usual 'peacetime' functions of the body. Cannon explained that the emotions were expressed through the action of the autonomic nervous system, which consisted of three divisions, the cranial, sacral, and sympathetic, respectively corresponding to the three major instincts of nutrition, sex, and self-preservation. Under the influence of strong emotion, the influence of the sympathetic division overrode the activities of the other divisions, in order that all the resources of the body could be directed towards fight or flight. This was described as analogous to the actions of nations in war, when 'the arts and industries which have brought wealth and contentment must suffer serious neglect or be wholly set aside both by the attacker and the attacked, and all the supplies and energies developed in the period of peace must be devoted to the present conflict'. The sympathetic division must achieve dominance because self-preservation was 'primary and essential'; without it, racial continuity would not be possible, and so all the resources of the organism were called forth.<sup>6</sup>

The reasons for the supremacy of the sympathetic division at the actual moment of danger, under the influence of intense fear or anger, were obvious enough. The needs this division served, however, were so fundamental that the organism must be ready to respond promptly to danger at any moment. For this reason, the sympathetic division was called into action not only in fear or anger, but in any emotion when sufficiently intense. If any instinctive impulse was met with opposition or obstruction, the 'combative instinct' would be provoked, and so 'milder affective states' could be suddenly transformed into fear or anger at a moment's notice. All strong emotions – whether felt as 'anger, terror, pain, anxiety, joy, grief, or deep disgust' – had the same effect on the central nervous system, causing the sympathetic division to become

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<sup>4</sup> Ibid., pp. 184-218.

<sup>5</sup> Ibid., p. 185 and p. 218; see also pp. 281-2.

<sup>6</sup> Ibid., pp. 267-75.

dominant. This rapid transmutation of emotion was vital in order that the evolutionary adaptation to danger achieve maximum efficiency.<sup>7</sup> Not only were fear and rage primitive emotions which conquered both will and body, but they were present in embryo in even the most benign and pleasurable affective states to which humans were subject.

In Cannon's view, these bodily changes had benefits extending beyond the capacity for fight or flight. An enormous sense of power accompanied bodily mobilisation; intoxicated by 'the joys of conquest', the individual was lifted to a new level of ability.<sup>8</sup> He did not linger on the possible pathological effects of intense emotion, noting only in a footnote that if the organism was prevented in some way from taking action once the bodily changes had been mobilised, the effect might be depressing or paralytic rather than stimulating.<sup>9</sup> It was left to doctors treating the war neuroses to explore this prospect, while after America entered the war Cannon turned his attention to the not entirely dissimilar problem of surgical shock.<sup>10</sup> However, Cannon did not just set out the physiology of the emotions. He constructed an argument in which animal fear and rage were not only primitive and all-powerful, giving no quarter to will or to the normal bodily functions, but were incipient in all emotional states. The apparently happy and unaware organism was perpetually prepared for an intense struggle for survival; the unstated corollary of this proposition was that even the most superficially benign environment could unleash threatening forces at any second. No matter how civilised man and his world appeared to become, nature red in tooth and claw lurked beneath both. In the face of danger, the animal inheritance would resurface and trample over the most recent and most human acquisitions of evolution. This destruction, perversely enabled only for the purposes of animal survival, was wreaked through emotion. There was novelty in Cannon's account of the physiological mechanisms by which this was achieved, but his researches could be slotted so easily into theories of shell-shock because his overall framework of interpretation fitted so exactly with that current in psychological medicine.

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<sup>7</sup> Ibid., pp. 275-9.

<sup>8</sup> Ibid., pp. 225-30.

<sup>9</sup> Ibid., fn p. 189.

<sup>10</sup> S. Benison, A.C. Barger, and E.L. Wolfe, 'Walter B. Cannon and the mystery of shock: a study of Anglo-American co-operation in World War I', *Medical History* 35 (1991), pp. 217-49.

## The physiology of emotion in theories of shell-shock

From 1917 onwards, the medical literature on the war neuroses was littered with references to the physiological effects of emotion. There has been little historiographical comment on this trend. Ben Shephard argues that British doctors ‘paid lip service to Cannon’s work but were not sure what its implications were’, and that these researches were therefore of limited importance for shell-shock.<sup>11</sup> This conclusion belies both the extent to which physiological considerations were taken on board by the medical community, and the ultimate significance of this open attitude to such explanations. There is no want of direct citations of Cannon’s work in the medical literature on the war neuroses.<sup>12</sup> Even more telling, however, are the manifold observations on the common appearance of enlarged thyroids, symptoms of Graves’ disease, or general metabolic and endocrine disturbances in invalided soldiers.<sup>13</sup> It is easy to miss the import of these remarks because they were sometimes offered almost as throwaway comments, but they demonstrate that the physiological effects of emotion formed a noteworthy component of the clinical picture of shell-shock.<sup>14</sup> The engagement with physiological theories was not a brief flirtation, discarded as psychological explanations came into vogue. As will be shown, these ideas could be incorporated within a predominantly psychological framework, but they were also invoked well into the post-war period.<sup>15</sup> Any account of shell-shock which does not

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<sup>11</sup> Shephard, *A war of nerves*, pp. 112-3 and p. 125.

<sup>12</sup> Armstrong-Jones, ‘The psychology of fear’, p. 347 and pp. 365-6; R. Armstrong-Jones, ‘Mental states and the war – the psychological effects of fear. I’, *Journal of State Medicine* 25:8 (August 1917), pp. 238-49, pp. 243-4; Read, ‘A survey of war neuro-psychiatry’, p. 366; R.H. Steen in ‘Discussion: functional gastric disturbance in the soldier’, p. 144.

<sup>13</sup> Garton, ‘Shell shock’, pp. 584-5; [Anon.], ‘Reviews: shell shock and its lessons’, *BMJ* 1917 (2), p. 47; Ballard, ‘The psychoneurotic temperament’, pp. 370-1; MacCurdy, *War neuroses*, p. 21 and p. 23; Eder, ‘An address on the psycho-pathology of the war neuroses’, p. 266; J.B. Tomblinson, ‘An account of twenty cases treated by hypnotic suggestion’, *Journal of the RAMC* 29:3 (September 1917), pp. 340-6; Burton-Fanning, ‘Neurasthenia in soldiers’, p. 910; Chambers, ‘Mental wards’, p. 173; Campbell, ‘War neuroses’, p. 503; Williamson, ‘Remarks on treatment’, p. 714; Tooth, ‘Neurasthenia and psychasthenia’, p. 328; Eager, ‘War psychoses’, p. 424; [Anon.], ‘British Medical Association special clinical meeting’, p. 710.

<sup>14</sup> There were also discussions on the possibility of a physiological basis for non-war neuroses. See for example H.G. Turney, ‘Presidential address: the vasomotor neuroses’, neurological section, *PRSM* 8:2 (1914-1915), pp. 1-26. The interest in these matters was an offshoot of the emergence of endocrinology as a distinct branch of biological medicine and clinical science between 1890-1905, as well as the attempts to investigate the effects of emotions on the brain through laboratory experiments (as in Cannon’s work). See R.B. Welbourn, ‘Endocrine diseases’, in W.F. Bynum and R. Porter (eds), *Companion encyclopedia of the history of medicine, volume 1* (London and New York: Routledge, 1993), pp. 484-509; O.E. Dror, ‘Techniques of the brain and the paradox of emotions, 1880-1930’, *Science in Context* 14 (2001), pp. 643-60.

<sup>15</sup> See particularly the summary of evidence in *RWOCESS*, p. 100.

include some reference to the physiology of emotion neglects an important aspect of its contemporary conceptualisation.

The physiology of emotion was incorporated into theories of shell-shock in various ways. It could be used to argue that the war neuroses, at least in some of their manifestations, were essentially physical disorders. This view was put forward by Arthur Hurst in an article of 1917, in which he drew extensively on the idea of suprarenal activity to explain the origin and symptoms of certain types of shell-shock. He concluded that the effect of prolonged emotion was to produce increased 'excitability of the central nervous system', which caused the appearance of terror to persist even after symptoms had been removed by suggestion.<sup>16</sup> The second edition of his *Medical diseases of the war* (1918) also contained a lengthy discussion of hyperadrenalism and hyperthyroidism. Here Hurst recommended isolation (accompanied by small doses of opium and belladonna) as a treatment for these disorders, stressing that the patient 'should be protected from any chance of being reminded of what he has passed through by thoughtless conversations or illustrated papers'.<sup>17</sup> This was exactly opposite to the advice being dished out by those physicians formulating psychological theories of the war neuroses. The 1944 edition retained this section in full, but a note that the 'best results are obtained with the same type of psychotherapy as that required for the anxiety neuroses' was tacked on the end of the comments on isolation.<sup>18</sup>

The use of physiological theories to bulwark a physical explanation of the war neuroses appears to have been particularly prominent among doctors who had served in a medical capacity in France. Taking Cannon's researches as his starting point, the neurologist William Johnson (1885-1949) analysed cases of hyperthyroidism at the NYDN centre he commanded. He argued that exhausted soldiers frequently presented a definite condition of exophthalmos, which then passed off and became indistinguishable from neurasthenia. He concluded that 'a large number of so-called psychoneuroses are cases in which the symptoms are due to a state of disordered internal secretion the result largely of emotional exhaustion, and, to a less degree, of physical exhaustion'. He proposed therefore to class this group as 'exhaustion

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<sup>16</sup> Hurst, 'Observations on the etiology and treatment of the war neuroses', p. 413.

<sup>17</sup> Hurst, *Medical diseases of the war* [1918], pp. 35-40.

<sup>18</sup> Hurst, *Medical diseases of war* [1944], p. 148.

syndrome', and proposed rest, diet, tonics, and the occasional dose of Dove's powder as a suitable treatment.<sup>19</sup> The same line was taken in the 1923 medical history of the war, which argued that 'the cases with exophthalmos were merely the more striking example of what was essentially one symptom-complex', and used the former as the model for its description of neurasthenia.<sup>20</sup>

A more common effect of physiological theories of emotion was to lead to a heightened awareness of the reciprocal influence of mind and body. The neurologist James Purves Stewart (1869-1949), consulting physician to the British armies in the Mediterranean and the Near East, argued that 'an atmosphere of confidence and cheerfulness' acted as a curative agent through 'the development of a happy, "emotional" feeling-tone, entirely reflex and subconscious, exercised through the vegetative nervous system and the endocrine glands'.<sup>21</sup> The neurologist Judson Bury (1852-1944) drew the conclusion from Cannon's work that the bodily changes produced by the effects of fear and shock were so extensive that they 'must also produce some change in the neurons of the central nervous system'. He believed this made nonsense of any attempt to 'divide cases clinically into functional and organic'.<sup>22</sup> The trend of several strands of research presented in medical journals, from an attempt to show that mechanical cardiac motor disturbances could produce emotional symptoms through a knock-on effect on the integrated physiological organism, to the theory that disturbance of the sympathetic system could produce organic lesions of the spinal cord, was to support the view that psychological causes could produce physical effects and vice versa.<sup>23</sup> Walter Langdon Brown (1870-1946), a distinguished physiologist who served as an RAMC captain in the 1st General Hospital, developed this theme in his 1918 Croonian lectures on the role of the sympathetic nervous system in disease. Here he attempted to demonstrate that through the sympathetic system, the 'evil effects of depressing emotions' could lead 'even to structural change'. He focused on the physiological side of the question, pleading that he was 'not competent' to deal with psychological factors, but his aim had

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<sup>19</sup> W. Johnson, 'Symptoms of hyperthyroidism observed in exhausted soldiers', *BMJ* 1919 (1), pp. 335-7, pp. 336-7.

<sup>20</sup> Macpherson *et al* (eds), *History of the Great War*, p. 21; see also p. 19.

<sup>21</sup> Stewart, 'The treatment of war neuroses', p. 24; see also Muirhead, 'The mental factor', p. 170.

<sup>22</sup> Bury, 'Remarks on the pathology of the war neuroses', p. 98; see also Armstrong-Jones, 'Mental states and the war. II', pp. 290-1.

<sup>23</sup> J.I. France, 'Nervous and mental symptoms of heart disease', *TMW* 4 (Jan-June 1915), pp. 355-7; [Anon.], 'The interdependence of the sympathetic and central nervous systems', *BMJ* 1918 (2), p. 471.

nevertheless been to explicate 'some lines of thought which make clearer the influence of the mind on the body'.<sup>24</sup>

Theories based on physiology could also display several points of contact with psychological explanations. Percy Hunter, a former asylum psychiatrist who worked at the Gateshead War Hospital and Maghull Military Hospital, defined neurasthenia as 'pre-eminently a state of exhaustion of energy', and explained that in the war neuroses this exhaustion was caused because prolonged emotion was 'pent-up or repressed and not properly expressed'. Although the exact physiology of the emotions was unknown, he proposed a 'theory of continuous cell activity as a result of repression'. The reflex character of emotion meant that if it was not expressed, then 'the machinery of the cell is put into action by the stimulus', but 'the stimulus is not transmitted to the muscular apparatus'. The cell therefore acted 'much as the engine of a motor car will do when running free', consuming energy until the supply was exhausted. The final result of this repression would be an outburst of emotion.<sup>25</sup> The soldier was encouraged by his military training and the necessities of warfare itself to repress emotion. The degree to which soldiers were able to maintain this self-control was determined by their intelligence and previous emotional experiences, but eventually all such attempts at repression were doomed to failure, 'for the machinery has been set in motion which is to devour their energy like a parasite, slowly consuming them and producing the intense exhaustion which only one process can arrest'. The only possibility of cure lay in 'persuading the patient to recount his experiences'. Hunter argued that this treatment worked because when the original stimulus of the emotion was recalled it 'put into action that muscular system by which we normally express it'. The reflex was therefore satisfied, the organism regained its stable equilibrium, and the patient could begin to rebuild his depleted stocks of energy.<sup>26</sup> Hunter took as literal truth the analogies of physical repression employed by psychologists, and reached the same conclusions regarding the ideal therapy.

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<sup>24</sup> W. L. Brown, 'The Croonian lectures on the role of the sympathetic nervous system in disease. IV', *Lancet* 1919 (1) [June 7 1919], pp. 965-70, p. 970.

<sup>25</sup> P.D. Hunter, 'Neurasthenia and emotion', *Practitioner* 103:5 (November 1919), pp. 343-57, pp. 343-7 and p. 357.

<sup>26</sup> *Ibid.*, p. 350 and p. 352-6.

The physiology of emotion could be invoked to support a view of the war neuroses as a physical disorder, or to argue that an originally psychological disturbance could spill into the somatic realm and produce structural damage. Most significantly, at every point in the spectrum of medical opinion, doctors drew on physiological theories. The fact that these theories appealed to a doctor such as Mott, who was keen to anchor shell-shock within a general theory of physical causation of mental disorders, requires no further explanation.<sup>27</sup> Those physicians most associated with psychological approaches to the war neuroses also, to varying degrees, incorporated physiological elements into their writings. In his first article on shell-shock, Grafton Elliot Smith (1871-1937), professor of anatomy at Manchester University who researched the war neuroses at Maghull Military Hospital, argued that an important factor in the maintenance of the psychical effects of shock was that 'the physiological expressions of the emotion excited at the time of the trauma [...] served to link on to the present trouble other incidents in the individual's past history which were associated with similar emotional effects'.<sup>28</sup> This strand was not developed much further in the book he co-authored with Thomas Pear (1886-1972), a colleague from the psychology department at Manchester, but there was a passing reference to Cannon's researches and the fact that 'the bodily concomitants of emotion' could only be very partially controlled by the will.<sup>29</sup> Although little space was given to physiology, it is clear that the authors saw it as an important aspect of the war neuroses. In their reply to an unfavourable review by Armstrong-Jones they referred the reader to Cannon's book for a full treatment of this subject, and repeated this injunction in the preface to the second edition of the book.<sup>30</sup> As will be shown in the next chapter, in the final years of the war some of the most prominent psychologists to work with shell-shocked men also began to explore more fully the physiology of emotion and to incorporate it into their theories. A rigid distinction between 'physical' and 'psychological' theories of shell-shock is not tenable, a conclusion which attains even further force from a consideration of the related topic of the perceived role of instinct in the war neuroses.

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<sup>27</sup> Mott, 'Two addresses on war psycho-neurosis. (I)', p. 127 and p. 129; F.W. Mott, 'The application of physiology and pathology to the study of the mind in health and disease', section of psychiatry, *PRSM* 8:3 (1914-1915), pp. 1-16, p. 15; Mott, *War neuroses and shell shock*, pp. 19-22; Mott, 'Two addresses on war psycho-neurosis (II)', p. 169 and p. 171; Mott, 'The psychopathology of puberty and adolescence', pp. 286-7; Mott, 'The neurological aspects of shock', p. 520; F.W. Mott, *The Harveian Oration on Some Developments of Harvey's Doctrine "Omne Vivum ex Ovo"* (London: John Bale, Sons & Danielsson, Ltd., 1925), p. 28; [Anon.], 'British Medical Association special clinical meeting', p. 709.

<sup>28</sup> G.E. Smith, 'Shock and the soldier. I', p. 816.

<sup>29</sup> Smith and Pear, *Shell shock and its lessons*, p. 8.

<sup>30</sup> *Ibid.*, p. x; Smith and Pear, 'Correspondence: shell shock and its lessons', p. 65.



## The psycho-biology of instinct

A range of doctors incorporated physiological elements into their theories of shell-shock with remarkable ease. One explanation for this fact is that the physiology of emotion, explicitly formulated and interpreted within an evolutionary framework, fitted perfectly into the model of mind prevalent in pre-war psychological medicine and which formed the backdrop of theories of the war neuroses. Cannon portrayed intense emotion as a primitive, animal response to danger which worked through the body and overwhelmed every other function or capability of the organism. His researches therefore provided a physiological counterpart for the psychological struggle between emotion and self-control. Cannon's interpretation of the origin and effects of emotion also dovetailed with another trend particularly evident in the British literature on shell-shock from 1917 onwards: the prominent role assigned to instinct.<sup>31</sup> For Cannon, the all-powerful effects of emotion were explained by the supremacy of the instinct of self-preservation. The concept of instinct as a motivating factor in human behaviour had a variety of sources, and was correspondingly deployed in many different ways in theories of shell-shock. All these uses, however, shared two features. Firstly, it was 'the great primordial instinct of self-preservation', with its accompanying emotion of fear, which was invoked.<sup>32</sup> Secondly, instinct itself was perceived as a legacy of man's animal inheritance. This application of instinct coalesced with other conceptualisations, which have been outlined above and will be further explicated in the next chapter, in the ultimate framing of the war neuroses as regression.

Theories which drew on Cannon's researches implicitly acknowledged the role of self-preservation, but instinct could also be invoked alongside the physiology of emotion in a less precise way. For example, Ballard believed that both suppression of emotional complexes and a 'hyperexcitability of the subconscious instinctive ego' were necessary to the production of an hysterical symptom. These two factors were interdependent, as the excitability of instinct was closely related to the action of the vasomotor and sympathetic systems. The over-stimulation of these systems resulted in 'emotionalism', making any unpleasant affective state 'intolerable', and liable to be suppressed at once.

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<sup>31</sup> See, for example, D.G. Thomson, 'Correspondence: psycho-analysis', *BMJ* 1917 (1), pp. 32-3, p. 33.

<sup>32</sup> Chambers, 'Mental wards', p. 158; for examples of this use, see Mott, 'Two addresses on war psychoneurosis. (I)', p. 127-8 and Ballard, 'The psychoneurotic temperament', p. 374.

This suppression in turn increased excitability, and the vicious circle was ended only by the intervention of a somatic episode.<sup>33</sup> A more conventional theory was put forward by Dudley Carmalt-Jones (1874-1957), commanding officer of the medical division of a military hospital in France, in his explanation of the physical basis of neurasthenia, which he defined as a 'state of fatigue of the central nervous system'. This condition, often found in 'degenerate' types with 'simian' characteristics, resulted from exhaustion of or intoxication with the products of the ductless glands. These substances were secreted in response to danger, but because the 'soldier under discipline has to suppress his instincts and act according to reason' the secretions were not 'properly mobilised by the actions they were intended to facilitate'. As in Ballard's theory, the two factors which produced neurasthenia were the prolonged stimulation of emotion and instinct, coupled with 'the continuous effort of self-control under impulses to seek safety'.<sup>34</sup>

Ballard and Carmalt-Jones drew together the physiology of emotion, the primacy of the instinct of self-preservation, and the soldier's efforts at self-control into unified theories. Although such links could be made wherever the physiological effects of emotion were employed or even just noted, it was rare for authors to directly and simultaneously invoke all three of these factors. It was more common for authors to describe shell-shock as a struggle between instinct and self-control. For example, David Forsyth (1887-1941), a psychoanalytically-inclined physician, argued that the war neuroses resulted from a situation of danger, against which 'the instinct of self-preservation rebels, employing as its weapon the powerful emotion of fear'. This protective and 'ineradicable' emotion could be 'coerced only by a still more powerful effort of will'. The difficulty of self-control increased with each new danger or strain, and eventually the man would break down.<sup>35</sup> In his evidence to the Committee of Enquiry, Bernard Hart (1879-1966), a psychologist who had held the wartime post of consultant in mental diseases to military hospitals in London, explained that the war neuroses were caused by 'a conflict between the self-preservation instinct on the one hand and on other [sic] a group of forces compounded of self-respect, duty, discipline,

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<sup>33</sup> Ballard, *An epitome of mental disorders*, p. 143.

<sup>34</sup> D.W. Carmalt-Jones, 'War-neurasthenia, acute and chronic', *Brain* 42:3 (October 1919), pp. 171-213, p. 171, pp. 175-6, p. 179, and p. 211.

<sup>35</sup> Forsyth, 'Functional nerve disease', p. 1401-2.

patriotism'.<sup>36</sup> These examples demonstrate how the physiology of emotion, the biological concept of instinct, and psychological ideas were used, in varying combinations, to arrive at theories of shell-shock which shared the same basic outline of a struggle between the higher and lower within the human.

David Forsyth and Bernard Hart were both heavily influenced by the Freudian model of mental conflict in the construction of their theories. This raises the interesting question of the extent to which basic Freudian precepts influenced theories of shell-shock. For most of the war psychoanalysis was a controversial and divisive subject. The war forced the issue of mental health into the mainstream of medical practice, and consequently raised awareness of psychoanalytic and other approaches to mind. But the greater publicity psychoanalysis gained also unleashed a venomous criticism at odds with the magpie assimilation of the pre-war years. Such vituperation played little part in the actual literature on the war neuroses, but sections of the wider medical community required little provocation to let loose, at great length, on the topic.<sup>37</sup> One consequence was that even those shell-shock doctors with clear sympathies towards these ideas felt compelled to publicly dissociate themselves from the contaminating words 'Freud' and 'psychoanalysis'.<sup>38</sup> Although the word 'psychoanalysis' was bandied about with increasing frequency from 1918, in many cases this was little more than lip service to the talking cure. Most often the term only connoted a conversation with the patient about his war experience, and doctors stressed their distance from Freud's theories and techniques.<sup>39</sup> Although shell-shock therefore fostered an increased awareness of its existence and main tenets, perhaps laying the groundwork for greater acceptance among the medical community in the 1920s, the extent to which this had a

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<sup>36</sup> B. Hart in *RWOCESS*, p. 77.

<sup>37</sup> See, for example, the letters under the heading 'Correspondence: functional nerve disease', *Lancet* 1916 (1), p. 154, pp. 210-211, p. 265, p. 318, p. 377, p. 430, pp. 588-9, pp. 933-4, p. 971; and those marked 'Correspondence: psycho-analysis', *BMJ* 1917 (1), pp. 32-3, pp. 64-5, pp. 102-4.

<sup>38</sup> Compare, for example, Millais Culpin's measured discussion of Freud to his defensive reaction when described as using 'psycho-analytical' methods: M. Culpin, 'Dreams and their value in treatment', *Practitioner* 102:3 (March 1919), pp. 156-62, p. 162; Culpin, 'Correspondence: the discussion on war neuroses', p. 501. The same unwillingness to be associated with psychoanalysis was shown by Grafton Elliot Smith: G.E. Smith, 'Correspondence: functional nervous disease', *Lancet* 1916 (1), p. 971; Smith and Pear, 'Letters: shell shock and its lessons', p. 64.

<sup>39</sup> D.E. Core, 'Some mechanisms at work in the evolution of hysteria', *Lancet* 1918 (1), pp. 365-70, p. 369; Fearnside, 'Essentials of treatment', pp. 47-8; R.H. Trotter, 'Neurasthenic and hysterical cases in general military hospitals', *Lancet* 1918 (2), pp. 703-4, p. 704; Stewart, 'The treatment of war neuroses', p. 16 and p. 24; Collie, 'The management of neurasthenia', p. 10; Ballard, 'The psychoneurotic temperament', pp. 374-5; Eager, 'A record of admissions', pp. 294-5; Eager, 'The early treatment of mental disorders', p. 559.

positive influence on perceptions of psychoanalysis during 1914-18 was severely limited.<sup>40</sup>

This whistle-stop tour through wartime attitudes to psychoanalysis illuminates the way in which contemporaries related instinctual explanations of shell-shock to Freud's theory of the neuroses. Although instincts were increasingly awarded a prime place among the pantheon of agents directing human behaviour, in broad agreement with the Freudian view of mind, the war neuroses were seen to provide ample evidence that the sexual instinct was not the most important of these.<sup>41</sup> A reactionary such as Robert Armstrong-Jones (who, somewhat prematurely, announced that 'Freudism is dead' in 1917) gleefully took this 'fact' as further ammunition in his campaign against psychoanalysis.<sup>42</sup> Even Ernest Jones accepted that self-preservation was the main instinct at stake in shell-shock, and rushed to explain that this was actually entirely consonant with the Freudian theory of the neuroses.<sup>43</sup> So far as the argument here is concerned, the extent to which instinctual theories of shell-shock drew on Freud is very much a side issue. The aim is to demonstrate a different point: that in its most important features, the depiction of instinct and the unconscious in British interpretations of psychoanalytic theory concurred with the general description of shell-shock as a struggle between emotion and will, and therefore between the animal and the civilised. To this extent, although theorists influenced by psychoanalysis were perceived and perceived themselves as outside the mainstream, a particular type of continuity can be demonstrated at all points on the spectrum of medical opinion on the war neuroses.

In British interpretations of psychoanalytic theory, the unconscious was characterised as the repository of instinct and emotion, and neurosis as the outcome of a conflict

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<sup>40</sup> In a similar vein, Paul Lerner has argued that in Germany, the 'story of psychoanalysis in World War I is suffused with questions and contradictions. While some doctors interpreted the war hysteria phenomenon as an irrefutable vindication of Freud's ideas, others saw it as their ultimate refutation'. Lerner, *Hysterical men*, p. 164.

<sup>41</sup> W.H.R. Rivers, 'A case of claustrophobia', *Lancet* 1917 (2), pp. 237-40, p. 239; F. Dillon, 'The analysis of a composite neurosis', *Lancet* 1919 (1), pp. 57-60; Ross, 'Certain inter-relations between peace and war neuroses', p. 20; Burton-Fanning, 'Neurasthenia in soldiers', p. 911; Hurst, *Medical diseases of the war* [1918], pp. 73-5. The criticism that Freud placed too much emphasis on the sexual instinct above that of self-preservation had also been made before the war. See [Anon.], 'United States of America', *Lancet* 1912 (1) [May 4 1912], pp. 1237-8, p. 1238.

<sup>42</sup> R. Armstrong-Jones, 'Correspondence: psycho-analysis', *BMJ* 1917 (1), pp. 64-5, p. 64; quotation from R. Armstrong-Jones, 'Dreams and their interpretation', *Practitioner* 98:3 (March 1917), pp. 201-19, p. 219.

<sup>43</sup> E. Jones, 'War shock and Freud's theory of the neuroses', section of psychiatry, *PRSM* 11:3 (1917-1918), pp. 21-36, pp. 31-3.

between unconscious and conscious forces which resulted in the undue dominance of the former. Thus William Stoddart (1868-1950), the ex-superintendent of Bethlem Hospital and a consulting physician in mental diseases, explained in his lectures on 'the new psychiatry' that 'our unconscious mind is on a lower, less mental, more neural, and more animal plane than our conscious mind, and it is pervaded with sexual thoughts and desires'. In neurosis, 'the unconscious tends to grow at the expense of the conscious; and it may be taken as a rule that the greater the emotional tone of the original complex the greater does that complex grow when it becomes unconscious'.<sup>44</sup> Ernest Jones emphasised that the unconscious life was 'of a rude and savage character incompatible with the demands of civilised standards'.<sup>45</sup> Constance Long, the author of several articles on psychoanalysis, depicted the unconscious as the storehouse of 'man's primitive tendencies', although she was keen to emphasise that it also 'indicated the means of his liberation from them'. She explained that for the insane and neurotic 'the unconscious rushes through into reality, against their will and with more or less violence, so that the lunatic lives in his dream, and the hysteric is at the mercy of his phantasies'.<sup>46</sup> These themes are reiterated in the work of David Eder. He argued that the war neuroses were the manifestation of emotions which had been repressed from consciousness and therefore had passed into the unconscious. The unconscious was the link between 'us, the heirs of all ages, mentally with primitive man'. The aim of psychoanalysis was to enable the individual, by his own 'will power', to 'surrender that which is infantile and immature in himself' and to become his own master.<sup>47</sup>

These examples demonstrate that although there were undeniable and extremely important differences between psychoanalytically-oriented physicians and those who were not, the association of the unconscious with instinct and emotion meant that there were several points of coincidence between these and more mainstream theories of the war neuroses. These similarities stemmed in part from Freud's use of authors central to pre-war British psychological medicine, most notably Darwin and Hughlings Jackson.<sup>48</sup> The latter was an important inspiration for Rivers' theorisation of shell-shock, but his

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<sup>44</sup> W.H.B. Stoddart, 'The Morison lectures on the new psychiatry. I', *Lancet* 1915 (1), pp. 583-90, p. 587 and p. 590.

<sup>45</sup> E. Jones, 'War and individual psychology', *Sociological Review* 8:3 (July 1915), pp. 167-80, p. 169.

<sup>46</sup> C.E. Long, 'Correspondence: Jung's papers on analytical psychology', *Lancet* 1916 (2), p. 439; for some of her publications on psychoanalysis, see the *Medical Directory* (1918), p. 246

<sup>47</sup> Eder, 'An address on the psycho-pathology of the war neuroses', pp. 264-6, and p. 268.

<sup>48</sup> See Sulloway, *Freud, biologist of the mind*, pp. 252-258 and pp. 270-1.

influence is evident elsewhere. Henry Head's championship of Jackson's theory of dissolution must have prepared many neurologists to accept the idea of mental disorder as the release of lower levels of nervous function.<sup>49</sup> Sir George Savage drew on Jackson to explain the loss of control evident in the war neuroses.<sup>50</sup> Stoddart even concluded his explication of Freud, perhaps as a sweetener to the audience, by claiming that the 'fundamental principles of our new psychiatry' had all been foreseen by 'the great man' back in the 1890s. The 'modern school' had only proved Jackson's theory that 'there is a positive and a negative element in every case of insanity, the negative being defect of consciousness or loss of *some* consciousness, the positive being activity of the consciousness remaining (on a lower level)'.<sup>51</sup>

The common fund of reference helped to bridge the gap between psychoanalytic theories and those propounded by less psychologically minded authors. Farquhar Buzzard, a neurologist by trade, happily expounded the view that the war neuroses occurred when 'primitive instincts and emotions cease to be corrected or controlled by higher mental activities which, from the individual and the racial point of view, are of later development'.<sup>52</sup> The author of the chapter on shell-shock in the *Times History of the War* is unknown, but from the comment that the healthy soldier should be 'dissociated from his brain' during battle, it seems fair to assume that his understanding of the latest psychological literature was sketchy at best. But he was still able to explain that the unconscious or subconscious mind was the repository of race instinct, and that it was spearheaded by fear, 'chief among the primitive or elemental emotions'. In shell-shock, the 'controlling power' of man was weakened, 'the conscious mind was in abeyance', and 'fear tended to assert itself and to gain dominion over the whole being'. The protective mechanism of fear had been 'carried out of the normal into the abnormal'.<sup>53</sup> Mott argued that Freud's theory was not so revolutionary after all: the concept of the censor did not 'differ essentially from inhibition exercised by the highest centres of control', and it was only the innovatory language which obscured the familiarity of the explanation.<sup>54</sup>

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<sup>49</sup> See, for example, H. Head, 'Some principles of neurology', *Brain* 41:3 and 4 (November 1918), pp. 344-54, p. 349.

<sup>50</sup> G.H. Savage, 'Mental war cripples', *Practitioner* 100:1 (January 1918), pp. 1-7, p. 1.

<sup>51</sup> Stoddart, 'The Morison lectures on the new psychiatry. I', p. 590.

<sup>52</sup> E.F. Buzzard in *RWOCESS*, pp. 74-5.

<sup>53</sup> [Anon.], 'The mental factor in modern war', pp. 321-2 and pp. 324-5.

<sup>54</sup> Mott, 'Two addresses on war psycho-neurosis (II)', p. 169.

The point to which this discussion of the physiology of emotion and the psycho-biology of instinct has been leading is that from the standpoint of physiology, biology, neurology, or psychology, the war neuroses were conceived as a triumph of the body, the animal, and the primitive over the highest accoutrements of human civilisation. Langdon Brown emphasised that the sympathetic system was 'for ever beyond the control of the will'. Although the 'highest organism is the most self-controlled [...] the sympathetic cannot be thus controlled'. Humans might learn to 'deaden' the emotions, but nothing could 'prevent the response to an emotion once evoked'.<sup>55</sup> The American psychologist Sidney Schwab concluded that in shell-shock, 'the soldier for the time being acts as an instinctive and primitive organism, under the guidance of the most primitive of impulses, that is, of self-preservation'.<sup>56</sup> One psychoanalytical interpretation of the war neuroses ended with the author's regrets that he had no space to discuss 'the close parallelism between the concept of a profound narcissistic regression and the return, from a physiological standpoint, to the phylogenetically earlier biochemical control of function by the endocrines'.<sup>57</sup> Although these theorists approached the problem from different angles, they all reached the same conclusion: shell-shock was a regression to a lower level of individual or racial development.

The concept of regression was at the heart of the conceptualisation of the war neuroses, and it united physicians whose theories seem wildly divergent on initial analysis. In the opinion of some, this regression stretched back further than the infancy of the individual; it reached back into the depths of the history of human evolution and beyond.<sup>58</sup> Oscar Pearn, a former asylum psychiatrist now serving at the Lord Derby War Hospital, regarded certain symptoms as examples of 'regression' because they represented 'an attempt at adaptation on lower psychic levels when the superior functions are in abeyance'.<sup>59</sup> William McDougall stated that in cases of severe amnesia, 'the patient's memory function seemed to be reduced to its most rudimentary or

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<sup>55</sup> W. L. Brown, 'The Croonian lectures on the role of the sympathetic nervous system in disease. I', *Lancet* 1919 (1), pp. 826-33, p. 833.

<sup>56</sup> S.I. Schwab, 'The mechanism of the war neuroses', *JAP* 14:1 and 2 (April-June 1919), pp. 1-8, p. 6.

<sup>57</sup> G.H. Fitzgerald, 'Some aspects of the war neurosis', medical section, *British Journal of Psychology* 2:2 (January 1922), pp. 109-20, p. 120.

<sup>58</sup> See C. Bird, 'From home to the charge: a psychological study of the soldier', *American Journal of Psychology* 28:3 (July 1917), pp. 315-48 for a particularly developed analysis of this theme. Bird was an American psychologist, but he based his argument largely on the British literature of shell-shock.

<sup>59</sup> Pearn, 'Psychoses in the Expeditionary Forces', p. 108. See also Maurice Nicoll in 'Discussion: the repression of war experience', p. 18.

primitive condition, such as we may suppose to obtain among the lower animals'.<sup>60</sup> The neurologist and RAMC captain Donald Core (1882-1934), meanwhile, explained the amnesias and anaesthesiae of the war neuroses as an 'inherited physiological reaction', the counterpart of auto-amputation of a wounded limb by crabs, newts, and lizards, or loss of appetite found in the brooding bird waiting for her eggs to hatch. All these actions served the same purpose as a hysterical symptom of dissociating the individual from painful impressions in order to ensure 'the welfare of the race'.<sup>61</sup> The effects of shock, claimed Stanford Read, were always 'more or less reversionary', and brought out 'prehistoric and sometimes even embryonic activities'. This 'phylogenetic aspect' was best seen in those 'stuporose states' similar to 'the cataplexy of animal life', which constituted 'a sort of defence of the organism and might be regarded in a biological light'. The 'essential motive in the functional psychopathic states of shell shock' was always 'a desire to get out of the situation', however, and to this extent all symptoms were a manifestation of regression.<sup>62</sup> These examples demonstrate the wartime prevalence of the view that shell-shock constituted a regression to a lower stage of evolutionary development. This conception was most fully developed in the post-war work of Rivers, the apparent sage and saviour of psychological understandings of the war neuroses.

### **Regression in the theories of W.H.R. Rivers**

William Halse Rivers Rivers (1864-1922) was fifty when the First World War broke out, and already well known for his contributions to neurological research and anthropology. During the war he embarked on a third career as an army psychologist, serving successively at Maghull Military Hospital, Craiglockhart War Hospital, and then attached in the capacity of psychologist to the Royal Flying Corps at the Central Hospital at Hampstead.<sup>63</sup> He is perhaps best remembered today for his 'treatment' of the poet Siegfried Sassoon at Craiglockhart War Hospital in 1917, an episode recorded by the latter in his trilogy of 'fictional autobiographies', and more recently retold for

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<sup>60</sup> William McDougall in 'Special discussion on shell shock', p. xxvi.

<sup>61</sup> Core, 'Some mechanisms at work in the evolution of hysteria', p. 366.

<sup>62</sup> Read, 'A survey of war neuro-psychiatry', pp. 365-6 and p. 369.

<sup>63</sup> The standard biography of Rivers is R. Slobodin, *W.H.R. Rivers* (New York: Columbia University Press, 1978), which focuses on his career as an anthropologist.



the general public by Pat Barker's *Regeneration* (1991).<sup>64</sup> The conventional historiography of shell-shock has caught something of the eulogistic tone of these depictions, highlighting Rivers' adoption of a modified Freudianism and his practice of analytic therapy.<sup>65</sup> Although undoubtedly of relevance to the history of the reception of Freud in Britain, the near-exclusive focus on this aspect of Rivers' work has tended to obscure how his theorisation of shell-shock relates to his other professional interests, and its place within the general context of theories of the war neuroses.

Although the discussion here touches on the former point, its main aim is to demonstrate that Rivers' theories of shell-shock are consonant with its widespread wartime conceptualisation as a struggle between the animal and human constituents of man which resulted in regression. This argument is developed primarily through an analysis of the depiction of the war neuroses in his *Instinct and the unconscious* (1920). Rivers actually published very little on shell-shock during the span of the war. In its final two years he published four articles, three of which explored in some depth the application of the Freudian model of mental conflict to the war neuroses.<sup>66</sup> These publications, all lucid explications of psychological theory and its practical value, appear to have formed the basis for the view of Rivers as a psychiatric pioneer. By contrast, the first impression on reading *Instinct and the unconscious* is of its utter strangeness. Here, Rivers drew on physiology, neurology and biology as well as Freud in the attempt to demonstrate 'the general biological function of the process by which experience passes into the region of the unconscious'.<sup>67</sup> Ben Shephard has argued that this work is a significant divergence from the psychoanalytical interpretation of the wartime articles and that 'Rivers was himself regressing back to his neurological past'.<sup>68</sup> Here, it is suggested instead that *Instinct and unconscious* was not only the logical endpoint of Rivers' approach to psychology, but also the culmination of a far more widespread conceptualisation of the war neuroses.

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<sup>64</sup> S. Sassoon, *Sherston's progress* (London: Faber and Faber, 1983) [1936]; P. Barker, *Regeneration* (London: Penguin, 1991).

<sup>65</sup> Leed, *No man's land*, pp. 176-82; Showalter, *The female malady*, pp. 167-94; Stone, 'Shellshock and the psychologists'.

<sup>66</sup> Rivers, 'A case of claustrophobia'; W.H.R. Rivers, 'Freud's psychology of the unconscious', *Lancet* 1917 (1), pp. 912-4; W.H.R. Rivers, 'The repression of war experience', section of psychiatry, *PRSM* 11:3 (1917-1918), pp. 1-17

<sup>67</sup> Rivers, *Instinct and the unconscious*, p. 5.

<sup>68</sup> Shephard, "The early treatment of mental disorders", p. 452.

In *Instinct and the unconscious*, Rivers proposed that the psycho-neuroses were the result of a failure in the maintenance of 'a state of equilibrium between instinctive tendencies and the forces by which they are controlled'. This imbalance was the result of either an 'increase in the power of the suppressed tendencies' [i.e. the instinct of self-preservation and its accompanying emotion of fear], or the 'weakening of the process by which they are controlled'. He believed that although both factors were always involved, the second was of more importance in the production of the war neuroses. The 'excessive nature of the strains to which modern warfare exposes the soldier' made the normal process of repression of instinctive tendencies difficult to maintain, while simultaneously the dangers to which he was exposed roused the activity of the instinct of self-preservation, which was 'rarely touched by the ordinary life of the member of the modern civilised community'. The psycho-neurosis resulted from the attempt 'to restore the balance between instinct and controlling forces'.<sup>69</sup> This explanation of the neuroses was entirely consonant with the theories Rivers had put forward in his wartime articles, where he had also focussed on the unprecedented strains to which the soldier was subjected, and the role of repression in the formation of an anxiety neurosis.<sup>70</sup> The similarities between this account and the instinctual theories outlined in the earlier part of this chapter, which it was argued recast but did not fundamentally alter the notion of a struggle between emotion and will, is also evident.

Rivers reiterated an argument he had put forward in his 1918 article on military hygiene and military training that the most important factor in determining the form the neurosis took was 'the nature of the process by which it is attempted to solve the conflict between the instinctive tendencies which have escaped from control, and the forces by which this control has been exerted'. Anxiety neurosis was again explained as the result of an unsuccessful attempt to suppress the instinct of self-preservation and its accompanying emotion of fear through the witting process of repression. But he now expanded this analysis to claim that repression failed as a means of solving the conflict between instinct and the forces by which they were controlled because suppression was an instinctive process that was 'especially potent and effective in childhood', and 'should become less potent and effective with advancing years'. The process of suppression could only be effective when it was unwitting, and anxiety neurosis

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<sup>69</sup> Rivers, *Instinct and the unconscious*. pp. 119-20 and p. 5.

<sup>70</sup> Rivers, 'The repression of war experience'.

resulted from 'the failure in the adult of a process which takes place naturally and without any special conflict in childhood'.<sup>71</sup> Significantly, Rivers now described anxiety neurosis as not only the result of a conscious and intelligent attempt to uphold the social standard of duty, but as the characteristic reaction of an adult which paradoxically failed because it attempted to reinstate a childish form of mental activity.

The explanation Rivers gave of hysteria, or in his terminology (for reasons which will become apparent) substitution-neurosis, constituted more of a departure from his earlier theory. Although the instinct of self-preservation had been given a central role in the causation of hysteria in his 1918 article, there he had focussed far more on suggestibility as fostered by military training and manifested in symptoms. He now argued that in hysteria 'the organism seeks to escape from the conflict by substituting another form of instinctive reaction for that which has been brought into activity, by the conditions which have acted as the immediate precursors of his disorder'. In his view, the most common hysterical symptoms found in the war neuroses, paralyses, contractures, and anaesthesias, were manifestations of the instinct of immobility, which in an earlier chapter he had described as an extremely primitive reaction to danger.<sup>72</sup> Therefore whereas anxiety neurosis was 'due to conflict between the primitive and instinctive tendencies and factors based largely or altogether on intelligence', hysteria was 'the result of the abrogation of the modifying principle based on intelligence' and originated in 'the substitution, in an imperfect form, of an ancient instinctive reaction in place of other forms of reaction to danger'.<sup>73</sup>

The most interesting part of *Instinct and the unconscious* from the present point of view, however, is the penultimate chapter, in which Rivers considered the extent to which the psycho-neuroses of war were 'examples of regression', or, following Hughlings Jackson, 'processes which enable us to study the general course of mental development on the assumption that in disease the organism tends to retrace the steps through which it has passed in its development'. He dealt with hysteria rather summarily, claiming that if it did actually represent the substitution of the instinct of immobility for other forms of reaction, then it was 'not merely an example of

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<sup>71</sup> Rivers, *Instinct and the unconscious*, pp. 120-6.

<sup>72</sup> On the physiological basis of the instinct of immobility, and its relation to hypnotism, see also [Anon.], 'A physiological puzzle', *Nature* 94 (Sept. 1914 - Feb. 1915), pp. 338-9.

<sup>73</sup> Rivers, *Instinct and the unconscious*, p. 55 and pp. 127-35.

regression, but of regression to a very primitive form of reaction', 'not merely [...] to a character of the infancy of the individual, but to a character which must go very far back in the process of development by which Man has become what he is'. Although the regression was less complete in anxiety neurosis, its major features – 'the strength and urgency of emotional reactions', nightmares, compulsive acts – were all 'an outcrop of a mode of reaction which is characteristic of infantile mentality'. He even suggested (although admitting that it might appear 'fanciful' to some) that the desire for solitude and lack of sociability shown by such patients was 'an instinctive reaction of the same kind as that which leads animals when ill, to withdraw from their fellows in order to die in solitude', and was therefore a 'regression to an instinctive reaction dating far back in the history of the race'.<sup>74</sup>

In *Instinct and the unconscious*, his final and fullest statement on the war neuroses,<sup>75</sup> Rivers skilfully wove the disparate strands explored by wartime authors – physiology, neurology, psychoanalysis – into a coherent and wide-ranging theory. Rivers was, however, exceptional only in the scope, intellectual consistency, and detail with which he worked out this theory. His broad conceptualisation of the war neuroses as regression coincided exactly with that put forward across the range of the wartime medical literature. Although Shephard has suggested that this book diverges from his expositions and applications of Freud in the latter years of the war, it appears more likely that the different focus reflects the context in which it was written. His immersion in Freud while at Maghull partly explains this focus in his earlier articles,<sup>76</sup> but their proselytising function is also important. Rivers stepped into the debates on Freud, ducking to avoid all the mud flying about, and put forward a quietly impassioned case for the practical value of a modified analytical approach. In 1917, shell-shock constituted a military and therefore a national emergency. The main criteria for publication of articles on the subject was the immediate relevance of a theory for understanding and treating the disorder. This is what Rivers aimed to achieve in his wartime writings.

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<sup>74</sup> Ibid., p. 148-52.

<sup>75</sup> His *Conflict and dream* (London: Kegan Paul, Trench, Trubner & Co., 1923) drew substantially on his work with shell-shocked patients, but was posthumously compiled by Elliot Smith from a course of lectures delivered at the Psychological Laboratory at Cambridge between 1920 and 1922.

<sup>76</sup> T.H. Pear, 'Some early relations between English ethnologists and psychologists', *Journal of the Royal Anthropological Institute of Great Britain and Ireland* 90 (1960), pp. 227-37, p. 232; see also A. Costall, 'Dire Straits: the divisive legacy of the 1898 Cambridge anthropological expedition', *Journal of the History of the Behavioral Sciences* 35 (1999), pp. 345-58.

It is unlikely that Rivers had fully formulated the theory put forward in *Instinct and the unconscious* at this point, but there is nothing in the earlier articles that conflicts with it. In his 1917 discussion of 'Freud's psychology of the unconscious' he defined the unconscious as a repository of ancestral (most prominently instinctive) as well as individual experience, a view which points towards his lengthier exposition of a biological theory of the war neuroses and was also representative of a wider trend, as shown above.<sup>77</sup> Allan Young's demonstration that a 'biological standpoint' derived largely from Herbert Spencer and Hughlings Jackson is a consistent strand running through all Rivers' varied professional researches militates against the notion that *Instinct and the unconscious* strikes a discordant note in his repertoire.<sup>78</sup> Rivers' writings on the future direction of psychological research also suggest that this post-war publication was a contribution towards his vision of the science. In 1916, he argued that psychology and sociology had essentially the same aims and each should learn from the methodologies developed by the other, a suggestion he underlined with reference to his own experience of studying primitive mentalities and cultures.<sup>79</sup> In May 1919 he further developed this idea of psychology as a science in which the various branches – introspective, experimental, educational, industrial, social, animal, and physiological psychology – should work together and with ethnology and medicine to 'form a harmonious organisation working [...] towards the better understanding of that which makes man what he is, which makes human society what it is – the Mind'.<sup>80</sup> This was the approach Rivers had taken in his own work, drawing on his own specialities, to date. *Instinct and the unconscious*, far from being an anomaly, was the work in which this vision was most fully developed.

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<sup>77</sup> W.H.R. Rivers, 'Freud's psychology of the unconscious', *Lancet* 1917 (1), pp. 912-4, p. 912. This was a conventional Victorian definition of the bodily unconscious. See Taylor, 'Obscure recesses'. It was also a prominent feature within Freud's psychoanalytic theory. See Otis, 'Organic memory and psychoanalysis'.

<sup>78</sup> See Young, 'W.H.R. Rivers and the war neuroses'; Young, *The harmony of illusions*, pp. 42-85. Young's work is the most significant contribution yet published to a 'joined up history' of Rivers' intellectual thought.

<sup>79</sup> W.H.R. Rivers, 'Sociology and psychology', *Sociological Review* 9:1 (Autumn 1916), pp. 1-13.

<sup>80</sup> W.H.R. Rivers, 'Psychology and medicine', *British Journal of Psychology* 10:2 and 3 (March 1920), pp. 183-93, p. 193.

## Conclusion

The notion that emotion revealed ‘human nature in its common character’ and taught ‘an equality which is no flattering ideal, but a convincing testimony to the descent of man’ pre-dated 1914.<sup>81</sup> The experience of shell-shock appeared to provide positive and depressing proof of its truth. Whether perceived as the dominance of emotion, the recrudescence of instinct, or the loss of self-control, shell-shock was always a regression. The war neuroses were described from a variety of perspectives by different authors: the physiology of emotion, the biology of instinct, and the psychology of the unconscious were all explored in the attempt to understand these disorders. But ultimately all conceptualised the nervous and mental disorders of war in terms of a struggle between the higher and lower in man, and as damning evidence of his animal origins.<sup>82</sup> This evolutionary framework linked apparently diverse explanations of shell-shock, and cut through the division between ‘physical’ and ‘psychological’ theories. But it also meant that the war neuroses were aligned with a much older complex of fears regarding human nature, civilisation, and its future development. These anxieties continued into the post-war era, and as will be shown in the remaining chapters, if anything were deepened by the experience of four years of highly advanced and scientific bloodshed.

The broken soldier was an ominous reminder that only the thinnest and most fragile layer of neural tissue separated the human from the animal. Shell-shock was a great leveller. If man could be reduced to beast by the burden of war, his creature cousins were not immune from its blasts. The phenomenon of shell-shock in fishes and cows has already been noted. In the first case, this resulted from proximity to explosions; in the second, from the physiological effects of emotion. Yet a third definition of the disorder was applied to animals, this time to army horses. In an unsigned article in the *Times* from December 1917, the observation that there was ‘a great difference in the horses as they go in and out of line’ led into a description of equine trauma which mirrored those of human sufferers. The horses eagerly went into the line full ‘of fire and beans’, but returned ‘plastered with mud and very tired, and show no interest in the

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<sup>81</sup> J.A. Hobson, *The psychology of jingoism* (London: Grant Richards, 1901), p. 31.

<sup>82</sup> Metaphors of animalism also pervaded British and European fiction produced in response to the war. See A. Bonadeo, *Mark of the beast: death and degradation in the literature of the Great War* (Kentucky: University of Kentucky Press, 1989), especially pp. 1-40.

gun teams that pass them on their way up'. The intelligence and courage of British horses was favourably compared to those of other nations, particularly the 'Argentine and Canadian horses that lie down and flounder in any shell-hole that gives them excuse for rest'. As with men, 'well-bred horses [...] suffer more from shell shock than the low-bred ones'. Finally, the story of a team of gun horses which had miraculously escaped injury from a shell explosion was told. The horses would never again 'approach that wall without shaking and quivering and falling down, or hear the sound of a near approaching shell without showing these same symptoms as a soldier might'. They 'had to be evacuated to a veterinary hospital well behind the lines and out of the range of shell and bomb till time brought forgetfulness and they could be sent up again'.<sup>83</sup> The identification between the shell-shocked soldier and the animal was complete.

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<sup>83</sup> [Anon.], 'Army horses: animal sufferers from shell shock', *Times* 28 December 1917

## Chapter 7

### The re-making of man: the role of will in theories and therapies

#### Introduction

From 1916, emotion was routinely listed as a crucial aetiological factor in discussions of the war neuroses. The previous chapter discussed theories of the war neuroses which invoked physiology and biology to explain the evolutionary significance and mode of action of emotion. In these theories, the idea of shell-shock as regression reached its height. This conceptualisation was present, however, even in writings which defined emotion as a psychological experience. This was because in the evolutionary model of mind, the essential counterpart of an over-abundance of emotion was a loss in the direction of will. As a consequence, shell-shock was always perceived, whether through the dominance of emotion or the lack of volition, as a deviation from the ideal of the civilised mind. Although the concepts of emotion and will were so closely related in descriptions of mental functioning that it is impossible to discuss one without the other, this chapter focuses on the ways in which the idea of volition, particularly in the form of self-control, was deployed in theories and therapies devised around shell-shock.

The first part of this discussion further develops the theme of the war neuroses as an imbalance of will and emotion, and demonstrates that the question of will was central to medical, military, and social meanings of shell-shock. The second explores the ways in which the concept of volition operated in a range of therapies. These have not been selected as representative methods of treatment. The broad sweep of therapeutic measures during the war was characterised by 'pragmatic eclecticism', and conventional methods such as warm baths and bromides remained widespread.<sup>1</sup> The focus here is on suggestion, with particular reference to the electrical cure used by the physiologist Edgar Adrian (1889-1977) and neurologist Lewis Yealland (1885-1954); the methods of abreaction and autognosis developed by the academic psychologist William Brown (1881-1952) during his service at a casualty clearing centre in France

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<sup>1</sup> P. Leese, "Why are they not cured?" British shellshock treatment during the Great War' in Micale and Lerner (eds), *Traumatic pasts*, pp. 205-21.



and later at Craiglockhart War Hospital; the ‘mental analysis’ pioneered by a group of physicians based at Maghull Military Hospital near Liverpool; and the ‘ergotherapy’ touted by Arthur Brock (1879-1947), a general practitioner who also worked at Craiglockhart. Although some comment will be made on the extent to which each of these methods found support among the wider medical community, the main aim is rather to highlight how will and emotion were understood as crucial components in the pathology of the neurotic individual, in the process of cure, and how these aspects reflected and served more widespread trends in medical and social thought. The aim of all these treatments was to restore proper self-control to the individual, and therefore to maintain the claim of the human against the animal. The chapter concludes by arguing that although fear was to some extent naturalised by the experience of war, this paradoxically entailed a heightened emphasis on the importance of will-power. At the end of the war, self-control was perceived as more important than ever to individual identity, military functioning, and the maintenance of civilisation.

### **The war neuroses as an imbalance of emotion and will**

The earliest reports on the nervous and mental disorders of war focussed on strain and stress as predisposing agents, although this did not preclude some reference to emotion.<sup>2</sup> But as the war progressed, it became standard to invoke emotion as an extremely important, and often the primary, aetiological factor in shell-shock. The emotion most frequently singled out, although not without some dissent,<sup>3</sup> was fear. This conceptualisation of fear covered not only the threat to life or limb; expressed as the fear of failing in duty, or fear of being afraid, it was also the vital constituent of anxiety.<sup>4</sup> Within the prevalent model of mind as dependent on the balanced functioning of feeling, thought and volition, the dominance of emotion could not help but have effects on these neighbouring spheres. In the mind of the shell-shocked soldier, these elements had been thrown into disarray. For the most part, however, negative effects on the intellect were minimised in medical accounts. Smith and Pear emphasised, ‘it is not in the intellectual but in the *emotional* sphere’ that causes must be sought for these

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<sup>2</sup> [Anon.], ‘The war and nervous breakdown’, p. 189; [Anon.], ‘Medical notes in Parliament: early treatment of mental disorder’, p. 777; [Anon.], ‘The Mental Treatment Bill’, p. 772.

<sup>3</sup> Smith, ‘Shock and the soldier. II’, p. 853; C.S. Myers, ‘Contributions to the study of shell shock. IV’, p. 467; Clarke, ‘Some neuroses of the war’, p. 72.

<sup>4</sup> Campbell, ‘War neuroses’, p. 503; Turner, ‘Remarks on cases of nervous and mental shock’, p. 835; [Anon.], ‘The mind of the soldier’, p. 188; R. Eager, ‘War psychoses’, p. 425.

conditions, which were 'characterised by instability and exaggeration of emotion rather than by ineffective or impaired reason'.<sup>5</sup> The war neuroses were overwhelmingly constructed as an imbalance of emotion and will.

The operation of emotion and will were not only closely related, but reliant on the maintenance of a fine tension. Allied to the view of the normal mind as the outcome of a balance of different components was the notion that in the disturbed mind, an abundance in one direction must be compensated by a loss in another direction. Ergo, where 'the emotional factor is paramount there is generally found weakness of the will, hyper-suggestibility, anxious tension, and apprehension'.<sup>6</sup> The war neuroses were perceived as a condition in which 'emotions have taken the place of a forceful will-power'.<sup>7</sup> The only way in which emotion could expand its empire was by encroaching on the territory of the will. Asked to define shell-shock, witnesses to the War Office Committee of Enquiry described it as 'a state of persistent or recurring fear, which overrides the self-control of the individual', or 'the sapping of a man's morale by sudden or prolonged fear which subordinates a man's power of will to his instinct of self-preservation and ultimately reduces him to a state wherein he cannot control his emotions'.<sup>8</sup> However, the particular attributes attached to emotion and will meant that this imbalance was endowed with both evolutionary and social significance.

The social aspect of the war neuroses is well illustrated by a paper the eminent ophthalmologist John Herbert Parsons delivered to the neurological section of the Royal Society of Medicine in 1915. The view that 'moral conduct is essentially social conduct', that the individual was always of necessity a social being, and that the highest stage of conduct was its regulation according to an ideal, was central to Parsons' explanation of the progress of recovery from shock. He defined character as the modification of physiological and instinctual reactions by 'volitional control which varies according to [the individual's] social environment and educative experience'.<sup>9</sup> In battle, the soldier was usually bodily fatigued, scared, and excited. All these conditions conspired to impair his control and judgment and 'to give his innate instincts

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<sup>5</sup> Smith and Pear, *Shell shock and its lessons*, p. 3: emphasis in the original.

<sup>6</sup> Wolfsohn, 'The predisposing factors of war psycho-neuroses', p. 179; see also Savage, 'Mental war cripples', p. 4.

<sup>7</sup> Veale, 'Some cases of so-called functional paresis', p. 608.

<sup>8</sup> T.R. Elliott and J.F.C Fuller in *RWOCESS*, p. 29 and p. 71.

<sup>9</sup> Parsons, 'The psychology of traumatic amblyopia', pp. 59-60.

ungoverned play'. The factors which enforced his volitional control were 'positive self-feeling, aided by suggestion and imitation, and the sentiments of patriotism, the honour of the regiment, his own honour, and so on'. A shell explosion, knocking the man unconscious, would temporarily remove this higher control and render the man 'more a victim of his lower instincts'. This was a uniform initial reaction, demonstrated by the emotional behaviour displayed in the early stages of recovery. Ultimately, however, the response of the individual to shock depended 'upon the degree of development of his self-regarding sentiment', an ill-defined phrase in Parsons' account but which seems to have meant the degree to which social ideals had penetrated the formation of individual character.<sup>10</sup>

Parsons explained that at the earliest stage of recovered consciousness, volitional control was abrogated and the man was 'merely an emotional animal, or rather worse, for he is deprived of that intelligent control which plays such an important part in animal life'. At this stage, 'the most potent of the primeval instincts – fear – holds almost undisputed sway, irrespective of the normal character of the individual, for the loss of volitional control implies the loss of co-ordination of all those complex factors which make up the character of the man'. As recovery proceeded and the 'self-regarding sentiment' was gradually restored, the man would seek either to mask or to suppress his fear. The 'naturally mean-spirited man' would seek only to hide fear through a sense of shame, and would therefore attempt to avoid renewed exposure to danger. The man of 'fine character', on the other hand, would suppress fear 'with ever-increasing vigour as he becomes more and more conscious of the ideals of conduct which have shaped his character', although even so he would 'require all the help which can be derived from the highest sentiments, reinforced by suggestion and by the active sympathy of discreet friends and advisors'. Parsons concluded that of central importance in determining recovery were the motives which had impelled the man to enlist. Those who had joined up only because their friends had done so were liable to remain 'partial wrecks, too fearful of a renewal of their terrifying experience to be of any use in the fighting line'. But the man 'impelled by a noble ideal' was likely to recover entirely, 'reinforced indeed by the sense of a moral victory won'.<sup>11</sup> In Parsons' model, an inability to recover connoted lack of patriotism and the highest development

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<sup>10</sup> Ibid., pp. 61-2.

<sup>11</sup> Ibid., pp. 63-4.

of the civilised mind. The failure of the confirmed war neurotic to recover only stamped the final seal on his inherent inferiority as a human and social being.

The evolutionary importance of emotion and will, the alignment of the former with the primitive and the latter with the civilised, was even more prominent in Armstrong-Jones' articles on the psychology of fear. He described the war neuroses as a condition in which fear, 'the oldest as well as the most intense of the emotions', overrode the action of the will, 'the highest and essentially the most human characteristic of the mind'.<sup>12</sup> In his view, the struggle of the individual soldier was nothing less than a re-telling of the story of human evolution itself. Man had 'experienced and recognised' fear 'from his earliest stages', but he had also 'tried to avoid and control' it, 'lest it should seize his whole personality'.<sup>13</sup> The apogee of human development was the faultless command of the will, and any condition in which the will was in abeyance – such as sleep and dreaming – was fundamentally regressive, associated with women, children, and the insane.<sup>14</sup> The terrifying dreams of soldiers were analogous to the night terrors of young children; both were explained by the 'phylogeny of sleep', as the semi-nocturnal habits of early man had undoubtedly served a protective function.<sup>15</sup>

The alignment of emotion and will with different stages of individual, social, and racial development has been demonstrated in several places in this thesis. In chapter four, comparisons of shell-shocked men to children were discussed, and the previous chapter examined the views of emotion as an animal, physiological event. It should nevertheless be underlined again that although these themes were particularly prominent in the writings of Parsons and Armstrong-Jones, they were also extremely widespread in the wartime literature. In his article on 'the wear and tear of flying', Thomas Rippon referred to the tests that were employed in different European countries to measure the nerve of the prospective pilot. He claimed that because self-control was 'a marked characteristic' of the average British man, it was not necessary to make assessments of his ability to keep calm under pressure: however, such

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<sup>12</sup> Armstrong-Jones, 'The psychology of fear', p. 349 and p. 351; Armstrong-Jones, 'Dreams and their interpretation', p. 201; Armstrong-Jones, 'Correspondence', pp. 407-8.

<sup>13</sup> Armstrong-Jones, 'The psychology of fear', p. 350 and p. 357.

<sup>14</sup> [Anon.], 'Discussion on the nervous child', *BMJ* 1923 (2), pp. 963-71, p. 969; Armstrong-Jones, 'Dreams and their interpretation', p. 205, pp. 210-11, and p. 213.

<sup>15</sup> Armstrong-Jones, 'The psychology of fear', p. 360.

measures were essential in the screening of 'the more emotional Latin type'.<sup>16</sup> At the mental ward he supervised in France, the asylum psychiatrist William Chambers claimed that mental defectives, hysterics, and negroes most often displayed the 'abandonment of all attempt at control' which characterised reactions of extreme terror in air raids.<sup>17</sup> The exercise of will lifted civilised man out of the primitive world of emotion, but it remained all that separated him from the child, woman, savage, or animal.

### **The role of will in theories of the war neuroses**

The symbiotic relation of emotion and will demonstrates that although either of these concepts could be stressed above the other, the problem of volition was always at the heart of the war neuroses. It might be implicated in the causation of the disorder, as in accounts which argued that emotion had achieved dominance through lack of self-control.<sup>18</sup> In this aspect, the question of will was also central to the implementation of military discipline, which depended on the degree to which the individual could be held responsible for his actions. As the Committee of Enquiry concluded, if an individual was capable of exercising self-control but nevertheless refused to 'face the situation', he was guilty of cowardice, a crime which carried the death penalty. The difficulty in cases of shell-shock arose from the delicate decision as to 'whether the individual has or has not crossed that indefinite line which divides normal emotional reaction from neurosis with impairment of volitional control'.<sup>19</sup> There was broad agreement in the medical community with Myers' statement that in practice 'every grade of transition may be met with between [...] quite uncontrollable functional disorder and [...] sheer purposeful malingering'.<sup>20</sup> There was less consensus on where to draw the separating line.<sup>21</sup>

Lack of will was also perceived as a defining symptom of all the various manifestations of shell-shock. The entire cabal of functional disorders were described by some as

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<sup>16</sup> T.S. Rippon, 'The wear and tear of flying', *TMW* 12 (1919) [April 25 1919], pp. 326-7.

<sup>17</sup> Chambers, 'Mental wards', p. 154 and p. 173.

<sup>18</sup> Mott, 'The Chadwick lecture', p. 39; A.F. Hurst, 'Nerves and the men (the mental factor in the disabled soldier)', *Reveille* 2 (November 1918), pp. 260-8, p. 260.

<sup>19</sup> Summary of findings, *RWOCESS*, p. 139.

<sup>20</sup> Myers, 'Contributions to the study of shell shock. IV', p. 466-7.

<sup>21</sup> See R. Cooter, 'Malingering in modernity: psychological scripts and adversarial encounters during the First World War' in Cooter, Harrison and Sturdy (eds), *War, medicine and modernity*, pp. 125-48.

characterised by a mechanical failure of the will, in which ‘the motive power to start the machinery cannot, as it were, be switched on’; for others this was the distinguishing feature of neurasthenia alone; while the most prominent trait of hysteria continued to be seen as ‘lack of control over the emotions and actions’ in several quarters.<sup>22</sup> The ‘will to recover’ was also perceived as a vital element in the maintenance or cure of symptoms. David Drummond, physician to Northumberland War Hospital, identified ‘loss of control’ as ‘the essence’ of the war neuroses as patients so frequently ‘give way and drift because they make no attempt to regain control by the exercise of desire and will’.<sup>23</sup> Collie similarly attributed failures of cure to ‘the stubbornness, lack of will-power, or refusal of further treatment by the patient’.<sup>24</sup> The individual could only conquer fear through the exercise of will, and so the ultimate aim of any treatment which purported to achieve more than the mere removal of symptoms was to restore will to its proper place in the mental functioning of the individual.<sup>25</sup> Cure was dependent on the reinstatement of will. The patient had to obtain ‘volitional control’ over his memories and emotions before he could be healed, an attainment which amounted to nothing less than ‘the recovery of the normal self’.<sup>26</sup>

Although will was always implicated in explanations of the war neuroses, the contrasting attributes attached to will and emotion meant that the portrait of breakdown differed significantly according to which of these aspects was emphasised. The relation of emotion and will was so close that this difference depended on subtle shifts rather than rigid distinction, but it nonetheless contributed to normative judgments of the shell-shocked soldier. This can be illustrated through a comparison of two accounts. In a widely reported lecture, John Collie persistently accentuated the role of emotion. He described the predisposing causes of war neuroses as ‘fear, fear of being afraid, terrifying experiences’, and the physical conditions of trench warfare. The soldier was caught up in a vicious circle in which ever more ‘intense emotion’ accumulated. The consequent loss of self-control was then portrayed as an essentially selfish reaction

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<sup>22</sup> Collie, ‘The management of neurasthenia’, p. 7; Collie, ‘Neurasthenia’, p. 533; Tooth, ‘Neurasthenia and psychasthenia’, p. 329; Armstrong-Jones, ‘Mental and nervous states in connection with the war and their mechanism’, p. 328-30.

<sup>23</sup> D. Drummond, ‘Correspondence: war psycho-neurosis’, *Lancet* 1918 (1) [March 2 1918], p. 349.

<sup>24</sup> Collie, ‘The management of neurasthenia’, p. 9.

<sup>25</sup> Spangler, ‘Correspondence’, pp. 406-7.

<sup>26</sup> Myers, ‘Contributions to the study of shell shock. (II)’, p. 69; Myers, *Shell shock in France*, p. 64.

based on fear and self-obsession.<sup>27</sup> The picture painted by William Tyrrell, a squadron leader in the Royal Air Force Medical Service, in his evidence to the Committee of Enquiry was quite different. He defined shell-shock as 'exhaustion of the nervous energy which controls will-power and self-control, with the resultant loss of control', resembling 'a paralysis of the inhibitory nervous system'. The effect of this description was almost to de-emotionalise the war neuroses, linking the physiology of exhaustion and the human attribute of will through the dual meaning of 'nerves'. Emotion was only indirectly alluded to through reference to the 'necessity for camouflage or repression'.<sup>28</sup> By stressing self-control rather than emotion, Tyrrell presented its eventual erosion as the sad end to a noble struggle, rather than the necessary result of the individual's egocentric attitude.

The same judgments are apparent in the patterns of breakdown, deemed to be dependent on 'the temperament of the individual', described in the official medical history of the war. In the first model, self-control was gradually eroded by exhaustion and a succession of painful or terrible incidents; in the second, it broke down suddenly as the result of horror or fear.<sup>29</sup> Myers' division of 'nervous subjects' into 'the good and the bad' followed the same lines. The former was 'often a highly intelligent person, keeping full control over his unduly sensitive nervous system; the latter, usually of feebler intellect, having little hold over his instinctive acts to escape danger, the emotions which impel him to them, and the resulting conflicts'.<sup>30</sup> Armstrong-Jones made a similar distinction between physical and mental exhaustion and 'another kind of fear which comes on suddenly and in neuropathic or hysterical men'. He even suggested that these types of fear were located at different evolutionary levels of the central nervous system. The 'reasoned fear out of which the most courageous and noble deeds of heroism arise' originated in the cerebral cortex, while 'panic-fears' had a sub-cortical or thalamic origin. Moreover, the first kind, 'the many slow grinding fears of a vague marginal subconscious kind' were characteristic of modernity, whereas 'sudden isolated instances' of fear were akin to those 'which occurred in the days of primitive

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<sup>27</sup> Collie, 'The management of neurasthenia', p. 2; [Anon.], 'Neurasthenia in soldiers', *Lancet* 1917 (1), pp. 962-3, p. 962; [Anon.], 'The management of neurasthenia and allied disorders in the army', p. 642; [Anon.], 'Cure of shell-shock', *Times* 14th June 1917

<sup>28</sup> William Tyrrell in *RWOCESS*, p. 30.

<sup>29</sup> W.G. Macpherson *et al* (eds), W.P. Herringham, T.R. Elliot and A. Balfour (eds), *History of the Great War*, pp. 11-12.

<sup>30</sup> Myers, *Shell shock in France*, p. 38.

man'.<sup>31</sup> Such distinctions led to the conclusion that 'the intensity of the "shock" is not measured in terms of trauma but of individual sensitiveness'.<sup>32</sup> This application of normative judgments to individual soldiers according to the perceived mode of breakdown acted to displace responsibility for psychological suffering from the war onto the soldier. In this manner, the concept of self-control was used to reinforce traditional social standards, a theme which will be returned to in the conclusion of this chapter. In order to demonstrate the centrality of will to constructions of shell-shock, however, it is first necessary to explore how this concept was deployed in various therapies.

### Suggestion

A method of treatment for hysterical symptoms feted in a host of articles, particularly in the last two years of the war, was suggestion. This could be carried out in a number of ways: under hypnosis, or chloroform, or through some trick such as telling the patient that a simple operation had never failed to restore the lost function.<sup>33</sup> Underlying the use of suggestion was the belief that the removal of the symptom constituted a cure, and analysis of the possible psychological causes of the neurosis was unnecessary. All techniques worked on the simple principle of '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'.<sup>34</sup> This could even be viewed as merely an exceptional extension of the traditional role of the doctor, as implied by an article in the *British Medical Journal* which claimed that there was 'a certain dose' of suggestion in the treatment of any illness, in which cure was facilitated, and sometimes enabled, by the ability 'to keep alive in the patient's bosom the spark of hope'.<sup>35</sup> More

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<sup>31</sup> Armstrong-Jones, 'Mental states and the war. II', pp. 290-1; Armstrong-Jones, 'The psychology of fear', p. 358 and p. 389; R. Armstrong-Jones, 'Psychological medicine', *Nature* 99 (March 1917-August 1917) [June 14 1917], pp. 301-2, p. 301.

<sup>32</sup> Wolfsohn, 'The predisposing factors of war psycho-neuroses', p. 180.

<sup>33</sup> For examples, see A.W. Ormond, 'The treatment of "concussion blindness"', *Journal of the RAMC* 26:1 (January 1916), pp. 43-9, p. 44; A.W. Ormond, 'Ophthalmic injuries of warfare', *Practitioner* 96:5 (May 1916), pp. 491-500; Tombleson, 'An account of twenty cases treated by hypnotic suggestion'; A.F. Grimby, 'The cure of spinal concussion in warfare by suggestion', *Practitioner* 100:3 (March 1918), p. 292; Johnson, 'Hysterical tremor'; J.L.M. Symns, 'Hysteria as seen at a base hospital', *Practitioner* 101:2 (August 1918), pp. 90-6; W.R. Reynell, 'Hysterical vomiting in soldiers', *Lancet* 1919 (1), pp. 18-20; C.S. Myers, 'Contributions to the study of shell shock. (IV)', p. 463.

<sup>34</sup> [Anon.], 'Medical societies: Royal Society of Medicine', *Lancet* 1918 (1), pp. 437-9, p. 438; Stewart, 'The treatment of war neuroses', p. 20.

<sup>35</sup> [Anon.], 'The psychical factor in therapeutics', *BMJ* 1917 (2), pp. 836-7.



than merely conventional, suggestion could even be viewed as primitive. The description of faith-healing, central to the art of the 'primitive medicine man', as 'consisting in restoring a frightened man to himself by imparting determination of thought and will' could also be applied to suggestion.<sup>36</sup> The analogy certainly occurred to Rivers, who ended a set of lectures on 'medicine, magic, and religion' in 1916 with a comment on the role of suggestion in primitive medicine. He concluded 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'.<sup>37</sup>

The most notable champion of suggestion among the shell-shock doctors was Arthur Hurst, who lauded the simplicity of the technique in a succession of articles, although eventually deciding that the same effects could be achieved through 'persuasion and re-education'.<sup>38</sup> (This usually consisted of telling the patient, or appealing to his reason to establish, that there was no organic damage, and then teaching him how to perform the lost function again). The supporters of suggestion emphasised many of its virtues, including simplicity and cheapness, but above all they stressed the speed of cures thus achieved.<sup>39</sup> It was boasted that Hurst and his medical officers were disappointed if the symptoms of hysteria had not been removed 'within twenty-four hours of admission', and had even dispatched with one aphonic patient in 'thirty seconds'.<sup>40</sup> The first of these estimates must have seemed a sign of unconscionable inefficiency to Henry Smurthwaite, another proponent of suggestion. He warned his audience that they must be prepared to pursue treatment for however long was necessary: 'To some of the

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<sup>36</sup> R.R. Marett, 'The primitive medicine-man', section of the history of medicine, *PRSM* 11 (pts 1 and 2) (1917-1918), pp. 48-9, p. 49.

<sup>37</sup> W.H.R. Rivers, 'The Fitzpatrick lectures on medicine, magic, and religion. II', *Lancet* 1916 (1), pp. 117-23, p. 122.

<sup>38</sup> A.F. Hurst and E.A. Peters, 'A report on the pathology, diagnosis, and treatment of absolute hysterical deafness in soldiers', *Lancet* 1917 (2), pp. 517-9; A.F. Hurst and E.A. Peters, 'Correspondence: war deafnesses', *Lancet* 1917 (2), p. 622; A.F. Hurst and J.L.M. Symns, 'The rapid cure of hysterical symptoms in soldiers', *Lancet* 1918 (2), pp. 139-41; A.F. Hurst, 'The bent back of soldiers', *BMJ* 1918 (2) [December 7 1918], pp. 621-3. Hurst was also responsible for the only film footage taken at a British shell-shock hospital: *War neuroses* (British Pathé, 1918). He presented the film to a meeting of the neurological section of the Royal Society in March 1918. See A.F. Hurst, 'Cinematograph demonstration of war neuroses', section of neurology, *PRSM* 11: 2 (1917-1918), pp. 39-42

<sup>39</sup> See, for example, Cooper, 'Correspondence: treatment of "shell shock"' and W. Milligan, 'Correspondence: treatment of "shell shock"', *BMJ* 1916 (2), pp. 242-3.

<sup>40</sup> [Anon.], 'Reports of societies: war neuroses', *BMJ* 1918 (1), pp. 345-6, p. 345; [Anon.], 'Reviews: the treatment of hysteria', *BMJ* 1918 (2), pp. 515-6, p. 516; C.H.L. Rixon, 'The hysterical perpetuation of symptoms', *Lancet* 1919 (1), pp. 417-9.

difficult cases I have given much time and trouble; often as much as three-quarters of an hour have I battled with a single case'.<sup>41</sup>

The speed of cures by suggestion raised suspicion in some quarters. One physician, evidently adhering to the literalities of the nervous economy, objected that no matter how quickly symptoms could be removed, time was always necessary for the unstable nervous system to accumulate capital. Only prolonged rest and graduated occupation could ensure lasting recovery.<sup>42</sup> The more conventional critique of suggestion proceeded along two lines. It was claimed by some that the method did not penetrate to the root of the disorder. The psychological origins of the disorder needed to be treated, not just its most obvious symptoms, otherwise relapse would ensue.<sup>43</sup> Others objected that the method did not entail any effort on the part of the patient. In a piece on hypnotic suggestion, it was argued that the 'effect of hypnotism is not towards development and strengthening of the character, but towards deterioration and weakness'. The patient should rather be 'led on to cut his own way through the tangle, and to save himself by his own efforts'.<sup>44</sup> This commentator recommended persuasion, but Elliot Smith put forward the same argument for re-education, on the basis that in cases where 'the patient has sufficient of his own will-power to enable the process [...] to be carried out, it is clearly undesirable, both on psychical and ethical grounds, for the doctor to impress his influence from without'.<sup>45</sup> David Eder also recommended psychoanalysis above other alternatives partly because of the difficult, even 'bitter', but ultimately beneficial exercise of will the method necessitated.<sup>46</sup>

There was however, one modified method of suggestion which did not bypass this effort of the will. This was the infamous electrical cure most associated with Lewis Yealland, resident medical officer and then registrar at the National Hospital, Queen

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<sup>41</sup> H. Smurthwaite, 'War neuroses', section of laryngology, *PRSM* 11 (parts 1 and 2) (1917-1918), pp. 182-5.

<sup>42</sup> Davy, 'An address on some war diseases', p. 837; see also letters under the heading 'Correspondence: treatment of war neuroses', *Lancet* 1918 (2), p. 219, p. 341-2, and p.370-1.

<sup>43</sup> T.A. Ross, 'The prevention of relapse of hysterical manifestations', *Lancet* 1918 (2), pp. 516-7; W. Brown, 'Hypnosis, suggestion, and dissociation', *BMJ* 1919 (1), pp. 734-6; E. Prideaux, 'Stammering in the war psycho-neuroses', *Lancet* 1919 (1), pp. 217-8.

<sup>44</sup> [Anon.], 'Reviews: sane psycho-therapy', *BMJ* 1915 (2), p. 605.

<sup>45</sup> Smith, 'Shock and the soldier. II', p. 856.

<sup>46</sup> Eder, 'An address on the psycho-pathology of the war neuroses', p. 268.

Square during the war.<sup>47</sup> The technique consisted of ‘a very brief suggestive treatment followed by rapid re-education, which is continued, if possible, without a pause until the normal function is entirely regained’. The preferred vehicle of suggestion was electricity, both because it was ‘mysterious’ enough to the layman to encourage a belief in cure, and because the current could ‘be made extremely painful if it is necessary to supply the disciplinary element which must be invoked if the patient is one of those who prefer not to recover’, or ‘strong enough to break down the unconscious barriers to sensation in the most profound functional anaesthesia’. Although electricity was a useful adjunct, the essential feature in cure was the patient’s conviction of its ultimate success. In order to achieve this, the physician must have ‘an air of authority which will brook no denial’.<sup>48</sup> Therapy was therefore envisaged as a titanic battle of wills in which the physician must use every means at his disposal to ensure his ultimate dominance.

The central elements in this brief outline – the dominance of the physician, the use of some trickery to suggest cure, and speed – were familiar components of suggestion. Historians have emphasised the atypical punitive and disciplinary elements of the treatment.<sup>49</sup> There is a further respect in which this technique did not accord with the usual practice of suggestion, and which has not been explored in the historiography.<sup>50</sup> This is the attempt to foster a positive attitude of self-reliance and self-control through ‘re-education’, which concurred with the trend of other therapeutic methods in which it was seen as necessary to demonstrate to the patient that he could overcome his disability by his own will-power.<sup>51</sup> Yealland’s technique was based on a view of ‘the hysterical type of mind’ as characterised by ‘weakness of the will and of the intellect, hypersuggestibility and negativism’. The patient’s will, feeble in every other respect, balked all attempts to break down his fixed belief in his disability. The treatment

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<sup>47</sup> The method was developed in conjunction with the physiologist Edgar Adrian, who later shared the Nobel Prize with Charles Sherrington for research on neuromuscular coordination. Adrian parted company with Yealland because he became convinced that it did not prevent relapse. Shephard, *A war of nerves*, p. 80. Yealland insisted in 1919 that he was still in touch with about 100 cases, and that ninety per cent of cures achieved this way were permanent. See [Anon.], ‘British Medical Association special clinical meeting’, p. 710.

<sup>48</sup> Adrian and Yealland, ‘The treatment of some common war neuroses’, p. 869 and p. 871.

<sup>49</sup> The technique is a staple of the literature on shell-shock: first discussed by Leed, it was then incorporated into Showalter’s account, which eventually formed the basis for the climactic scene of Pat Barker’s novel *Regeneration* (1991) and the film of the same name. See Leed, *No man’s land*, pp. 170-86; Showalter, *The female malady*, pp. 176-89; *Regeneration* (dir. G. MacKinnon, 1997).

<sup>50</sup> See however the comments in Stryker, ‘Mental cases’, pp. 162-3, which are similar in some respects to the interpretation given here.

<sup>51</sup> See, for example, Stewart, ‘The treatment of war neuroses’, p. 21.

therefore had to tackle both 'the fixed idea which is giving rise to the functional symptom', and the 'unconscious resistance to cure'.<sup>52</sup> The aim of the re-education which followed was to make the patient participate in his own cure through his own efforts.

Yealland told one patient, "I am treating you with, 'I will' [...] You must give up that subconscious 'I will not'; now make every attempt to walk alone, you will not fall".<sup>53</sup> The 'I will' referred perhaps partly to the will Yealland himself put behind the treatment, but also to the will of the patient, which had to be re-directed.<sup>54</sup> The underlying ethos of the treatment was that if there was 'no alternative between walking and falling down the patient will usually find himself able to walk'.<sup>55</sup> This statement was a prosaic warning to doctors not to provide chairs or beds to which the patient could cling, but it was also a manifesto. One mute patient, on finding he could shout without the 'aid' of electricity, attempted to kiss Yealland's hand. He was told, "There is no time just now for you to yield to your emotions; you must be practical and put forth every effort to speak".<sup>56</sup> Suggestion removed the symptom, but ultimately the patient had to rely on his own efforts to perform the function. The logic behind the brutality of the treatment was not punishment, but that the weak-willed hysteric needed a strong and even painful spur in order to be returned to normal health.

The aim here is not to launch a defence of Yealland, but to highlight this unexamined aspect of his treatment. In its emphasis on self-reliance, Yealland's treatment attempted to restore to the patient not only his lost function, but his lost identity as a soldier. This is exemplified in the famous 'case A1', a private who had been mute for nine months after participation in virtually every major battle of the war to that date: Mons, the Marne, Aisne, First and Second Ypres, Hill 60, Neuve Chapelle, Loos, and Armentières. Yealland began by reminding the patient of his status as a soldier and a man: 'Remember, you must behave as becomes the hero I expect you to be [...] A man who has gone through so many battles should have better control of himself'. The

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<sup>52</sup> Adrian and Yealland, 'The treatment of some common war neuroses', p. 868.

<sup>53</sup> Yealland, *Hysterical disorders of warfare*, p. 151.

<sup>54</sup> Smurthwaite viewed his treatment as a transference of his own will to the patient: 'The patient has lost his will power and confidence, which we must restore by force of our own energy and influence [...] We instil that necessary power into him'. Smurthwaite, 'War neuroses', p. 183.

<sup>55</sup> Adrian and Yealland, 'The treatment of some common war neuroses', p. 871.

<sup>56</sup> Yealland, *Hysterical disorders of warfare*, pp. 16-7.

application of increasingly painful currents proceeded until the patient could whisper, at which point he began to cry and attempted to leave the room. Yealland reminded him he was a hero, and better behaviour was expected. He ended by saying, 'You are already doing splendidly, and I am satisfied that you are now determined to talk and I am very pleased with you; more than that, I am proud of you'. The patient's 'attitude then changed very considerably, and from that time he made every attempt to recover'. The treatment lasted for several hours more, as every time one symptom was removed another developed in a different part of the body. When there were finally no further physical disabilities to deal with, Yealland told the man, "You are a hero".<sup>57</sup> The modern reader will find Yealland's treatment shocking in more ways than one. But the ends were believed to justify the means; and it is because so many shared a belief in the righteousness of the ends that the method enjoyed a short-lived popularity.<sup>58</sup>

### **Abreaction, autognosis, and mental analysis**

There were few voices raised against Yealland's brutal treatment, at least as long as the war lasted. A method which attracted far more contemporary opprobrium was hypnosis.<sup>59</sup> This was usually employed as an adjunct to suggestion, and as such it was open to the same criticisms: it removed the symptom without treating the underlying causes, and it entailed no effort on the part of the patient. It was also perceived to heighten the suggestibility and tendency to dissociation of already vulnerable patients. Most potent of all was the fear that hypnosis involved not only the weakening of the subject's will, but its replacement by the will of the operator. As one commentator pointed out, it was 'no small problem for a physician to determine whether he has the right to suppress the free will of his patient, and make him act against his own volition'.<sup>60</sup> The very word hypnosis raised the spectre of its long and largely disreputable heritage: the association with the charlatanism of Mesmer, the predatory

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<sup>57</sup> *Ibid.*, pp. 7-14.

<sup>58</sup> [Anon.], 'Hysterical disorders of warfare', *BMJ* 1918 (2), p. 134; [Anon.], 'Review: Hysterical disorders of warfare', *Lancet* 1918 (2), p. 242.

<sup>59</sup> In Germany, the hypnotic 'miracle cures' of shell-shocked soldiers achieved by the neurologist Max Nonne provoked similar fears and objections. See P. Lerner, 'Hysterical cures: hypnosis, gender and performance in World War I and Weimar Germany', *History Workshop Journal* 45 (1998), pp. 79-101

<sup>60</sup> [Anon.], 'Reviews: sane psycho-therapy', p. 605.

powers of Svengali, and most recently, the menace of Freudianism.<sup>61</sup> The manifold dangers were perceived to threaten the operator no less than the subject. Charles Myers, after noting that hypnotism ‘savours of the uncanny, mysterious, and unknown’, claimed that the ‘first attempts at hypnotism demand even more self-mastery than one’s first sight of an operation’.<sup>62</sup>

The academic psychologist William Brown (1881-1952), who served first as a consulting neurologist in France and then at Maghull Military Hospital near Liverpool, and Craiglockhart War Hospital in Edinburgh, believed that he had developed a technique which overcame these objections.<sup>63</sup> He used light hypnosis, only in severe hysterical cases, to achieve abreaction of the emotional affect caused by a traumatic incident. The hypnotised patient was led ‘through his original terrifying experiences again, his memories recurring with hallucinatory vividness’. He was then told that he would remember all that had happened under hypnosis, and woken very gradually while Brown continually talked to him, ‘passing backwards and forwards from the events of his sleep to the events in the ward, the personalities of the sister, orderly, doctor, and patients – i.e., all the time re-associating or re-synthesising the train of his memories and interests’. The method was dependent not on suggestion, but on inducing ‘the recall of the lost memories with hallucinatory vividness’. The ‘extent to which the symptoms disappeared varied in proportion with the extent to which I succeeded in reinstating the original emotional experience’. Abreaction dissipated the emotion, the underlying cause of the patient’s original dissociation, and so it also removed the tendency to development of an alternative symptom or to relapse.<sup>64</sup>

Brown emphasised that the abreaction produced by light hypnosis was not a suitable treatment for all patients. For patients whose breakdown was caused by ‘earlier mental worry’, or whose symptoms had persisted for a longer duration, Brown used a process he termed ‘autognosis’ (self-knowledge). This entailed ‘mental analysis’, in which the

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<sup>61</sup> See R. Harris, *Murders and madness: medicine, law, and society at the fin de siècles* (Oxford: Clarendon, 1989); D. Pick, *Svengali’s web: the alien enchanter in modern culture* (New Haven and London: Yale University Press, 2000); D. Forrest, *Hypnotism: a history* (London: Penguin, 1999).

<sup>62</sup> C.S. Myers, ‘A final contribution to the study of shell shock: being a consideration of unsettled points needing investigation’, *Lancet* 1919 (1), pp. 51-4, p. 54.

<sup>63</sup> Leys provides an interesting discussion of the conflicting theories behind the wartime uses of hypnosis, focussing on a debate on ‘the revival of emotional memories and its therapeutic value’ published in the *British Journal of Medical Psychology* in 1920. See Leys, ‘Traumatic cures’.

<sup>64</sup> W. Brown, ‘The treatment of cases of shell shock in an advanced neurological clearing centre’, *Lancet* 1918 (2), pp. 197-200, pp. 197-9; Brown, ‘Hypnosis, suggestion, and dissociation’, p. 735.

doctor negotiated the ‘battlefield of conflicting emotional tendencies’ in the patient’s mind in order to show him ‘the true emotional significance of them and their connexion with his present disability’. The aim was for the patient to understand himself, and for this self-knowledge to bring with it ‘self-control in the psychic domain’, but the efficacy of the method again depended on ‘the abreaction of the original emotional disturbance or disturbances’. Brown also emphasised that ‘mental analysis is the ideal method of treatment, provided that it is carried far enough to produce true abreaction of emotional states’. Light hypnosis was a ‘short cut’ which was only of use in early cases which manifested severe hysterical symptoms.<sup>65</sup>

The techniques of abreaction and autognosis employed by Brown illustrate several points of relevance to this argument. His articles provoked a flurry of debate in the letters columns of the medical press. Brown reiterated that he used hypnosis only on a small proportion of severe cases, that he took safeguards against dissociation, and that the aim was to produce an abreaction of emotion for which mental analysis was the ideal vehicle. But correspondents picked almost obsessively over its manifold dangers. Hypnosis remained controversial because, despite the mantra of ‘autognosis’, it struck too deeply at the ideals of rationality, autonomy, and self-control. The threat of hypnosis was such that it had to be confined within the bosom of the medical community; Charles Mercier moved his criticisms from the pages of the *Times* to the *British Medical Journal*, as a more proper venue for the debate.<sup>66</sup> Secondly, Brown’s emphasis on the twin action of abreaction and autognosis further demonstrates the symbiotic relation of emotion and will: until abnormal levels of emotion had been removed, there could be no self-control.

In this respect, Brown’s use of hypnosis operated on the same principle underlying ‘mental analysis’. There were three main elements to this technique as practised by a cluster of physicians at Maghull Military Hospital under the aegis of its superintendent Richard ‘Ronald’ Rows: the annulment of the effects of emotion, an understanding of

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<sup>65</sup> Brown, ‘The treatment of cases of shell shock’; W. Brown, ‘War neurosis: a comparison of early cases seen in the field with those seen at the base’, *Lancet* 1919 (1), pp. 833-6, p. 836; Brown, ‘Hypnosis, suggestion, and dissociation’, p. 736; W. Brown, ‘Correspondence: functional nervous disease’, *Lancet* 1916 (1), p. 265.

<sup>66</sup> See correspondence under the heading ‘Hypnosis in hysteria’, *Lancet* 1918 (2), pp. 404-5, p. 433, and p. 471; under the heading ‘Hypnotism’, *Times*, 22, 23 and 25 April, 1919; and correspondence under the heading ‘Hypnotism, suggestion, and dissociation’, *BMJ* 1919 (1), p. 561, pp. 592-593, p. 593, p. 624-625, and p. 693.

the factors which had produced the symptom, and the consequent restoration of the patient's self-control.<sup>67</sup> It was based on the view that the patient's symptoms stemmed from a fixation on an emotional element of his war experience, leaving him 'incapable of reasoning about his condition', and resulting in over-emotion and lack of self-control. Once the 'excessive emotional tone' had been stripped from the incident by a thorough analysis, he was able to 'appreciate the real value of the incident' and to begin recovery.<sup>68</sup> In similar terms, Colin McDowall outlined the treatment as 'the removal or control of the offending emotional tone', achieved by 'understanding your patient, giving him true insight into the production of his symptoms, removing any worrying element, and gradually restoring to the individual that self-confidence which has been lost'.<sup>69</sup> The most extensive discussion of 'mental analysis' was Smith and Pear's *Shell shock and its lessons* (1917). This described the aim of mental analysis as to reveal to the patient 'the real significance and history' of his present mental condition. This self-knowledge provided him with the tools 'to cure himself'. Although he usually still required some re-education in the form of advice and encouragement, the patient was thereby "freed from himself," liberated from the exaggerated emotional tone which has become attached to so many of his memories, and so enabled to face life anew with a harmonious and integrated mind'. Again and again they emphasised that the success of this procedure depended on the intelligence, will-power, and efforts of the patient.<sup>70</sup> The mantra of psychological understanding was new, but it drew on the established view of healthy mental functioning as the balance of feeling, thought, and will; and it emphasised the will of the patient by attempting to make him the master of his own fate.

There is another respect in which Brown's theories coalesce with broader trends in medical attitudes to shell-shock. In 1919 he substantially revised the theoretical basis for his recommendation of abreaction. He had earlier argued that physical symptoms were the equivalents of repressed emotional memories, and that abreaction cured by neutralising the psychological effects of strong emotion. He now argued that shock did not only cause 'psychical' dissociation, but also a dissociation between 'the psychical

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<sup>67</sup> On the community at Maghull, see Pear, 'Some early relations between English ethnologists and psychologists'; Shephard, "The early treatment of mental disorders".

<sup>68</sup> Rows, 'Mental conditions following strain and nerve shock', p. 441 and p. 443.

<sup>69</sup> McDowall, 'Functional gastric disturbance', p. 88.

<sup>70</sup> Smith and Pear, *Shell shock and its lessons*, p. 72; see also p. 40-2, p. 49, and p. 67.



and physical counterparts of fear' which caused the sympathetic nervous system to mobilise and the physical symptoms to persist 'instead of being evanescent'. He proposed that 'the reinstatement of intense emotion [in abreaction] acted physically in overcoming synaptic resistances in specific parts of the nervous system, and so put the nervous system into normal working order again'.<sup>71</sup> This type of sweeping theoretical overhaul was rare, but other psychologically-inclined doctors also began to lay a new emphasis on physiological factors in the later years of the war. In 1918 Rows conducted experiments with David Orr which showed that disturbances of the sympathetic nervous system could produce organic lesions, and he returned to the subject of endocrine disturbances in 1920.<sup>72</sup> Charles Myers' 'final contribution to the study of shell shock' in 1919 urged the necessity for further research on the effects of the sympathetic system and the extent of its influence in the war neuroses. He concluded that in Britain at least, 'we have been paying so much attention to the mental aspect of the war neuroses that a detailed examination of the accompanying bodily symptoms has been generally neglected'.<sup>73</sup>

### **The cultivation of will-power: Arthur Brock and 'ergotherapy'**

Suggestion, hypnosis, and mental analysis all gained a certain cachet in different circles. By contrast, the method of 'ergotherapy' devised by Arthur Brock, best known for his treatment of Wilfred Owen at Craiglockhart, does not appear to have won any disciples among the shell-shock doctors.<sup>74</sup> However, it is not only an interesting addition to this collection of therapies based on the cultivation of self-control, but his theories also point forward to themes which will be elaborated in the following chapter. In Brock's view, the neurasthenic's experience of the particular environment of war had made 'the whole battle of life in its widest and most normal sense' abhorrent to him. His symptoms sprang from the refusal to face his circumstances, and constituted a dissociation not only from himself but from his entire environment. Brock argued that

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<sup>71</sup> Brown, 'War neurosis', p. 835; Brown, 'Hypnosis, suggestion, and dissociation', p. 735. In the former article, Brown also gave his support to Mott's theories regarding the role of the endocrine glands in the war neuroses.

<sup>72</sup> [Anon.], 'The interdependence of the sympathetic and central nervous systems', p. 471.

<sup>73</sup> Myers, 'A final contribution to the study of shell shock', p. 53. He reiterated in 1940 that an emphasis on psychological aspects 'led to a neglect of possible factors of a physical nature'. Myers, *Shell shock in France*, p. 12.

<sup>74</sup> See D. Hibberd, 'A sociological cure for shellshock: Dr. Brock and Wilfred Owen', *Sociological Review* 25 (1977), pp. 377-86.

because 'struggle and endeavour are normal conditions of life', man 'only feels his best when overcoming difficulties'. The neurasthenic's refusal to engage with life therefore fostered 'loss of self-confidence' and well-being. The treatment he propounded consisted of 'a reintegration of the individual, a replacement of him in his *milieu*' achieved above all by 'self-help': the role of the doctor was simply to 'help him to help himself'.<sup>75</sup>

The central symptom identified by Brock was 'a reluctance to start functioning'. This was first treated by inducing the patient to work on his physical environment, producing reports on an aspect of the environment in which he was particularly interested – botany or geology, for example. The reports of all patients were shared at a weekly meeting. By this means a vision of the world and a method of functioning was encouraged which was individual, but also synoptic and co-operative.<sup>76</sup> The next step was to integrate the patient with his social environment. He was encouraged to spend time with his family, to correspond with absent friends, to take part in the communal life of the institution, and finally to join in civic activities such as helping out at meetings of Boy Scouts. Alongside these activities, the patient must practice renunciation. The neurasthenic had to 'learn to do without things' and to 'impose a considerable amount of stoic discipline upon himself'. Minor stoicisms, such as taking a cold bath or a swim before breakfast, prevented the man from losing the ground gained by ergotherapy through minor self-indulgences. The ultimate aim was to ensure that patients were capable of carrying on the task of functioning in the world by their own efforts. The ideal model of functioning envisaged by Brock necessitated the internalisation of discipline and a correct view of the individual's role in and relation to the world.<sup>77</sup>

There are two further features of Brock's theory which are of particular interest. Firstly, he perceived the war neuroses as a disruption of 'the evolutionary movement'. The normal relation of the individual to his past, present, and future was disturbed in the disorder. He might be divorced from his past through amnesia, or from his future by aboulia, improvidence, or hopelessness; or he might become 'temporarily arrested upon

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<sup>75</sup> A.J. Brock, 'The re-education of the adult. 1: the neurasthenic in war and peace', *Sociological Review* 10:1 (Summer 1918), pp. 25-40, p. 26 and pp. 29-30.

<sup>76</sup> *Ibid.*, pp. 31-2.

<sup>77</sup> *Ibid.*, pp. 34-6.

some element of his past or future experience', 'just as a stammerer "sticks" at and over-emphasises some word or syllable'. Most often, however, the neurasthenic was 'driven back' upon his past in its widest sense, showing symptoms such as 'night-terrors, dreading the dark, calling for his mother' or even more 'atavistic' behaviour 'going back either to racial or personal memories or experiences'.<sup>78</sup> In Brock's view, life itself consisted of the 'Organism in constant active interplay with Environment', advancing 'along the path of Evolution, gathering up ceaselessly its Past within it, and pressing forward as ceaselessly into the Future'. Neurasthenia was therefore 'a halting, a "stammer," or even a reversal of the evolutionary movement'.<sup>79</sup> The diagnosis once again was regression.

Secondly, this reversal of the evolutionary movement was characteristic not just of the war neurotic, but the whole trend of modern life. Brock viewed each shell-shock hospital as 'a microcosm of the modern world, showing the salient features of our society (and its weaknesses) intensified, and on a narrower stage'. The war neuroses were nothing more than 'an "acute exacerbation of a more or less chronic or "sub-acute" condition, from which our society had been suffering long before the flare-up of the present war'. The entirety of modern 'social and political practice has tended increasingly to treat man as will-less and unable to help himself, and it hence goes on multiplying machinery to help him *ab extra*'. The war neurasthenic was therefore only 'an extreme instance of the chronically fatigued person so common in our modern world – the *vaincu de la vie*'.<sup>80</sup> The horrors of the battlefield were 'the last and culminating terms in a series that begins in the infernos of our industrial cities'. The 'competitive world' of peace had only been 'latent war', causing 'strains and repressions' which incited the 'instinctive reactions of the more virile organisms' to 'an environment that starves them of the means for life more abundant'. Nothing short of a full scale, 'truly evolutionary' civic regeneration could cure the pathology of modern life.<sup>81</sup>

Brock perceived shell-shock as an evolutionary reversal which was only an extreme example of the pathology of modern civilisation. His anxieties about modernity and his

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<sup>78</sup> Ibid., p. 28.

<sup>79</sup> Ibid., p. 39.

<sup>80</sup> Ibid., pp. 25-6 and p. 30.

<sup>81</sup> Ibid., p. 40.

formulation of ergotherapy preceded the war. In a recent article, David Cantor has explored the roots of Brock's thought in the early twentieth-century humanist revival within medicine, and demonstrated the continuity across his career in his explanations of neurasthenia, organic diseases such as cancer, and views on topics as diverse as child guidance clinics, religion, abortion, and the Medical Peace Campaign.<sup>82</sup> Brock's denunciation of civilisation as a 'Canceropolis' was in many ways a natural development from nineteenth-century sociological analyses of the degenerative effects of urbanisation which were framed in and by language and concepts derived from medicine and biology.<sup>83</sup> In the wartime context, his examination also chimed to a certain extent with social demands to create for a land fit for heroes, and even eugenic proposals which demanded that heroes be awarded higher than average pensions to allow them to repopulate the land.<sup>84</sup> His 1918 article on 'the neurasthenic in war and peace' was part of a series of 'Papers for the present' published by the *Sociological Review* on behalf of a Cities Committee campaign for post-war reconstruction based on an 'evolutionary conception of civics'.<sup>85</sup> In Brock's eyes, the particular achievement of shell-shock was to have 'given us a clue both to the pathology and the treatment of our present troubles'.<sup>86</sup> The particular therapies he recommended did not gain widespread acceptance. But, as will be shown in the next chapter, Brock was not alone in diagnosing civilisation as suffering from a perilous disease, revealed but not caused by the lesions of shell-shock.

## Conclusion

It has been shown that the concept of will retained a central role in the theories and therapies devised around shell-shock. Ultimately, this emphasis on self-control overrode all other concerns. It has been argued by some historians that the acknowledgement that any man could break down under sufficient stress 'forced

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<sup>82</sup> Cantor, 'Between Galen, Geddes, and the Gael'.

<sup>83</sup> See R.A. Nye, 'The bio-medical origins of urban sociology', *Journal of Contemporary History* 20 (1985), pp. 659-75; G. Stedman Jones, *Outcast London: a study in the relationship between classes in Victorian society* (Penguin: London, 1984), pp. 281-314.

<sup>84</sup> [Anon.], 'Clean wigwams for civilized men', *BMJ* 1916 (2), pp. 499-500, p. 499; [Anon.], 'Disabled combatants and the future of the race', *BMJ* 1917 (2), p. 836. On the demands for a land fit for heroes and the response of government and charities, see D. Cohen, *The war come home: disabled veterans in Britain and Germany, 1914-1939* (Berkeley, Los Angeles and London: University of California Press, 2001), pp. 15-60.

<sup>85</sup> See *Sociological Review* 10 (Summer 1918), pp. 60-66.

<sup>86</sup> A.J. Brock, *Health and conduct* (London: Williams and Norgate, 1923), p. 250.

western society to take note and modify its views on mental illness, human motivation, and other issues far beyond the immediate problems of disabled soldiers'.<sup>87</sup> From this perspective, shell-shock revealed the crucial fragility of the human psyche, undermined the bombastic stoicism applied to so many areas of social life, and helped to create a more sympathetic attitude towards not only the broken, but the damaged or nervous individual. In this argument, the emphasis is on the normalisation of emotion and the undermining of the ideal of self-control in the post-war re-shaping of social attitudes. From the writings of shell-shock doctors, however, it becomes apparent that the normalisation of fear had definite limits. Although the notion of courage was reshaped as a result of the experience of war, this proceeded hand-in-hand with an even greater emphasis on the importance of self-control. The requirements of not only the military, but the standards of social life, meant that this conclusion could not be avoided.

By the end of the war, there was not only widespread acceptance that every soldier felt fear to some degree, but fear was presented as a necessary constituent of courage.<sup>88</sup> Armstrong-Jones emphasised that 'it is not the man who is incapable of fear that has the highest form of courage'. There were people 'like children with fire, that are not afraid, because they have never experienced fear, and there are others who are too stolid, too obtuse, or too unimaginative to feel fear'.<sup>89</sup> Smith and Pear went further, claiming that 'brave' could not be used to describe a man who did not feel fear. The only truly brave man was 'one who, feeling fear, either overcomes it or refuses to allow its effects to prevent the execution of his duty'.<sup>90</sup> Alan Grimby, a former asylum psychiatrist now serving as a surgeon in the Royal Navy, agreed with this statement, and even argued that fear 'forms the foundation of the fighting efficiency of our Navy'. He also, however, made it clear that there was a definite line between courage and cowardice. Fear was only one part of courage. The other was self-control. In cowardice, fear had triumphed 'over the will'.<sup>91</sup> There were definite limits to the normalisation of fear. In this respect, it is questionable to what extent the formulations of bravery in shell-shock texts represented a departure from earlier views. Even in the recruitment propaganda of the early months of the war, it had been accepted that the soldier felt

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<sup>87</sup> Feudtner, "Minds the dead have ravished", p. 409; see also Bogacz, 'War neurosis and cultural change in England', p. 250; Stone, 'Shellshock and the psychologists', pp. 265-6.

<sup>88</sup> Hurst, *Medical diseases of the war* [1918], p. 1; Bird, 'From home to the charge', p. 335.

<sup>89</sup> Armstrong-Jones, 'The psychology of fear', p. 357.

<sup>90</sup> Smith and Pear, *Shell shock and its lessons*, p. 9.

<sup>91</sup> Grimby, 'Neuroses and psycho-neuroses of the sea', p. 248.

fear, and the same line had been drawn between courage and cowardice. The role of military discipline was to teach a man that he 'can master fear, can still be afraid in the sense of realising danger, and yet by an exercise of will power can say to himself, "Yes, I see it and in a sense fear it, put please God; 'funk' it I never will!" for fear and funk are far apart'.<sup>92</sup>

The acceptance of fear as a natural emotion only heightened the necessity for its control by 'strong will power'.<sup>93</sup> The requirements of the military machine could allow nothing less. This was exemplified in the Committee of Enquiry's recommendations for instruction on training. The soldier should be instructed that 'every man feels fear at some time and to some extent in action, and that to feel afraid is a natural thing and nothing to be ashamed of'. It should also be reinforced, however, 'that no good soldier ever allows this feeling to influence him, that to give way to fear is reprehensible, and that no properly-trained soldier will have difficulty in carrying out his duty whatever the circumstances'.<sup>94</sup> These instructions underlined the importance of individual and collective will-power. Any man would inevitably be "rattled" by the experience of battle, 'but discipline and self-control will steady him'. Discipline was achieved by 'the training of the mind', and self-control was 'the product of will-power'. This power could be developed, 'just as muscular strength can be increased', by exercise: each 'time a muscle is exercised it is strengthened; every time an effort of will is made the will-power is increased'. The aim of training was to teach the soldier to 'endure the hardship of war and the exertion of battle [...] and make the superhuman effort which battle demands'. For, in the final analysis, victory was 'gained by the army with the greatest intensity of purpose', and this purpose was only another form of will-power. Will-power was both 'the driving force, the determination to get there', and 'the controlling force which keeps man calm and controlled when shells are bursting'. The 'striving and controlling force' of an army depended 'upon the will-power of the individuals of which that army is composed'. The most important part of the military machine, the oil which kept its wheels turning, was the self-control of the individual. It was because warfare was ultimately 'based upon and limited by the human factor' that the loss of this control in shell-shock disrupted the smooth working of the entire

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<sup>92</sup> J.C. Kernahan, *The experiences of a recruiting officer* (London: Hodder and Stoughton, 1915), p. 72.

<sup>93</sup> Marr, *Psychoses of the war*, p. 47.

<sup>94</sup> Recommendations of *RWOCESS*, p. 155.

apparatus.<sup>95</sup> The grim reality was that when the human organism broke down, a mechanical failure could easily mutate into a virus.

The reasons behind the military emphasis on self-control are evident, but this persistent stress on the relation of the individual soldier to the army anticipates the final chapter of the thesis, which explores some of the ways in which, and reasons why, shell-shock was framed as a social pathology. In war, the needs of the army were also the needs of the country. The soldier's symptoms were perceived as a struggle between 'selfish and social tendencies'. The role of the doctor was to 'throw his weight into the scale on behalf of the latter'.<sup>96</sup> The war made the exercise of the will into a matter of life or death for the individual soldier and the army he served, but it was also necessary for the maintenance of the society he represented and defended. The fact that 'the structure and wholesomeness of human society' depended on the repression of instinct and emotion was thrown into relief by the war.<sup>97</sup> The loss of self-control in shell-shock could not be confined to the individual, but was a totem of the danger faced by civilisation itself. At the same time, it struck at the core of what it meant to be human and to be civilised, underlining the tenuousness of this identity. This may help to explain the peculiar horror the war neuroses aroused. Vera Brittain's friend Maurice Ellinger suffered a 'queer breakdown' only two months after joining up, and later shot himself in the head (he did not sustain any serious injury). In February 1916, her diary listed the depressing consequences of war service for friends of her brother: two dead, two wounded, one poisoned by gas, one nearly killed by meningitis, and 'Maurice Ellinger given over to a fate worse than any of these'.<sup>98</sup>

These attitudes were not dispersed by greater familiarity with the phenomenon of the shell-shocked soldier. In September 1918, a contributor to the *Medical World* pondered the effects of the war on British psychiatry. The experience of shell-shock had revealed grave defects in psychological medicine. The prevalence of bromides, massages, and sea voyages as treatments, and the bankruptcy of a 'psychological education' based on dead brains and the microscope were deplored. Nevertheless, the author believed that in

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<sup>95</sup> Ibid., pp. 203-6.

<sup>96</sup> Ibid., p. 130.

<sup>97</sup> Armstrong-Jones, 'Dreams and their interpretation', p. 204.

<sup>98</sup> See A. Bishop and T. Smart (eds), *Chronicle of youth: Vera Brittain's war diary, 1913-1917* (London: Gollancz, 1981), p. 113, p. 125, p. 152, p. 186, p. 189, and p. 316.

one respect the attitude of the British public and legislators towards insanity was and always had been absolutely correct. 'To lose control of oneself, to become something that is not oneself [...] the public will always dread THAT more than anything else': and rightly so, the piece concluded. The stigma attached to mental illness was a necessary 'protective mechanism' which sheltered the individual from himself, and the society from the individual.<sup>99</sup> There could be no quarter given to deviations from the normal mind. Although the mentally disturbed could be looked on with sympathy and better methods should be developed to treat these disorders, the horror must remain. Too much was at stake if it should be lost. The war had exposed the frailty of not only individual minds, but of the human condition. The individual inexorably bled into the social as shell-shock was dissected. The soldier represented and defended the nation, and for the British this meant civilisation itself. On his body, its pathologies were mapped out.

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<sup>99</sup> M.N., 'Dr. Weatherly's offensive', *TMW* 11 (July-Dec 1918), p. 202.



## Chapter 8

### The paradox of civilisation and war: individual and social pathologies

#### Introduction

In October 1915 Sir William Osler (1849-1919), Regius Professor of Medicine at Oxford University, asked whether science had been a force for good or evil in the modern world. On the one hand, science had enabled a war of unprecedented scale and destruction to be waged; on the other, advances in medical knowledge had managed to stem the resultant flow of suffering and death from illness and wounds to a degree unimaginable only fifty years previously. On balance, Osler decided, 'the wounded soldier would throw his sword into the scale for science – and he is right'. This measured conclusion followed several pages in which Osler had refused to flinch from the horrific consequences of scientific advancement for warfare, and offered only weary and scant consolation. But for all this striving towards brutal truth, the manifest content of the lecture belied the depth of fear unleashed by the terrible marriage of science and war in modern times. These anxieties surfaced in full force at only one moment:

I had a dream not long since that explorers in Central Africa had accidentally opened a vein of deadly radium which flowed slowly but imperceptibly like an unseen lava over the surface of the earth, killing by the exhalation of an irrespirable gas. It had crossed beneath the Mediterranean, swept through Europe, and had reached England. Convocation had been summoned by the Chancellor and the members of the University in full academics awaited the end of all things. On came the irresistible and deadly vapour, swept down the ranks, reached me, and I awoke – gasping for breath.<sup>1</sup>

Although the dream evidently made a strong impression on Osler, in his lecture it served only as a dramatic introduction to the subject of Germany's 'diabolical' use of chemical warfare. He had barely recounted this outline before he returned to drawing up profit and loss columns in the impossible attempt to balance technological advance with its human cost. Nor is it likely that his audience of Leeds University medical

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<sup>1</sup> Osler, 'An address on science and war', p. 798 and p. 801.

students made many efforts at further interpretation. Over the following three years, the royal road to the unconscious would become a familiar feature on the maps of British psychological medicine, even though many would read it only as a variant of the medieval signifier 'Here be monsters'. But in 1915, dream analysis along Freudian lines had made little impact on psychiatric practice in Britain.<sup>2</sup>

At the distance of almost a century, Osler's dream resonates all the more forcefully because it is presented to us as a moment of revelation crystallised, but not consciously realised, in the psyche of an individual. The recognition was dawning that the cumulative achievements, all the vaunted and cherished progress of the nineteenth century, had resulted in a terrible paradox. Nature, apparently harnessed and smelt into new form, had doubled back upon man. All the efforts of civilisation had led to this: the resurgence of the primitive within, equipped not only with its own powers, but those gifted it by modern industry and technology. The deadly gas of Osler's dream originated in the very antithesis of civilisation, the 'darkest Africa' that haunted the imagination of the late nineteenth century; but it had been released by representatives of the West, 'explorers' whose attempts to colonise the resources of the unknown land for their own purposes had proved an invasion too far. Once liberated it flowed forth, crushing all before it with the irresistible force of a natural disaster, and even the accumulated rationality and learning of the potentates of the University of Oxford, itself one of the most potent symbols of civilisation in the cultural repertoire of the educated British man, were powerless to stop it. It spilled out even from the grotesque world of the nightmare, and Osler awoke fighting for breath. His own subconscious conspired to choke him. This was the reality of the war played out on the individual: from the depths of its being, with the instruments of its loftiest heights, civilisation was killing itself.

These anxieties regarding the Janus face of civilisation were channelled into the conceptualisation of shell-shock as a regression provoked by the strains of the modern battlefield. The social dimension of the war neuroses is usually perceived in the prosaic light of manpower crises and an elongated pensions bill, but as an agent which both exposed the weaknesses of civilisation and threatened to hasten its collapse, shell-shock

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<sup>2</sup> This is not to say that dreams were not subjected to any interpretation at all: see D. Pick and L. Roper, 'Introduction' in D. Pick and L. Roper (eds), *Dreams and history: the interpretation of dreams from ancient Greece to modern psychoanalysis*, pp. 1-21.

also provided a unique locus for the fears of the modern age. This chapter explores some of the ways in which the war neuroses were constructed as a social pathology. As throughout the thesis, one of its aims is trace areas of continuity between pre-war and wartime medical discourse. The apprehensions expressed in theories of shell-shock did not erupt fully formed in 1914, but were given a new inflection and urgency by the war. Against a background of philosophic individualism, the converging and interrelated forces of industrialisation, urbanisation, and democratisation had made the function of the individual within the social organism one of the most pressing topics of early twentieth-century intellectual thought. The spectre looming over these debates was, as always, Darwin. One historian has argued that the effect of Darwinism was ‘nothing less than a new conceptualisation of man, resulting from a fresh emphasis on the collective dimension of life coupled with a richer and more momentous notion of environment’, and inevitably this became allied to concerns about ‘the adequacy of the human material to the demands of a mass society’. After Darwin, ‘individual self-interest pure and simple could hardly be considered rational behaviour in view of the needs of the social organism as a whole’, a shift in world view which coincided, hardly incidentally, with the coming into being of more intricate patterns of social interdependence.<sup>3</sup>

Before the war, the designation of man as always and inevitably a social animal proceeded apace within psychological medicine as in other spheres.<sup>4</sup> In 1910, the *Lancet* voiced its concerns regarding the ‘large number of cases of hysteria and other nervous troubles’ which had been reported among telephone operators. It blamed these disorders on the trying nature of work at the telephone exchanges, which ‘puts a constant strain on the attention, while rigid self-control is asked for in anyone who during long business hours has to enter upon incessant dialogues with a public that is generally in a hurry’. The public was urged to be more patient in its dealings with operators, and to remember that ‘any individual operator with whom we get into communication is, himself or herself, part of a great and complicated scheme any failure in which may often be felt at a distance from its cause’.<sup>5</sup> The phenomenon of breakdown among telephone operators illustrated perfectly the problematic relation of

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<sup>3</sup> R. Romani, *National character and public spirit in Britain and France, 1750-1914* (Cambridge: C.U.P., 2002), p. 4-5 and p. 231.

<sup>4</sup> See Thomson, ‘Psychology and the “consciousness of modernity”’, pp. 106-7.

<sup>5</sup> [Anon.], ‘The nerves of a telephone operator’, *Lancet* 1910 (2) [July 9 1910], p. 114.

the modern individual and social organism: the combined pressures of modernity placed the individual under unprecedented and often unbearable strains, but the increasing interdependence of social life also meant that failure in any part redounded on the whole. Like the telephone network, the nervous system was the model and microcosm of modern society, a complex and highly evolved structure dependent for perfect functioning on the unified action and communication of each cell.<sup>6</sup>

The conception of society as the product of this entire network of individual relations was matched by a redefinition of the individual as not only an element in, but the reiteration of this social system. In his *History of psychology* (1913), James Baldwin (1861-1934) stressed that the individual was a social artefact, in his external relations and his internal 'selfhood'. He was born into a society which was not 'merely a loose aggregate, made up of a number of biological individuals', but 'a body of mental products, an established network of psychical relationships'. The child entered this 'network as a new cell in the social tissue, joining in its movement, revealing its nature, and contributing to its growth'. Indeed, it was only through the entry into this social 'tissue' that 'the new individual is differentiated'. The self emerged from a 'social dialectic' between 'the individual and his social fellows'. The individual remained always 'part of the whole out of which he has arisen, a whole that is collective in character and of which he is a specification'. It was only through man's status as an element in the social network that 'his individuality and independence become possible or have any meaning'. He was 'a society individualised'.<sup>7</sup> The trend of pre-war thought emphasised that the individual was defined by its relation to the social, and the social was reliant on the relation of its individuals. Individual and social identities, responsibilities, and actions were inseparable. The danger was, of course, that a pathological society produced sick individuals, while deficient individuals resulted in a malfunctioning society.

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<sup>6</sup> The telegraph system provides the analogy for the workings of the nervous system in C. Buttar, 'The anatomy of the brain and nervous system', in Rhodes, *The mind at work*, pp. 14-27, pp. 25-7; see also Wilson, 'The effects of high explosives on the ear', p. 353. Although the particular analogy of the modern communications network was an innovation of the Edwardian period, dependent on specific technological advancements, it developed from the eighteenth century metaphor of nervous system as microcosm of the political state. See G.S. Rousseau, 'Towards a semiotics of the nerve: the social history of language in a new key' in P. Burke and R. Porter (eds), *Language, self, and society: a social history of language* (Cambridge: Polity Press, 1991), pp. 213-75, p. 225.

<sup>7</sup> J.M. Baldwin, *History of psychology: a sketch and an interpretation. Volume 2: John Locke to the present time* (London: Watts and Co., 1913), pp. 107-10.

As the age of nervous breakdown slid into the era of shell-shock, there was also increasing focus on the role of instinct as the motivating force in human behaviour at the individual and social level. In Britain, the collision of crowd psychology with Darwinism produced the concept of the herd instinct, as formulated by the surgeon Wilfred Trotter (1872-1939). The gregarious instinct was not invented by Trotter, but he awarded it a new primacy in the psyche of the individual and made it the guiding force of socio-biological evolution. The analysis here of the shifting focus of Trotter's theory as it was propounded before, during, and after the war illuminates the changing concerns surrounding the relation of the individual to society and state. It is then shown that the herd instinct was also incorporated into theories of shell-shock, where its inherent ambiguity as source of suggestibility and panic on the one hand, and of altruism and duty on the other, was reflected but not resolved.<sup>8</sup> Through the herd instinct and more nebulous fears of social contagion, the war neuroses were linked to debates on the putative effects of the war on British society. The chapter concludes by arguing that the alignment of shell-shock with instinct underlined the truth revealed by war: that civilisation, like humanity, was founded on the animal within. The army was the nation, and its weaknesses were those of Britain as a whole. The war could not be confined to foreign fields, nor the enemy to Germany and her allies; its bitter lesson was that the pathology of civilisation was not a microbial infection, but a cancer.

### **The herd instinct in peace and war**

A footnote to Freud: that appears to be history's judgment on Wilfred Trotter. Although his *Instincts of the herd in peace and war* (1916) went through a rapid succession of reprints until the 1940s, and was reissued as recently as 2003, the book has attracted little academic attention.<sup>9</sup> He does not even merit an entry in the index to one of the most recent and voluminous histories of the crowd.<sup>10</sup> He is probably encountered by most via Freud's short discussion in 'Group psychology and the analysis of the ego'

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<sup>8</sup> In addition to the discussion below, see particularly Gordon, 'War neuroses', pp. 361-3; E. Prideaux, 'Suggestion and suggestibility', *British Journal of Psychology* 10:2 and 3 (March 1920), pp. 228-41, p. 237; Moran, *The anatomy of courage*, pp. 52-3, p. 63, and p. 150-3.

<sup>9</sup> The notable exceptions are R.N. Soffer, 'New elitism: social psychology in prewar England', *Journal of British Studies* 8 (1968-1969), pp. 111-40; R.N. Soffer, 'The revolution in English social thought, 1880-1914', *American Historical Review* 75 (1970), pp. 1938-64; H.C. Greisman, 'Herd instinct and the foundations of biosociology', *Journal of the History of the Behavioral Sciences* 15 (1979), pp. 357-69.

<sup>10</sup> J.S. McClelland, *The crowd and the mob: from Plato to Canetti* (London: Unwin Hyman, 1989).

(1921).<sup>11</sup> This might even be a fitting legacy: although Trotter achieved considerable eminence as a surgeon, his most important contribution to the development of British psychology was to introduce Ernest Jones to Freud's work.<sup>12</sup> In the current context, Trotter's theory of the herd instinct merits consideration in its own right. In his work, the conception of the individual and the social as a single and irreducible entity reached its height. Trotter but made the herd instinct the guiding principle of the human mind and human evolution. The contradictory status of the herd as the source of both suggestibility and altruism was emphasised in his account, a feature carried over into theories of shell-shock which incorporated the herd instinct.

Trotter's theory of the herd instinct was first put forward in two articles published in the *Sociological Review* in 1908 and 1909. These met with a favourable reception, and formed the nucleus of his *Instincts of the herd in peace and war* (1916).<sup>13</sup> In 1919 a postscript was added to the book which mused further on the future of social evolution in the post war period. The basis of Trotter's argument was that 'the social and the individual' were 'absolutely continuous', and he proposed that the herd instinct was 'the unknown "x" which might account for the complexity of human behaviour'. This instinct was seen as fundamental to human evolution: it was only the protection of the herd which had enabled increased variability within the species. It was also the factor which shaped human psychology: the herd was 'not only the source of [man's] opinions, his credulities, his disbeliefs, and his weaknesses, but of his altruism, his charity, his enthusiasms, and his power'.<sup>14</sup> These basic features of Trotter's concept of herd instinct were never altered, but the changing focus of his argument before, during and after the war mirrored the social context in which the contributions were offered.

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<sup>11</sup> S. Freud, 'Group psychology and the analysis of the ego' (1921), *SE*, vol. 18, pp. 69-143, pp. 118-21. Freud's main criticism was that Trotter's theory 'leaves no room at all for the leader'.

<sup>12</sup> Jones, *Free associations: memories of a psycho-analyst*, p. 159. This is by far the most detailed source of personal information on Trotter, but for further biographical information see W.R. Merrington, *University College Hospital and its medical school: a history* (London: Heinemann, 1976), pp. 171-8; [Anon.], 'Obituary: Wilfred Batten Lewis Trotter', *Lancet* 1939 (2), pp. 1244-46; 'J.T.', 'Obituary: Wilfred Batten Lewis Trotter', *BMJ* 1939 (2), pp. 1117-19.

<sup>13</sup> One review claimed that the Sociological Society 'constantly received enquiries' for the articles from their initial publication until *Instincts of the herd* appeared. See 'M.E.R.', 'Dr. Trotter on the herd instinct', *Sociological Review* 9:1 (Autumn 1916), p. 60. The theory had achieved further exposure through its incorporation in B. Hart, *The psychology of insanity* (Cambridge: C.U.P., 1912), pp. 133-7.

<sup>14</sup> W. Trotter, 'Herd instinct and its bearing on the psychology of civilised man', *Sociological Review* 1:3 (July 1908), pp. 227-48, p. 227 and p. 231-5.

In Trotter's view, sensitivity to the behaviour of the herd was the most important factor governing the structure of the mind. Only suggestions deriving from the herd were acceptable to the mind, and so humans were both suggestible and insensitive to experience. The discipline of crowd psychology which had developed in the late nineteenth century had stressed the suggestibility and irrationality of the mob but Trotter internalised these features and made them normal conditions of the mind. Humans were not 'suggestible by fits and starts, not merely in panics and in mobs, under hypnosis, and so forth, but always, everywhere, and under any circumstances'.<sup>15</sup> However, because the herd was also the source of some of the most valuable aspects of human behaviour suggestibility could not, as some eugenicists proposed, be bred out of the race. Conscience and altruism derived from the knowledge that an action or belief would arouse the disapproval of the herd. The emotions of guilt and duty were therefore also based on herd suggestion. There was no glory, dignity, or meaningful selflessness in altruism: it was merely an indirect result of the gregarious instinct. The gregarious animal felt that other members of the herd were to 'a certain extent identical with himself and part of his own personality', and therefore the most apparently selfless act was only an 'expansive egoism'.<sup>16</sup> Although conscience was thereby stripped of its intrinsic status, it still served the ordained purpose of social evolution.

The herd instinct was not only the fount of suggestibility and mindless altruism, but the origin of the mental conflict which was portrayed as the central and inevitable fact of civilised human existence. The other three instincts [of sex, nutrition, and self-preservation], tended to act sequentially, over short periods, under special circumstances, and their satisfaction resulted in pleasure. Conflict between these instincts was therefore infrequent, 'and the animal possessing them alone, however highly developed his consciousness might be, would lead a life emotionally quite simple, endowed with the feelings of free-will and reality to a superb degree, wholly unperplexed by doubt and wholly secure in his unity of purpose'. But the gregarious instinct was characterised by its exercise of 'a controlling power upon the individual from without' in which 'it is not the actual deed which is instinctively done, but the order to do it which is instinctively obeyed'. Even if the deed itself was 'resisted from

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<sup>15</sup> Ibid., pp. 237-9 and pp. 242-3.

<sup>16</sup> W. Trotter, 'Sociological application of the psychology of the herd instinct', *Sociological Review* 2:1 (January 1909), pp. 36-54, pp. 36-9 and pp. 52-3; W. Trotter, *Instincts of the herd in peace and war* (London: Ernest Benn Ltd, 1919), pp. 122-5.

the individual side', it would still be 'forced instinctively into execution'. The herd instinct therefore introduced 'a mechanism by which the sanctions of instinct are conferred upon acts by no means necessarily acceptable to body or mind'. Although this meant that the instinct could be utilised through a vastly increased range of activities, it also meant that complexity and conflict were necessary aspects of human life. Mental conflict began in childhood when experience first began to clash with herd suggestion, and was the normal condition for 'all inhabitants of a civilised state'.<sup>17</sup>

Trotter argued that civilised human societies were divided into two great classes of people, distinguished by their differing responses to the conflict between herd instinct and individual experience. The solutions by rationalisation, indifference, or a combination of the two produced the 'mentally stable', the 'great class of normal, sensible, reliable middle age with its definite views, its resiliency to the depressing influence of facts and its gift for forming the backbone of the State'. The dominance of this group resulted in political stability, but it meant that the state was entrusted to 'a class which their very stability shows to possess a certain relative insensibility to the value of feeling and to suffering and a decided preference for herd tradition over all other sources of conduct'. The second group were the mentally unstable, linked only by their tendency to 'speak or act in ways different to a variable extent from the average of the herd'. These individuals had 'demonstrated by the mere fact of instability that they possess the quality of sensitiveness to feeling and to experience, for it is this which has prevented them from applying the remedy of rationalisation or exclusion when they have met with experience conflicting with herd suggestion'. But although the mentally unstable possessed the adaptability that the stable lacked, they were weak in motive energy, persistence, always changeable in their opinions, and sometimes displayed definite defects of will-power. Society was therefore 'cleft by the instinctive qualities of its members into two great classes, each to a great extent possessing what the other lacks, and each falling disastrously below the possibilities of human personality'.<sup>18</sup>

In 1909 Trotter came down on the side of the mentally unstable. Where others diagnosed degeneracy, Trotter saw 'an indictment of the disorderly environment which has ruined' these individuals. He argued that mental conflict was inevitable unless

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<sup>17</sup> Trotter, 'Sociological application of the psychology of the herd instinct', pp. 39-43.

<sup>18</sup> Ibid., pp. 43-50.



society was perfectly organised: ‘manifestations of mental disintegration are not diseases of the individual in the ordinary sense at all, but inevitable consequences of man’s biological history and exact measure of the stage now reached of his assimilation into the gregarious life’.<sup>19</sup> These remarks about the mentally unstable were cut considerably when *Instincts of the herd in peace and war* was published in 1916, although the rest of the original articles were reproduced virtually in full. The focus of Trotter’s argument had changed. Although he had previously acknowledged that the dissonance between herd tradition and individual experience which produced nervous breakdown ‘as surely deprives the state of its best treasure – a working citizen – as if it had eaten away his flesh with the comparative humanity of its dreadful rivals consumption and cancer’, he had also seen the happiness of the individual as an important aim. In 1909, the most pressing problem of the immediate future was described as ‘to readjust the mental environment in such a way that sensitiveness may develop and confer on man the enormous advantages which it holds for him, without being transformed from a blessing into the curse and menace of instability’.<sup>20</sup> In 1916 the thrust of argument was directed instead towards how the force of the individual could be harnessed for the good of the state.

Trotter presented the book as a practical contribution to the rational direction of morale. He explained that a ‘satisfactory morale’ gave ‘smoothness of working, energy and enterprise to the whole national machine, while from the individual it ensures the maximal outflow of effort with a minimal interference from such egoistic passions as anxiety, patience, and discontent’. By it, ‘the resources of the nation are made completely available to the nation’s leaders, [but] without it every demand upon the citizen is liable to be grudgingly met or altogether repudiated’. The ultimate aim, the perfect social unit, would be ‘a new creature, recognisable as a single entity; to its million-headed power and knowledge no barrier will be insurmountable, no gulf impassable, no task too great’.<sup>21</sup> In the gregarious animal, the perfect development of the social habit meant ‘the moulding of the varied reactions of the individual into functions beneficial to him only indirectly through the welfare of the new unit – the

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<sup>19</sup> Ibid., pp. 52-3.

<sup>20</sup> Ibid., pp. 48-50 and pp. 53-4.

<sup>21</sup> Trotter, *Instincts of the herd*, p. 5-7, p. 102, p. 209 and p. 212-213. It has even been suggested that Trotter wrote the book at the suggestion of a member of the government. See D. Holdstock, ‘Wilfred Batten Lewis Trotter (1872-1939)’, *ODNB*, vol. 55, pp. 430-2

herd', and was dependent on a balance between the capacity for varied reaction and for communication. Although humans possessed a highly developed power of varied reaction, the power of intercommunication was undeveloped in contemporary society. If man was 'conscious as a species of his true status and destiny, realising the direction of the path to which he is irrevocably committed by Nature, with a moral code based on the unshakeable natural foundation of altruism', he 'could begin to draw on those stores of power which will be opened to him by a true combination, and the rendering available in co-ordinated action of the maximal energy of each individual'.<sup>22</sup>

The hive of the honey bee was held up as the most perfect development of the social habit. In contrast to the mere herd, the hive was 'an elaborate mechanism for making use by co-ordinate and unified action of the utmost powers of the individual members', 'a complete substitute for individual existence'; indeed, 'a new creature rather than a congeries united for some comparatively few and simple purposes'. This perfection of communal life was dependent on the bee's minute mental development and subsequent lack of capacity to assimilate experience, allied to a physical structure that had evolved in response to the needs of the hive rather than the individual. The bee community was efficient precisely because the worker bee could not 'react freely and appropriately to stimuli external to the hive'. The 'standing miracle of the bee' was 'her sensitiveness to the voice of the hive and her capacity to communicate with her fellows, and this would undoubtedly be less marvellously perfect if she were not at the same time deaf to all other voices'. Trotter noted approvingly that the worker bee 'has practically no activities which are not directly devoted to the hive, and yet she goes about her ceaseless tasks in a way that never fails to impress the observer with its exuberant energy and even its appearance of joyfulness'. The outcome of this dedication? 'It is thought that the average worker bee *works herself to death* in about two months'.<sup>23</sup> The right and proper end of the social instinct was to submerge the individual in the social to the point of literal extinction.

There were therefore ominous, although entirely unwitting, overtones in Trotter's argument that the foreordained path of England, although still 'infinitely behind' the

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<sup>22</sup> Trotter, 'Sociological application of the psychology of the herd instinct', pp. 50-1; Trotter, *Instincts of the herd in peace and war*, p. 105 and p. 139.

<sup>23</sup> W. Trotter, *Instincts of the herd*, pp. 106-8 and p. 166.

fulfilment of this ideal, was the way of the bee.<sup>24</sup> England embodied the spirit of the hive, with a kind of communal mind. The English were described as ‘an old and isolated people, developing by the slow mingling and attrition of their ideas, and needs, and impulses, a certain deeply lying unity which becomes a kind of “instinct” for national life, and gives to national policy, without the conscious knowledge of any individual citizen, without the direction of statesmen, and perhaps in spite of them all, a continuity of trend, and even an intelligence, by which events may be influenced in a profoundly important way’. If England continued on her current path, she would eventually ‘attain access to a store of moral power literally inexhaustible, and will reach a moral cohesion which no hardship can shake, and an endurance which no power on earth can overcome’.<sup>25</sup> The war, because it constituted a threat to the whole herd, acted upon man as a member of the true unit, the nation. It therefore provided an intense stimulus to the social instinct, and the individual had reacted in the most vigorous way. The ‘disciplined mob’ had shown itself ‘to be capable of facing dangers the facing of which by isolated individuals would be feats of fabulous bravery’. The homogeneity fostered by war had created ‘moral power, enthusiasm, courage, endurance, enterprise, and all the virtues of the warrior’.<sup>26</sup> This unity foreshadowed, albeit temporarily, the future harmony of the English hive.

In 1919 Trotter added a postscript to the book. He maintained that the war had furnished ‘the most powerful of all stimuli to the social instinct’, setting in motion ‘a tide of common feeling by the power of which union and energy of purpose and self-sacrifice for the good of the social unit become possible to a degree unknown under any other circumstances’. Had this great mobilisation of social power taken place at a later point in evolution, it ‘might have been taken advantage of to unify the nation to a completely coherent structure which the cessation of the external stimulating pressure would have left firmly and nobly established’. As it was, this stream of moral power was already drying up. The individual was turning to class rather than nation for ‘moral vigour and interest’ once more, and the state again seemed ‘remote and quasi-hostile’. Yet having ‘so to speak, tasted blood’, the individual was unlikely to be satisfied with

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<sup>24</sup> The German herd instinct, on the other hand, was analysed as the aggressive type typified by the wolf pack. Trotter insisted this was not mere analogy, but ‘a real and gross identity’. *Ibid.*, pp. 191-2. Freud’s comment that the book ‘does not entirely escape the antipathies that were set loose by the recent great war’ was something of an understatement. Freud, ‘Group psychology and the analysis of the ego’, p. 118.

<sup>25</sup> W. Trotter, *Instincts of the herd*, p. 201, p. 204 and p. 207.

<sup>26</sup> *Ibid.*, pp. 142-3.

the 'tasteless social dietary of pre-war England'. The nation might even be in a worse condition than before: the war had also weakened conventional restraints on class hostility and accustomed the populace to change, violence, and irreverence for established traditions. Finally, the war itself was a symptom of social defects which had not been remedied.<sup>27</sup> This conclusion added new layers of pessimism to an account not hitherto lacking that quality. The social cohesion of the war was a mirage, a temporary hiatus in the steady crumbling of civilisation. Trotter outlined a 'rational statecraft' but held out little hope of its implementation. Humanity was driven by instinct, but separated from the animal by an intelligence which it refused to use: and the 'object lesson' of the war was ultimately not the benefits which could be accrued from unity, but 'how easy it is for man, all undirected and unwarned as he is, to sink to the irresponsible destructiveness of the monkey'.<sup>28</sup>

### **The herd, the nation, and the army**

The outbreak of war raised the health of the individual and the social organism, a problem of some import even before 1914, to the level of national emergency. The material resources of the nation were seen as of secondary importance: 'its bulwarks are the breasts of its manhood, the courage, endurance, and fortitude of its individual units'.<sup>29</sup> The importance of morale was realised early on. In March 1915, a *British Medical Journal* editorial outlined 'the nature of the very ultimate standard made by a belligerent State upon its people'. The state 'demands of its fighting men the ability to suffer and to go on suffering the terrific and nerve-shattering onslaught of modern gunfire and still retain in their depleted ranks an effective and alert organisation; and from its civilian population the State demands the ability to suffer, proudly and gladly it may be, but to suffer and to go on suffering the increasing pinch of adversity and the loss of its bravest and best-loved sons'. The outcome of the war would depend on the ability of Britain's people to meet these demands. Before the war, 'disruptive forces' had threatened 'all groups, from the family to the State', in every sphere from 'dress and deportment at one end of the scale to preparation for civil war at the other'. But the war had effected 'the sudden settlement of differences, the fusion of opposed bodies, the

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<sup>27</sup> Ibid., pp. 234-40.

<sup>28</sup> Ibid., pp. 255-6.

<sup>29</sup> W. Milligan, 'The value and importance of physical exercises from a national standpoint', *Journal of State Medicine* 26:2 (February 1918), pp. 33-43, p. 33.

bending to a common purpose of antagonistic forces, and the steady conversion of a nation devoted to peaceful arts into a nation of warriors, not at the command of any autocratic head, but from the righteous demand of a free people to suffer in a righteous cause'. The 'most striking psychological effect of the war on our national as on our individual consciousness' had been 'the shedding of a thousand distracting influences in the face of a single and plain duty'.<sup>30</sup>

It was in this atmosphere that Trotter sat down to draft his book. He may also have been prompted by renewed interest in his work. A week after the above editorial appeared, the *Lancet* published the first instalment of Stoddart's lectures on 'the new psychiatry', which meshed Trotter's theory of the herd instinct with a lucid outline of the basic tenets of Freudian psychopathology and concluded that 'by far the greater majority of conflicts occur between a personal complex and a herd complex'. Stoddart's purpose was exposition rather than sociological analysis, and the only mention of the herd instinct in relation to war was that 'a man who worries about the ultimate result of the war ceases to do so when he enlists in Kitchener's army' because he had 'the unconscious feeling of being in the fold'.<sup>31</sup> The topic was more fully elucidated by Gilbert Murray (1866-1957), a Professor of Greek at Oxford University, as part of a lecture series on 'the international crisis in its ethical and psychological aspects' delivered at the University of London in February and March 1915. This discussion highlighted the ambiguous moral status of the gregarious instinct as source of both suggestibility and altruism, the consequent implications for the individual within the social organism in war, and finally the dangers of the rule of instinct. It not only drew out the ethical problems raised by Trotter's analysis of the herd instinct,<sup>32</sup> while remaining faithful to his conception of its nature, but revealed prominent fears regarding the social effects of war which could also be expressed without reference to the herd instinct.

The first and most important consequence of the war in Murray's view had been to unite the herd. Before the war Britain had been besieged by the campaign of the

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<sup>30</sup> [Anon.], 'The psychological effect of war', *BMJ* 1915 (1) [March 13 1915], pp. 475-6, p. 475.

<sup>31</sup> Stoddart, 'The Morison lectures. I', pp. 583-6.

<sup>32</sup> The lecture was met with approval from Lord Bryce, but William McDougall criticised Murray for laying too much emphasis on the negative aspects of the social instinct. See G. Murray, *Herd instinct: for good and evil* (London: George Allen & Unwin, 1940), p. 3.

militant suffragettes, 'an utterly abnormal number of strikes', rebellion against trade union leaders, 'trouble in India' and 'terrific threats from Ireland': 'our whole people seemed at strife with itself'. On the whole, 'these various enemies have now "made it up"'.<sup>33</sup> Yet the unity achieved under the herd instinct had a cost. All the emotions which were felt in common were intensified under its stimulus, but this increased the suggestibility of the individual and the group. Those desires normally suppressed were given an outlet through the sanction of the crowd, and individual responsibility was repudiated, hence the performance of socially reprehensible acts became more likely. The loss of individuality also proceeded in another direction. As well as heightening emotions shared by the group, the herd instinct 'deadens and shuts down those which are only felt by the individual'. Murray illustrated this fact with the example of a soldier whose feet bled during a march, but did not make any remark or even feel the pain. The needs of the individual were subordinated entirely to those of the herd. He gave another example, painful in the light of future experience. A procession of ants encountering a trail of copper sulphate did not turn aside, but 'each ant as he came up threw himself on the horribly corrosive stuff and devoured it till he fell dead; and presently the main army marched on over a line consisting no longer of bluestone, but of dead ants'.<sup>34</sup> Unlike Trotter, Murray viewed this complete submergence of individual existence with some horror. He argued that rational thought should be used not to direct the herd instinct, but to counteract its effects: 'if we yield to the stream of instinct and let scruples and doubts and inhibitions be swept away, we shall not really find life easier [...] For the powers to which we yield will only demand more and more'.<sup>35</sup>

In Murray's view, the anarchical tendencies of the crowd lurked under the apparent social cohesion achieved by the declaration of war. Britons had not only sunk their political differences, but their individual selves, their rationality and personal responsibility, in pursuit of the common goal. The national unity necessary for the prosecution of war was fundamentally flawed because it originated in animal instinct rather than human intelligence, and therefore constituted a seductive but potentially

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<sup>33</sup> G. Murray, 'Herd instinct and the war' in E.M. Sidgwick, G. Murray, A.C. Bradley, L.P. Jacks, G.F. Stout, and B. Bosanquet, *The international crisis in its ethical and psychological aspects* (London: O.U.P., 1915), pp. 22-45, pp. 28-9.

<sup>34</sup> *Ibid.*, pp. 25-6 and pp. 34-5.

<sup>35</sup> *Ibid.*, p. 45.

limitless descent from the standards of civilised social life. The thoroughgoing pessimism of this vision, outlined by a future Liberal candidate for Parliament and chairman to the executive council of the League of Nations, found few wholehearted adherents in 1915. But nonetheless, others recognised the crowd latent in the nation. In an address on 'Nerve and nerves', Osler mused on the 'contagion' of fear, 'a state in which the nerves were unstrung'. The recent rumours of Russian troops passing through Britain, and the (not related) moral panic unleashed at the prospect of an explosion of war babies were cited as evidence of the action of herd instinct, stripping reason from the mind of the crowd. The nation 'needed steadying, more self-control, more cultivation of the will, which alone had the key to our reservoirs of unused energies'. These 'nerves' must be replaced by 'nerve – that well-strung state so needful for our final victory'.<sup>36</sup>

The essential problem for both the civilian and military population was to attain the benefits of unity without losing the individuality of the British national character. One writer argued that for decades the education of the German people had been 'systematically directed to warlike ends'. The result, 'on a people strangely obedient to the voice of authority and unaccustomed to exercise individual judgement and personal initiative', had been 'to produce a special sort of national or collective consciousness'. Although 'a source of strength', the German nation was consequently 'highly susceptible to the influence of mass-suggestion, and liable to the influx of waves of emotion overwhelming the reason'. Under the 'shock of war', the British empire had united 'as never before', and a collective consciousness was also emerging. The British were, he concluded, shielded from the concomitant dangers because 'the collective consciousness must be largely determined by the character of the units composing it'. An epidemic of emotion was not to be feared when collective consciousness arose 'spontaneously in a free people, nurtured in independence of thought and action and accustomed to the unfettered exercise of their own judgment'.<sup>37</sup> Although the author drew back from the brink, seeking refuge in assertions of the essential difference of the Britons, the spectre of identification with the enemy had been raised.

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<sup>36</sup> [Anon.], 'Nerve and nerves: address by Sir Wm. Osler, Bart.', *TMW* 5:16 (July-Dec 1915), p. 492.

<sup>37</sup> [Anon.], 'The psychological effect of war', p. 476; see also [Anon.], 'Dr. G.L. Finlay on German "nerves"', *TMW* 4 (Jan-June 1915), p. 8.

As both the guardian of the nation and an organised crowd which depended for its efficiency on the subordination of the individual, the army was a locus for anxiety concerning the ambiguous legacy of the herd. The fine balance necessary between the individual and the unit presented a difficulty at the basic level of training.<sup>38</sup> The aim must be to overcome individual self-interest in order to achieve a unified and predictable response to the dangers of battle, but for discipline to be effective 'the voluntary spirit, the spirit of individual effort' must also be internalised.<sup>39</sup> This predicament was given a nationalistic twist in Armstrong-Jones' discussion. He believed that the war was the outcome of the German 'belief that the highest function of man is to work his will upon people and things outside of him; in other words that he can change the world without changing himself'. This fundamental attitude could also be seen in the working of the German military machine, in which 'the dominant thought of cohesion' was instilled 'by orders from without and not from within the troops themselves'. In contrast, the 'collective will power' of the British army was created 'from among themselves and from within'. The 'dissociated, uncertain, and disconnected "will powers"' of the mob had been forged into a 'solid cohesive whole'. The security of the unit could not be secured, however, because this effect was achieved through the elimination of individual difference. Drill induced an automatic response at the expense of initiative, and so the unit was not prepared to meet unexpected events, 'for no over-drilled individual possesses the initiative or the originating capacity to construct new plans'. He maintained that the British army was 'composed of individuals who have not been dragooned into secondarily automatic machines', but nevertheless revealed that the 'collective mind' could not be viewed with complacency.<sup>40</sup>

### **The herd instinct and shell-shock**

The war neuroses were always and inevitably a social problem. The individual who failed to perform his military duty placed the whole unit in danger, not only as a

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<sup>38</sup> Hew Strachan discusses the success of training, particularly drill, during the First World War in creating individual and collective confidence and preparing the soldier to act effectively in the heat of battle. H. Strachan, 'Training, morale, and modern war', *Journal of Contemporary History* 41 (2006), pp. 211-27, especially p. 217-21.

<sup>39</sup> Recommendations of *RWOCESS*, pp. 208-9.

<sup>40</sup> Armstrong-Jones, 'The psychology of fear', p. 356, and p. 383; Armstrong-Jones, 'Mental states and the war . I', pp. 238-9.



malfunctioning cog which disrupted the working of the machine, but as a latent virus within the organism. The 'infectious character of loss of control was a menace not to be disregarded', and consequently the medico-military attitude was that shell-shock, 'like measles, [was] so infectious that you cannot afford to run risks with it at all'.<sup>41</sup> The breakdown of the individual not only threatened the army, but burdened the state, a theme which became prominent in articles on shell-shock from 1916. The broken soldier who had never been suitable for war had 'cost as much as a cartload of shells'; the 'money and energy' wasted on his training could have been more profitably expended on 'the manufacture of munitions'.<sup>42</sup> The success or failure of treatment was described as 'the difference between a useless burden to the State and a useful civilian or even a useful soldier'.<sup>43</sup> If unsuccessful, the result would be the creation of a class of men who were 'a helpless drag upon themselves and an additional burden to the finances of the country'.<sup>44</sup> The plea for reform of military and civilian health services was presented as an economics of productive citizenry: true, it cost more on a daily basis to repair a car than to garage it, but the extra was gladly paid 'for the simple reasons that a motor car in its garage is of no use to us, and that the daily charge for housing the car would amount to a colossal figure if paid for many years'.<sup>45</sup> The aftershock of the shell rippled out from individual, to unit, army, and eventually nation-state.

At the most basic level, shell-shock was viewed as an unwitting assertion of the individual against the needs of the army and nation. The symptoms of the war neuroses were described as a repudiation of social relationships, mutism and deafness as attempts to cut off 'the two main channels of intercourse with others'.<sup>46</sup> In its essence, shell-shock was antisocial. This theme was anticipated early in the war in bombastic

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<sup>41</sup> [Anon.], 'The mental factor in modern war: shell shock and nervous injuries', p. 325-6; Lord Gort in *RWOCESS*, p. 50; see also pp. 28-9, pp. 38-9, p. 66, and p. 121; Myers, *Shell shock in France*, p. 95; Smith, 'Shock and the soldier', p. 813.

<sup>42</sup> Mott, 'The Chadwick lecture', p. 40; Mott, 'Two addresses on war psycho-neurosis (I)', p. 128; see also Savage, 'Mental disabilities for war service', p. 653.

<sup>43</sup> Adrian and Yealland, 'The treatment of some common war neuroses', p. 867; see also Culpin, 'Practical hints on functional disorders', p. 549; Tooth, 'Neurasthenia and psychasthenia', p. 345; Grimby, 'Neuroses and psycho-neuroses of the sea', pp. 253-4 and p. 258.

<sup>44</sup> Veale, 'Some cases of so-called functional paresis', p. 614; see also Tombleson, 'An account of twenty cases treated by hypnotic suggestion', pp. 345-6.

<sup>45</sup> Smith and Pear, *Shell shock and its lessons*, pp. 125-6; see also Henderson, 'War psychoses', p. 177 and p. 187.

<sup>46</sup> Myers, 'Contributions to the study of shell shock. (IV)', p. 465; see also MacCurdy, *War neuroses*, p. 7, pp. 28-9, p. 34, and p. 86.

paean to the benefits of the military life, which apparently cured the self-indulgence of 'the podgy shopkeeper', the alcoholic and the neurasthenic. The 'implacable pursuit of a common object, the sharing of a common danger, and the perpetual emulation render selfishness despicable and make the man conscious of his individual insignificance; his personality is sunk in the common weal'. Only the 'weaklings' would 'go to the wall'.<sup>47</sup> The accusatory tone of such interpretations was mitigated by theories which constructed the war neuroses as a conflict of self-preservation and duty, but not dissolved. In William Chambers' phrase, shell-shock consisted of conduct 'favourable to the individual but unfavourable to the herd'. The anxious patient was one whose impulses 'offended against the herd', but who nevertheless engaged in 'prolonged and stubborn resistance to the tendencies of individualism', and developed pathological symptoms as a result of this struggle.<sup>48</sup> David Eder described the hysterical symptom as the outcome of a similar conflict, but conflated 'the gregarious instinct' with 'the soldier's instinct': neurosis was therefore a refutation of the soldier's role and the social milieu which endorsed it.<sup>49</sup> John MacCurdy took a harsher view, describing the soldier's 'disinclination to return to the front' as 'essentially a selfish desire to avoid his responsibility as a citizen'. The prospect of cure depended on the patient's conscious decision either 'to be a slacker or to assume his share of the country's burden'.<sup>50</sup>

The herd or social instinct was not only the foundation of patriotism, altruism, and self-sacrifice. The fears outlined earlier in this chapter regarding the dual nature of the 'collective mind' were also mirrored, and even intensified, in theories of the war neuroses. This is evident in Mott's work. On the one hand, the herd instinct increased with the progress of civilisation, enabled the sacrifice of 'individual interest and life in the interests of the herd', acted to control the lower instincts, and generated feelings of duty and patriotism.<sup>51</sup> On the other, it was also a source of suggestibility and imitation, which could either be turned to good use in the creation of *esprit de corps* or could initiate an epidemic of shell-shock. The aim of mental hygiene must be to ensure a balance between the individual and the social spirit, 'by encouraging all those factors

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<sup>47</sup> [Anon.], 'Military life and physical health', *BMJ* 1915 (2) [August 14 1915], p. 267.

<sup>48</sup> Chambers, 'Mental wards', p. 156; see also Read, 'A survey of war neuro-psychiatry', p. 372, p. 376 and pp. 380-1.

<sup>49</sup> Eder, 'An address on the psycho-pathology of the war neuroses', p. 266.

<sup>50</sup> MacCurdy, *War neuroses*, p. 85.

<sup>51</sup> Mott, 'Body and mind', p. 3; Mott, 'The psychopathology of puberty and adolescence', p. 288-90; F.W. Mott, 'Two addresses on war psycho-neurosis. (I)', p. 129.

and conditions in education which support moral [sic], discipline, self-sacrifice, and *esprit de corps*, in the home by respect and pride of family, and in schools, universities, in the services, and in industries by respect and pride in such institutions' without 'repressing or destroying that individual self-control and independent originality in thought and purposive action which is essential for national progress'.<sup>52</sup> MacCurdy's explanation of individual adaptation to warfare provided a different conception of the two-pronged action of herd instinct. He argued that the soldier was able to sacrifice personal comfort and safety because when the social instinct was stimulated he became 'less of an individual and more an integral part of the society to which he owes allegiance'. War also became a palatable prospect, however, because tendencies to savagery and cruelty, repressed in ordinary life through the action of the gregarious instinct, now received the sanction of the community by the same means.<sup>53</sup> The herd instinct in war compensated the individual for his self-sacrifice by gratifying those 'individualistic tendencies' it normally could not endorse.

This presentation of herd instinct as simultaneously fount of civilisation and agent of the primitive was also revealed, but neither acknowledged nor resolved, in Rivers' theory of the war neuroses. Rivers explained the war neuroses as the result of 'a conflict between the instinct of self-preservation and certain social standards of thought and conduct, according to which fear and its expression are regarded as reprehensible'.<sup>54</sup> Other authors, such as MacCurdy and Stanford Read, adopted a similar formulation in which the herd instinct roughly corresponded to these 'social standards'. But Rivers did not correlate duty and the herd instinct. He defined the purpose of the gregarious instinct as 'to produce and maintain the cohesion of the group'. In his writings, it was always associated with the lower: it was a characteristic of primitive societies, the source of suggestion, of 'the mass-reactions of the crowd', and was invoked particularly to explain the extremely ancient reaction to danger by immobility of which the major hysterical symptoms were manifestations.<sup>55</sup> This consistent alignment of the herd instinct with the primitive left no space for its putative role in the formation of the anxiety neuroses, explained as the product of a heightened

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<sup>52</sup> Mott, 'A British Medical Association lecture'; [Anon.], 'British Medical Association special clinical meeting', p. 709.

<sup>53</sup> MacCurdy, *War neuroses*, pp. 11-13.

<sup>54</sup> Rivers, 'War-neurosis and military training', p. 514.

<sup>55</sup> Rivers, *Instinct and the unconscious*, p. 41, p. 90, pp. 94-8, p. 106, pp. 132-3, and p. 149.

sense of duty. The social imperative which drove the repression of fear must have had an origin, but Rivers studiously avoided relating these higher ideals in any way to the concept of the herd instinct. He preferred the vaguer 'social standards'. It seems that for Rivers the anxiety neurosis, as an essentially intelligent (although misdirected) and civilised reaction, must always be presented as a step beyond and away from instinct.

This interpretation is strengthened by Rivers' handling of the concept of sublimation. In 1918 he defined sublimation as 'a process in which an instinctive tendency, more or less fostered by experience, which would normally find expression in some kind of undesirable conduct, has its energy directed into a channel in which it comes to have a positive social value'. In his view, sublimation was one of the main methods through which *esprit de corps* was fostered by in the officer class through military training, enhancing the sense of social and personal responsibility which determined the formation of anxiety symptoms. It was contrasted to suggestion, which heightened an instinctive tendency and was the main factor at work in the training of the private soldier.<sup>56</sup> When he came to write *Instinct and the unconscious* the definition of sublimation had changed slightly. It was now a process in which 'the energy arising out of conflict is diverted from some channel which leads in an asocial or antisocial direction, and turned into one leading to an end connected with the higher ideals of society'. The education of the child and the re-education of the neurotic soldier was essentially a long process of sublimation, by which 'innate or instinctive tendencies' were directed 'to an end in harmony with the highest good of [...] society'. Rivers argued that although the war had revealed that conflict between instinct and 'controlling forces', and therefore instability, was an inevitable aspect of the human psyche, when sublimated the energy produced by this conflict was responsible for the greatest of human achievements.<sup>57</sup> Sublimation was now awarded a central role in the foundation and continuance of civilised society, but it was also removed even further from instinct. It was no longer simply the channelling of instinct to higher ends, but the re-directing of energy produced by a conflict in which instinct was only one of the players. Rivers ended his book, a long disquisition on the continuing power of animal inheritance in human behaviour, with this chapter on sublimation. It cannot help but read as an attempt to rescue the human from the rubble of his own conclusions.

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<sup>56</sup> Rivers, 'War-neurosis and military training', pp. 522-4.

<sup>57</sup> Rivers, *Instinct and the unconscious*, pp. 156-8.

## The boundaries blurred

There were manifold ways in which shell-shock provoked social anxiety. Perhaps the most important of these, however, was that it could not be perceived as a threat confined to the army. This was a war conducted by civilians: as one anonymous author wrote in 1917, 'The nation is the army'.<sup>58</sup> Its problems, its weaknesses, were those of Britain as a whole. The boundaries between the civilian and military spheres were inexorably blurred, and so shell-shock spilt out from the NYDN centres and special hospitals into the national psyche. A report from September 1915, ostensibly denying the long-term significance of the war neuroses, unintentionally underlined the slippage between two worlds. It began by noting a 'curious feature of the psychology of the crowd at all times', which had been 'much in evidence during the present world-war', namely 'the way in which assumptions of a far-reaching character are based on slender evidence and forthwith taken to be facts, which subsequent evidence is rarely utilised to dispute'. The most recent example of an unfounded allegation which had attained the status of popular truth was the notion that the many 'agonising experiences of trench warfare' led to 'the development of neuroses and insanity'. The proposition had no sooner been made than 'evidence, in the shape of letters from the front, or actual cases coming under personal observation, is forthcoming to point in the required direction', the topic was 'taken up in the lay press, and questions are asked in Parliament'. The author argued that this rumour-mongering had little foundation in reality. The majority of soldiers had 'so vivid a consciousness of the greatness and nobility of the principles for which they are contending that they are in a sense protected from the effects which sights and sounds of a terrifying nature might otherwise exercise over them'. In fact, the spectacle of such sacrifice would most likely lead to 'a great decrease in the amount of mental instability' as the inspired populace responded by returning to 'the virtues of a simpler life'.<sup>59</sup> The conclusion was utterly conventional for this stage of the war, but already an indirect link had been made between neurotic soldiers and hysterical civilians.

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<sup>58</sup> [Anon.], 'The mind of the soldier', p. 188.

<sup>59</sup> [Anon.], 'Insanity and the war', p. 553.

In the eyes of many, the war had not provoked change but had merely forced the hidden diseases of civilisation into the light. The most cherished beliefs of modern humanity had been 'shaken to their foundations', and as 'the ancient edifice came tumbling about our ears, we wondered at the structural enormities revealed in its ruins'. The accretions of centuries were revealed as 'founded on the flimsiest basis, and we are amazed that they could have held together so long'.<sup>60</sup> These lessons applied above all to the neuroses. There was nothing new in shell-shock; its apparent prevalence signalled only that no blemish could be concealed in war. A man might 'be capable of earning his living in the city and playing his part in social life, but the defect in his organism [was] brought to the surface' under the stresses of war.<sup>61</sup> The neurotic could lurk safely in the shadows of the city, hiding his symptoms by avoiding all social contact; the ruthless military gaze allowed no such obfuscation, and the eccentric soldier was packed off to hospital forthwith.<sup>62</sup> Nevertheless, the epidemic did hold a new significance. This was a civilian army. Its mental health reflected that of 'the male moiety of the entire British nation'.<sup>63</sup> Small wonder that Mott, looking back, judged that the main lesson of shell-shock was 'what a large proportion of the male population of a highly civilized country possesses a neurotic or neuropathic predisposition'.<sup>64</sup>

He was not alone. In 1918, John O'Brien, a medical correspondent to the *Lancet*, took issue with William Brown's statement that only hysterical people could be hypnotised. He adduced an array of statistics to demonstrate that hypnosis could be produced in virtually anyone, and claimed that if Brown was right then he 'must believe that three-quarters of the globe is hysterical or conclude that nearly everyone is not right in the head'.<sup>65</sup> The gauntlet was taken up with alacrity and aplomb: the widespread liability to hypnosis did not disprove his assertion, Brown declared, but showed that 'most people, if not all, have some hysterical flaw, some dissociation following upon mental conflict, in their mental make-up'.<sup>66</sup> Even this claim was not sufficiently radical to satisfy Donald Core, who instructed both correspondents that 'all human beings are hysterical

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<sup>60</sup> H. Head, 'Disease and diagnosis', *BMJ* 1919 (1), pp. 365-7, p. 365.

<sup>61</sup> Grimby, 'Neuroses and psycho-neuroses of the sea', p. 244.

<sup>62</sup> Eager, 'The early treatment of mental disorders', p. 558.

<sup>63</sup> Pearn, 'Psychoses in the Expeditionary Forces', p. 101.

<sup>64</sup> Mott, 'The neuroses and psychoses in relation to conscription and eugenics', p. 13.

<sup>65</sup> J.R. O'Brien, 'Correspondence: hypnosis in hysteria', *Lancet* 1918 (2), pp. 404-5, p. 405.

<sup>66</sup> W. Brown, 'Correspondence: hypnosis in hysteria', *Lancet* 1918 (2), p. 433.

to a certain extent, in that they are human'.<sup>67</sup> These damning conclusions were not dispelled by the advent of peace. In June 1919, a letter to the *Times* objected to the proposal to signal the signing of the peace treaty by naval and military salutes. It 'might have been thought that most of us had had about enough' of 'sudden explosions, startling and nerve-racking' [sic] by this point. The letter was signed 'Shell shock'.<sup>68</sup> The war, it seemed, was seeping into peace just as it had leaked out into the civilian world. Thirteen years later, John Fuller concluded that 'the Western world is still shell-shocked'.<sup>69</sup>

Fuller reached this conclusion as a result of his study of war and democracy; he might as well have turned to some recent literature. Richard Aldington's *Death of a hero* (1929), is not typical of the fiction and autobiographies produced in the wake of the war. It was deemed the most 'hysterical' of all the war novels, and led D.H. Lawrence to believe that its author was 'evidently on the way to an insane asylum'.<sup>70</sup> It nevertheless testifies to the invidious leaching of the war into civil life, into peacetime society, and even into the past. In a remarkable passage, Aldington transposes the world of trench warfare onto the map of pre-war London.<sup>71</sup> Kensington is a system of communication trenches linking the support to the front lines; cities are the sites of 'intricate trench systems and perpetual warfare, concealed but as deadly as the open warfare of armies'. The whole peacetime world of family and business, its 'incests', 'cruelties', 'sacrifice' and 'horror', is a battleground, as 'fierce and implacable and concealed as the desperate warfare of plants and the hidden carnage of animals'. The authorial presence deliberately destroys the illusion of time as an orderly and logical progression. The future world of war and the ancient past are all as one. The pavements of London conceal not only 'the subterranean veins of electric cables, the arteries of gas and water mains, the viscera of underground railways', but 'far, far down, the fossilised bones of extinct animals and their coprolites'. The 'sabre-toothed tiger roared and

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<sup>67</sup> D.E. Core, 'Correspondence: hypnosis in hysteria', *Lancet* 1918 (2), p. 471.

<sup>68</sup> 'Shell shock', 'Letters to the editor: peace guns', *Times* June 26 1919, p. 8.

<sup>69</sup> J.F.C. Fuller, *War and Western civilisation, 1832-1932: a study of war as a political instrument and the expression of mass democracy* (London: Duckworth, 1932), p. 268.

<sup>70</sup> A. Loveman, 'Books of the fall', *Saturday Review of Literature* 6 (1929-1930), p. 262; R. Aldington, *Life for life's sake: a book of reminiscences* (London: Cassell, 1968), p. 303.

<sup>71</sup> Atypical as Aldington's book is in many respects, the ex-soldier's reconfiguration of the landscape of peace into a battlefield was a theme of other 'war stories'. See R. Graves, *Goodbye to all that* (London: Penguin, 1960) [1957], p. 235 and D.L. Sayers, 'The unsolved puzzle of the man with no face', in D.L. Sayers, *Lord Peter: the complete Lord Peter Wimsey stories* (New York: Perennial, 2001) [story originally published 1928], pp. 226-56, p. 252.

savagely devoured its victims, the huge-horned deer darted in terror; wolves howled; the brown bear preyed; overhead by day screamed eagles and by night flitted huge bats' – this was the daily scene in Notting Hill, way back when 'the Channel was the Rhine's estuary'.<sup>72</sup>

In Aldington's nightmarish vision, the past, present and future of London, capital of England and centre of empire, are indistinguishable. There are no clear lines separating war and peace or civilisation and its animal past. But as he imagined this primitive tableau, Aldington also blurred the boundary between the English Channel and the Rhine, between Britain and Germany, between self and enemy. This was perhaps the last taboo. In wartime, for the dweller on the home front, the ultimate fear was to become like the German. At a point when civilisation could be defined as 'the united culture of all the Allies', Germany was its antithesis and its most threatening source of contagion.<sup>73</sup> The only case Rivers recorded in which he could find no redeeming feature whatsoever with which to console and cure the patient was that of a young officer 'who was flung down by the explosion of a shell so that his face struck the distended abdomen of a German several days dead, the impact of his fall rupturing the swollen corpse'. For Rivers, the peculiar horror of this experience seemed to lie in the soldier's partial ingestion of 'the decomposed entrails of an enemy'. A careful writer who hedged his theories with 'perhaps' and 'might', the description is deliberate in its particulars. The implication is that the episode would have been less horrible had the corpse been British. This may be speculation, but Rivers' total recoil from the vicarious memory seems to demand some special explanation. In an article written especially to convince the medical community that repression as much as war experience was responsible for symptoms, he admitted advising this patient to go 'into the country, far from all that could remind him of the war'.<sup>74</sup>

The literal and perilous closeness of the German and British armies was the defining feature of trench warfare and encouraged fears of moral contagion. Alan Macphail, describing a day's work on the Western front, depicted the German as a Morlock, who 'worked in science as in war, throwing out saps underground, living and moving and

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<sup>72</sup> R. Aldington, *Death of a hero* (New York: Garden City Publishing Co., 1970) [1929], pp. 118-9; see also p. 147 and p. 255.

<sup>73</sup> Armstrong-Jones, 'Mental states and the war. I', p. 239.

<sup>74</sup> Rivers, 'The repression of war experience', p. 7.



having his being in darkness'. Although this hellish underworld was the creation of the enemy, the British soldier also lived and breathed this atmosphere: he 'got to know' the 'burrowed area', 'even as a worm knew its own cheese, and the underground plan was easier to follow than were some of the streets of London'.<sup>75</sup> The castigation of everything German ultimately, and without irony, indicted civilisation. In one report from 1917, the 'almost daily bombardments' of London were cited as evidence of the German 'policy of frightfulness'. The majority of Londoners had responded to this threat with 'admirable' calm and grit, but an 'exception to this good behaviour' had been 'afforded by certain elements of the alien population of the east end'. These miscreants had 'crowded into the tubes and thronged the platforms of the principal railway stations and the trains going even as far as thirty or forty miles from London', invading the surrounding localities and imposing on the local populations. The only solace was that 'if air raids and the measures taken for their repulse can produce such a state of nerves in these aliens, it is probable that raids over German towns would have a similar effect on their inhabitants'.<sup>76</sup> The alleged reaction of aliens within Britain to the reprehensible German policy of targeting civilians was used as putative justification for adopting the same strategy. The boundaries were no longer blurred. They had collapsed completely.

### **Conclusion: the paradox of civilisation and war**

Musing on the potential causes of functional conditions in 1917, Thomas Harwood, an ophthalmic officer working in a military hospital, could be sure of only one fact: 'that civilisation plays a large part in their production'. He added that in recent months, 'Kultur has brought CO into prominence as a possible cause of neurasthenia and has shed an illuminating light upon the whole question'.<sup>77</sup> Despite this topical twist, Harwood's analysis was a couple of decades too late to earn any accolades for originality. In the closing years of the nineteenth century, those in the medical community who chose to reflect on contemporary society had discovered a troubling paradox: modern civilisation, the source and outcome of the undeniable achievements

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<sup>75</sup> A. Macphail, "'A day's work'", *BMJ* 1917 (1), pp. 887-8, p. 888.

<sup>76</sup> [Anon.], 'The air war', *BMJ* 1917 (2), pp. 457-8, p. 457.

<sup>77</sup> Harwood, 'Functional conditions in the light of head injuries', p. 699.

of the previous hundred years, was a source of disease.<sup>78</sup> The conclusion that Britain was suffering the ‘penalties of civilisation’ was expressed through the language of nerves: this was the ‘age of neurasthenia, nervous breakdown, and “brain fag”’.<sup>79</sup> The interaction of physiological and social evolution produced nervous disorders. The highly evolved nervous system of the civilised individual was exquisitely sensitive to both pleasure and pain. The desire for happiness resulted in the proliferation of technologies and goods to make life easier and more comfortable; but the organism, already tuned to a fine pitch, was consequently less able to face the manifold pressures, the speed and assaults on the senses, of urban and industrial civilisation.<sup>80</sup>

These analyses inevitably informed medical responses to shell-shock. The German forces had barely entered Belgium before the question of the ability of the modern nervous system to meet the test of modern warfare was raised in the British medical press.<sup>81</sup> It took a little longer to conclude that if nervous conditions were ‘the outcome of the stress and strain of a civilisation which differs from those of other epochs’, then the war neuroses were the result of a war which differed ‘from all preceding wars’, ‘the product of modern warfare under modern conditions’.<sup>82</sup> The paradox, now reformulated to meet the new situation, was that industrial war among civilised nations was pathological because it was so utterly modern. Smith and Pear explained that the explosion of instinct which constituted shell-shock was forced by the unnatural conditions of trench warfare, which did not allow the soldier to ‘give vent to his pent-up emotion, by rushing out and charging the enemy’. The technological advancements of modern society and the strategical necessities of modern warfare condemned the soldier to be ‘attacked from within and without’, defenceless against himself because he was defenceless against the relentless onslaught of shells.<sup>83</sup> The war not only stimulated instinct, but caused it to manifest in twisted and unprecedented ways.

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<sup>78</sup> The idea of ‘diseases of civilisation’ had a long and distinguished pedigree, but it was in the nineteenth century that it attained ‘its greatest credibility and its maximum scare-power’ through a convergence of medical, intellectual, and social trends including the stress on heredity as a cause of illness, social Darwinism, industrialisation, and urbanisation. R. Porter, ‘Diseases of civilization’ in W.F. Bynum and R. Porter (eds), *Companion Encyclopedia of the History of Medicine, Volume One* (London, 1993), pp. 585-600, p. 592.

<sup>79</sup> [Anon.], ‘The prevention of national decadence’, *BMJ* 1915 (1), pp. 654-5, p. 654; Armstrong-Jones, ‘Drug addiction’, p. 38.

<sup>80</sup> Hobson, *The psychology of jingoism*, pp. 6-8; G. Rankin, ‘The highly strung nervous system’, *BMJ* 1916 (2), pp.545-8, p.545; Milligan, ‘The value and importance of physical exercises’, p. 35.

<sup>81</sup> [Anon.], ‘The new recruits and their training’, *BMJ* 1914 (2), pp. 592-3, p. 593.

<sup>82</sup> [Anon.], ‘Lord Knutsford’s special hospitals for officers’, p. 1202.

<sup>83</sup> Smith and Pear, *Shell shock and its lessons*, pp. 9-10.

Donald Core described shell-shock as an 'instinct-distortion neurosis', in which individuals were 'thrown into an atmosphere so wildly at variance with any known scheme of life that the very sources of their nerve energy may be attacked; their instincts from all sides – perceptive, emotional, and conative – are excited and at the same time suppressed, and the result is a nerve breakdown along the line of these instincts'.<sup>84</sup>

The language of these theories reveals the new layer added to the same old paradox. As it doubled back on itself, modernity not only caused its own breakdown, but also a revival of the primitive. The war neurotic was characterised as regressive because his conduct was determined by instinct and emotion, rather than the conscious direction of the will. It was war, however, which had scratched away these higher attributes, which had provoked 'the primitive emotions and passions, and their instinctive reactions'.<sup>85</sup> The terrible accuracy of Osler's dream, recounted at the beginning of this chapter, was confirmed with each new case of shell-shock. As men hurtled headlong into a confrontation with all that modern technology could throw at them, they too came to be haunted by nightmares of the primitive enemy within. One soldier was terrified by a dream in which he 'was in a mine passage at the front when he met a leper who came towards him'; the dream transposed an incident during his service in South Africa, when a leper had been housed in an adjoining sangar, to his experience on the Western front.<sup>86</sup> Another soldier dreamt alternately of 'black men coming to kill him in the most blood-thirsty and savage manner', and of an ambush of his unit by Sinn Feiners in which the scout and corporal complied too willingly with the orders of their attackers.<sup>87</sup> Two men and three nightmares selected from thousands upon thousands is too slim an evidential base for an analysis of the universal psyche of the soldier: but it speaks volumes that doctors chose to record these dreams, above the others they heard, as representative of the essence of shell-shock.

The terrible realisation occasioned by shell-shock was that the cerebral cortex and the cumulative social achievements of two thousand years of civilisation provided, in the

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<sup>84</sup> Core, 'Some mechanisms at work in the evolution of hysteria', p. 365.

<sup>85</sup> Mott, 'The Chadwick lecture', p. 39; see also Rivers, *Instinct and the unconscious*, p. 5.

<sup>86</sup> Mott, 'Two addresses on war psycho-neurosis. (II)', p. 172.

<sup>87</sup> J. Young, 'Two cases of war neurosis', medical section, *British Journal of Psychology* 2:3 (April 1922), pp. 230-6, pp. 232-3.

end, only the flimsiest cage for the animal passions and emotions. This revelation was not only an indictment of the individual, but of war and of civilisation itself. The soldier could be restored to humanity, but humanity itself was in crisis. At an intellectual level the shell-shocked individual was implicated as well as indicted through a fine network of relations to social needs and ideals. He was the most potent symbol that the catastrophe of modern civilisation was an oxymoron: that the ultimate power and tenacity of the human was only too limited, but it had taken the triplicate triumph over nature of industry, technology, and science to drive this point home. The judgments doctors made concerning the causes and nature of the war neuroses were mirrored in their disquisitions on war and civilisation. It is not surprising to find Ernest Jones concluding that 'the facts of the War itself accord with Freud's view of the human mind as containing beneath the surface a body of imperfectly controlled and explosive forces which in their nature conflict with the standards of civilisation'; war itself was a cumulative explosion of repressed impulses, a reaction against societal and ethical standards which constituted a 'reversion to a more primitive level of civilisation'.<sup>88</sup> But these sentiments were echoed by observers from all medical perspectives and backgrounds.

These commentators split the paradox of war and civilisation into two lessons. The first was that beneath 'a skin-deep civilisation were the same old elemental passions ready to burst forth', and that all the supposed progress of previous years had not removed 'the savage instincts ground into the very fibre of [human] being'.<sup>89</sup> All the concerted efforts at nurturing the child in the best possible way, at altering the environment, had been in vain. There was no force in civilisation or nature which could 'change man's normal nature to its very depth, to eradicate all potentiality towards the primitive savage'. The only effect of education was to cover 'with a thin veneer of moral polish the savage beneath', and 'the spots from which the veneer may be removed only appear the worse from contrast'.<sup>90</sup> In this respect, the war was a harsh reminder that 'our civilisation is but a thin fringe like the layer of living polyps on the coral reef, capping the dead generations on which it rests', and that it was still in its 'childhood'.<sup>91</sup> The

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<sup>88</sup> Jones, 'War shock and Freud's theory of the neuroses', p. 25; Jones, 'War and individual psychology', pp. 176-7.

<sup>89</sup> Osler, 'An address on science and war', p. 796.

<sup>90</sup> H. Campbell, 'The biological aspects of warfare', *Lancet* 1917 (2), pp. 433-5, p. 434; C.B. Moore, 'Some psychological aspects of war', *Pedagogical Seminary* 23 (1916), pp. 367-86, pp. 376-7.

<sup>91</sup> Osler, 'An address on science and war', p. 795.

second and more dreadful aspect of revelation was that the dilemma of war was the problem of instinct itself, the imperishable force which drove and constituted it. In the gloomy post-war world, Mott assumed the mantle of seer and looked to a future in which humanity might conceivably and finally manage to overcome the animal within. He concluded that the 'predatory instinct of man' could not be abolished by statute, and neither could the onward march of science be halted:

What is to hinder a nation then with a secretly prepared fleet of aeroplanes manned by specially trained crews loaded with high explosives and poison gas, disregarding conventions, and launching a war without any notice? Within twenty-four hours such widespread death and destruction in crowded cities could occur that further resistance would be impossible. There would be no question of Natural Selection and Survival of the Fittest, the weak and the strong, the fit and the unfit, would alike perish.<sup>92</sup>

The end of war would come only when an overweening and overreaching humanity took the final step and annihilated not only civilisation, but evolution itself.

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<sup>92</sup> Mott, 'The neuroses and psychoses in relation to conscription and eugenics', pp. 21-2.

## Conclusion

Between 1991 and 1995, Pat Barker published a set of novels collectively known as the *Regeneration* trilogy. The first volume, *Regeneration*, was a fictional re-imagining of the encounter between the poet Siegfried Sassoon and William Rivers at Craiglockhart in 1917. Sassoon had embarked on a protest against the war, refusing further service with the intention of forcing the military authorities to court-martial him. He hoped in this way to open up a public debate on the aims of the war and the terms on which peace should be settled. On learning of his intentions, Sassoon's friend Robert Graves immediately began to pull strings at every level possible to save him from becoming 'a martyr to a hopeless cause'. Graves managed to attain assurances that if Sassoon consented to appear before a medical board, he would not be treated as a disciplinary case. He succeeded in breaking down Sassoon's resistance to this notion with a bare-faced lie, claiming he had also been assured that unless Sassoon co-operated, he would be locked up in an asylum for the remainder of the war.<sup>1</sup> The board agreed that Sassoon was in need of medical treatment, and sent him to Craiglockhart. Rivers did not think that Sassoon was suffering from shell-shock, but diagnosed an 'anti-war complex'. The encounter had a powerful influence on both men. In the course of treating a patient who he realised 'was not suffering from any form of psycho-neurosis', Rivers was forced to confront the potential clash between his duties as a doctor and as a representative of the military, and to realise that so 'long as I was in uniform, I was not a free agent'.<sup>2</sup> For Sassoon, Rivers became his 'father-confessor'. The final volume of his own trilogy of 'fictional autobiography' ended with the protagonist, Sherston, feverish in hospital. His 'futile demons fled' when he awoke to find Rivers by his bed: 'he seemed to empty the room of everything that needed exorcising'.<sup>3</sup>

The introduction here of an historical novel from the 1990s may seem a little strange, given the resolute determination in the preceding pages not to move far beyond the meanings ascribed to shell-shock by doctors during the war itself. The thesis began, however, with the argument that shell-shock has always had multiple meanings, and that this is one reason why it has remained historically resonant. The reception of

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<sup>1</sup> Graves, *Goodbye to all that*, pp. 212-7; S. Sassoon, *Memoirs of an infantry officer* (London: Faber and Faber, 2000) [1930], pp. 222-44.

<sup>2</sup> Rivers, *Conflict and dream*, pp. 165-75.

<sup>3</sup> Sassoon, *Siegfried's journey*, quotations p. 35 and p. 149.

*Regeneration*, and the trilogy itself, illuminates several points regarding the ways in which the history of shell-shock has been written. This conclusion suggests ways in which the history provided by this thesis affects the conventional historiography of the topic. It also speculates on how histories of shell-shock relate to the broader project of the ways in which we imagine history, and particularly the history of the First World War. Barker's novel, which occupies an ambiguous space between reconstruction, imagination, and fiction, is an apt place to begin the discussion.

*Regeneration* garnered accolades from the moment of its publication. A second volume, *The eye in the door*, followed in 1993, and a third, *The ghost road*, won the Booker Prize in 1995. Although the invented character Billy Prior played a much larger role in these novels, the hero of all three was Rivers, portrayed throughout as a humane and enlightened psychiatric pioneer. The novel has been criticised by historians for projecting the preoccupations of the 1990s onto its wartime protagonists.<sup>4</sup> Barker was, however, deeply immersed in the history and historiography of shell-shock. The 'author's note' at the end of the novel refers the reader to a number of primary sources, as well as the histories written by Leed and Showalter.<sup>5</sup> The influence is clear to the knowledgeable student, particularly in the dramatic scene in which Rivers watches Yealland's electrical treatment of patient A1 (discussed in chapter seven of this thesis). Although no historian has claimed that this was an actual encounter, the interpretations of Leed and Showalter similarly contrasted Yealland's punitive therapeutic method with Rivers' analytic approach.<sup>6</sup> If there are inaccuracies or flaws in the story of shell-shock presented by Barker, they stem from its reliance on particular historiographical accounts as much (if not more than) its fictional elements.

The critiques historians have made of Barker's novel are also, however, evidence of its immediate impact on British perceptions of shell-shock. In 1997, an abridged version of Richard Slobodin's 1978 biography of Rivers was published. A red banner on the cover proclaimed, 'As seen in *Regeneration*'; it was placed beneath a photograph from the film based on the novel, showing the actor Jonathan Pryce as Rivers.<sup>7</sup> In 1998

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<sup>4</sup> Barham, *Forgotten lunatics*, p. 388, fn. 3; see also Shephard, *A war of nerves*, p. xx, and Shephard, "The early treatment of mental disorders", p. 434.

<sup>5</sup> Barker, *Regeneration*, pp. 251-2.

<sup>6</sup> Leed, *No man's land*, pp. 170-86; Showalter, *The female malady*, pp. 176-89.

<sup>7</sup> R. Slobodin, *Rivers* (Stroud: Sutton Publishing, 1997).

Wendy Holden published *Shell shock*, written to accompany the Channel 4 series of the same name. The book relates 'one incident in which, having cured a man, Yealland took offence at his ironic smile and proceeded literally to wipe it off his face, applying repeated doses of electricity, until the corners of the man's mouth had been turned down again'.<sup>8</sup> This incident occurs in *Regeneration*, but not in any of Yealland's case histories. Even in the novel, only one application of electricity is made in order to remove the man's smile. Holden not only portrays an episode from a novel as historical fact, but adds a new fictional elaboration. These examples might all be dismissed as tangential, not related to the work of 'serious' historians, but virtually all the major academic studies of shell-shock in Britain published since 1995 have also made reference – favourable, critical, or simply thoughtful – to *Regeneration*.<sup>9</sup> The novel is mentioned, almost as a standard source of received views on shell-shock, in reviews of these books published in academic journals.<sup>10</sup>

It is difficult to think of another topic in which historians would so readily perceive an historical novel as worthy of reference, refutation, or discussion. This engagement with *Regeneration* reflects in part the fact that fiction has always played an enormous role in histories of the First World War. The literacy and articulacy of the participants in this war ensured a legacy of poems, novels, autobiographies, and plays unmatched in any conflict before or since.<sup>11</sup> Its history has been shaped as much by academics with literary as those with military interests; and public perceptions of the psychological impact of the war have been influenced by the writings of soldier-poets such as Sassoon and Owen perhaps more than any other source. The fiction of the war provided the primary evidence base for Paul Fussell's *The Great War and modern memory* (1975), a work so influential that it has recently been suggested that much subsequent research has 'an oedipal relation to this grand narrative'.<sup>12</sup> A current growth area in scholarship on the First World War is the construction of the cultural memory of the

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<sup>8</sup> Holden, *Shell shock*, p. 51.

<sup>9</sup> Young, *The harmony of illusions*, p. 68; Leese, *Shell shock*, pp. 173-5; Shephard, *A war of nerves*, p. xx and p. 109; Barham, *Forgotten lunatics*, p. 388, fn 3; Jones and Wessley, *Shell shock to PTSD*, p. 60.

<sup>10</sup> P. Leese, 'Essay review: making shell-shock', *British Journal of Psychology* 92 (2001), pp. 411-15, p. 411; S. Wessely, 'Essay review', *History of Psychiatry* 15:4 (2004), pp. 489-94, p. 490.

<sup>11</sup> See Hynes, *A war imagined*.

<sup>12</sup> Santanu Das, quoted in M. Bostridge, 'Feel my scars', *Times Literary Supplement*, June 16 2006, pp. 4-5, p. 4.



war in Britain.<sup>13</sup> Histories which examine the relationship between literature and history, fact and fiction, in understandings of the war are one logical consequence of the way in which it has been remembered in this national context. Another, however, is the kind of fictional recreation which Barker provided.

The reception of *Regeneration* also illustrates an inescapable dilemma involved in writing the history of shell-shock. Historians alleged that Barker projected current concerns onto the historical figures she portrayed. The critical acclaim and popular success the novel achieved suggests that its themes chimed with modern audiences. The relation of the past to the present, the ways in which the preoccupations of our age shape the stories we choose to tell and how we tell them, is a necessary, if often only implied, constituent of any history. This relation is particularly problematic in writing about shell-shock, history or fiction. It might be true that Barker's book is loaded with 'modern baggage' and tells us more about '1980s "counselling culture"' than about the relationships of soldiers and psychiatrists in 1918.<sup>14</sup> The British public may have eagerly devoured her novels because they felt they were reading a dramatic version of their own stories, legitimated by a gloss of history. There is also a reason, however, why no less than eight English language books have been published since 1995 which are either full-length histories of shell-shock in Britain or which devote several chapters to the episode, while Barker could draw on no published secondary source more extensive than an article or a single chapter in a book when she started writing *Regeneration*. If the modern age is obsessed with trauma, then this is an imperative which drives the writing and reading of history as much as that of fiction.

All historians of shell-shock, the author of the present piece included, are implicated in this obsession. It was argued in the first chapter of this thesis that extant histories of shell-shock are constructed as narratives of development, and the story told is always the gradual recognition of psychological suffering, even if the active construction of psychiatric diagnoses is also recognised and examined. This thesis was conceived as an alternative approach to shell-shock, one which concentrated on the meanings contemporaries ascribed to the disorder. It has argued that the retrospective division of theories of the war neuroses into 'physical' and 'psychological' explanations belies the

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<sup>13</sup> See B. Bond, *The unquiet Western front: Britain's role in literature and history* (Cambridge: C.U.P., 2002); D. Todman, *The Great War: myth and memory* (London: Hambleton and London, 2005).

<sup>14</sup> Shephard, *A war of nerves*, p. xx.

emphasis on the interaction of mind and body, and the diversity of approaches – neurological, biological, physiological, psychological – which even a single medical response to the disorder might encapsulate. It has challenged the conventional historiographical narrative of a transition from physical to psychological understandings of mental disorder, arguing that physical theories were less prevalent and more persistent than previously realised, and that such theories were not especially characteristic of the opening years of the war, but emerged as a distinctive school of thought in tandem with psychological explanations from 1916. The resultant history has restored a sense of the flux within, and multiplicity of, the meanings which doctors ascribed to shell-shock.

This thesis has focussed on continuity rather than change. It has demonstrated that doctors drew on established diagnostic categories such as hysteria, neurasthenia, and the traumatic neuroses, in their formulations of the concept of shell-shock. In the opening chapter, the tensions inherent in this project were acknowledged. The risk that significant changes in modes of thought will be insufficiently realised is inherent in the attempt to uncover evidence of the persistence of traditional modes of understanding. In this case, the history of shell-shock has been governed for so long by the assumption of a transition to modern psychological approaches to mind, that an overstatement of the opposite case might even be necessary to provoke debate. The detailed examination of pre-war diagnostic concepts here has, at the least, shown that when making judgments regarding the degree of change, there must be concrete standards against which this is measured. The thesis has aimed, however, for more than this. The deconstruction here of the tripartite historiographical analysis regarding class, gender, and treatment has undermined parts of the argument of virtually every historian to have published on shell-shock in Britain. This thesis has tackled some of the most basic assumptions of historical accounts of the war neuroses. It remains to be seen whether subsequent research will support or refute the arguments made here: but the way in which this history is conceived has hopefully also provided a sense of the possibilities for future histories of shell-shock, and their ability to step outside the boundaries imposed by the conventional historiographical narrative.

This leads onto a further point which the reception of *Regeneration* helps to illuminate. As already mentioned, the first volume of the trilogy was structured around the

encounter between Siegfried Sassoon and William Rivers in 1917. This story was already familiar from many sources, including the first-hand accounts of Sassoon, Rivers, and Graves and explorations of the literature of the war. It is hardly surprising that it also became a customary feature of histories of shell-shock. Sassoon was not a typical patient, and Rivers was not a typical doctor, but there is no other case in which both sides of the doctor-patient relationship were recorded, albeit in a very limited form on Rivers' side. This episode has become so entrenched in the narrative of shell-shock that there is considerable surprise when it is *not* retold.<sup>15</sup> It is the part of Barker's novels which is most remembered. The 1997 film, although it incorporated elements from all three books, was essentially an adaptation of *Regeneration*. A 1996 review of *The ghost road* in the *British Medical Journal* lingered on the Rivers-Sassoon relationship, although this was not a central feature of the book. It also discussed Yealland's treatment methods, referred to only in the first volume of the trilogy.<sup>16</sup> Although Barker explored several other themes throughout the trilogy, those aspects which chime with the familiar story of shell-shock have attracted most attention.

This thesis does not support the view of shell-shock in Barker's novels as an episode which transformed attitudes towards mental health. The title *Regeneration*, a reference to the nerve experiments carried out by Rivers and Henry Head, even encapsulates a perspective on the disorder antithetical to the stress on degeneration throughout the present work. Nevertheless, it is arguable that she has provided the most wide-ranging and innovative explorations of the significance of shell-shock, and in crucial respects anticipated areas covered here. Recent histories of military psychiatry have added to our empirical knowledge of the disorder, but the *Regeneration* trilogy offers an inspirational sense of the different, although equally historical ways in which shell-shock can be written about and imagined. This is not a contradiction of the earlier suggestion that Barker's books, if anything, were too grounded in the historiography and reproduced many of their flaws. The novels are always tied to the narrative of progress which this thesis has argued against. At the same time, however, they join up aspects of the history of shell-shock in a way which the historiography has largely failed to achieve. In *The ghost road*, Rivers' experiences with shell-shocked patients

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<sup>15</sup> Hugh Freeman, for example, thought it surprising that Sassoon's account of Rivers was not included in Jones and Wessely's recent history of military psychiatry. H. Freeman, 'Wounds of war', *Times Literary Supplement*, December 16 2005, p. 28.

<sup>16</sup> T. Smith, 'Spring books: The Ghost Road', *BMJ* 312: 7039 (4 May 1996), p. 1171.

persistently drive him back to memories of the anthropological expeditions he made. The novel ends with Rivers, in a half-sleeping state, seeing an apparition of Njiri, the medicine man with whom he formed a powerful bond in Eddystone, in the wards of the Empire Hospital.<sup>17</sup> The passage is open to many interpretations, but most of all it suggests an awareness of the confrontation between civilisation and the primitive, the sense of a closeness between these two categories, which this thesis has argued was central to contemporary understandings of shell-shock.

Although she used the knowledge to very different purposes, Barker wrote a passage which resonates with the ideas discussed in this thesis because she acknowledged that Rivers' ideas were shaped by all three of his areas of professional specialisation: neurology, anthropology, and psychology. In chapter six, it was suggested that Rivers' theory of the war neuroses as regression put forward in *Instinct and the unconscious* was based on an amalgamation of approaches derived from these and other disciplines, and that to this extent it represented the culmination of a prevalent trend of wartime thought. Doctors who treated shell-shocked men were drawn from a range of professional specialisations, and drew on an equally diverse range of ideas in formulating their theories. The consistent strand running through the medical literature on the nervous and mental disorders of war, however, is regression. It has been argued here that theories of the war neuroses were formulated within an evolutionary framework of understanding, and demonstrated that the central concepts of emotion and will around which these theories coalesced were imbued evolutionary meaning. Whether depicted as the outcome of an abundance of emotion or a loss of self-control, shell-shock always represented a deviation from the ideal of civilised mental functioning. The debates on the war neuroses were an extension of older fears regarding the nature of human identity in the wake of the Darwinian revolution. The shell-shocked soldier was seen to reveal the latent animalism of all humans, and the essential fragility of civilisation itself. It not only posed a threat to military manpower, but was a powerful symbol of the dangers contained within the human psyche.

The First World War looms large in the British national memory and imagination. It is seared onto the historical landscape, a scar which has not faded; and while we wonder at the whiteness and tenderness of the newly exposed epidermal layer, we often fail to

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<sup>17</sup> P. Barker, *The ghost road* (London: Penguin, 1996), p. 276

notice that it is composed of the same type of cells which make up the healthy tissue surrounding it. The war was a wound, but not an amputation. It did not constitute a definitive break with the past, although it is easy to understand why those who lived through it sometimes felt that the rupture was absolute. The distance of time does not automatically confer a superior perspective. It provides different vantage points, but as we shift position, the objects in our range of sight alter too. The writing of history is an attempt to achieve a synoptic vision of the past, an ever more penetrating depth perception: but as we gain glimpses of new vistas, previous objects of focus are relegated to the periphery, and sometimes disappear altogether. In our focus on the ways in which the First World War acted to change notions of the world and the self, we have lost sight of the extent to which contemporaries formulated their fears in the language provided by another epoch-making event. This thesis was conceived as an act of recovery, a reconstruction of the intellectual currents which contributed to the formation of medical concepts of shell-shock, but it has also attempted to build a bridge between eras which have been artificially divided in the historical imagination. Our acts of recovery are perhaps always partial, limited by the ways in which our relation to the past is determined by our situation in the present. Without bridges, however, we would be stranded; and if one path does not carry us far enough, we have nevertheless gained ground, and can start building anew from a more propitious location.

## Appendix A

### 1) Table of signed articles on shell-shock and related nervous and mental disorders of war in the British medical press, 1914-19

#### Note on compilation of table:

This table consists of all the articles on shell-shock and related nervous and mental disorders of war in eight medical journals from 1914-19. These journals are the *Lancet*, *British Medical Journal*, *Practitioner*, *Journal of Mental Science*, *Journal of the RAMC*, *Proceedings of the Royal Medical Society*, *Medical World*, and *Journal of State Medicine*. The *Journal of the RAMC* often reprinted articles which had appeared elsewhere. These are listed on the table below according to the original place of publication. It also includes all articles which conform to the criteria outlined below from three journals founded in 1918 or 1919: *Reveille*, *Mental Hygiene*, and *Archives of Neurology and Psychiatry*. An article from the *Sociological Review* by Arthur Brock has also been included, as it is discussed in some detail in the thesis (chapter seven). It is the only article from this journal for the specified period which meets the criteria for inclusion here. An article from *Brain* and another from the *Bristol Medico-Chirurgical Journal* have also been included, although these journals have not been checked for relevant articles for the entire period.

Only articles specifically formulated as contributions to the debates on shell-shock and mental and nervous disorders of war in soldiers have been included in this table. Therefore articles on 'war shock' in civilians have been excluded, as have those on trench foot or disordered action of the heart, which certain doctors perceived as psychosomatic disorders but were mostly perceived and written about as separate syndromes. Short descriptions of cases given at meetings of sections of the Royal Society of Medicine have also been excluded, as they mostly consist of a list of symptoms for which the audience suggested diagnoses. Contributions to discussions following papers have also been excluded. An exception here is F.W. Mott's opening paper to the special discussion on shell-shock without visible injury held by the sections of neurology and psychiatry of the Royal Society of Medicine in January 1916. This was clearly written as a paper, to which other audience members responded. Only articles published in the British medical press or by British authors are included (e.g. articles by British authors published in American journals, or American authors published in British journals, are included, but articles by American authors published in American journals are not).

Ref. no	Title	Author (s)	Journal abbreviation	Date	Volume	Page refs
1	A case of hysterical paraplegia	Abrahams, A	<i>Lancet</i>	July 24 1915	(2)	178-9
2	The treatment of some common war neuroses	Adrian, E.D; Yealland, L.R	<i>Lancet</i>	June 9 1917	(1)	867-72
3	Dreams and their interpretations	Armstrong-Jones, R	<i>Practitioner</i>	March 1917	98:3	201-19

4	The psychology of fear and the effects of panic fear in wartime	Armstrong-Jones, R	<i>JMS</i>	July 1917	63:262	346-89
5	Mental states and the war – the psychological effects of fear	Armstrong-Jones, R	<i>Journal of State Medicine</i>	August 1917	25:8	238-49
6	Mental states and the war – the psychological effects of war	Armstrong-Jones, R	<i>Journal of State Medicine</i>	October 1917	25:10	289-9
7	The psycho-pathology of the barbed wire	Armstrong-Jones, R	<i>Nature</i>	September 6 1917	100	1-3
8	Mental and nervous states in connection with the war and their mechanism	Armstrong-Jones, R	<i>Practitioner</i>	November 1919	103:5	321-42
9	Some notes on battle psycho-neuroses	Ballard, E.F	<i>JMS</i>	July 1917	63:262	400-5
10	The psychoneurotic temperament and its reactions to military service	Ballard, E.F	<i>JMS</i>	October 1918	64:267	365-77
11	The relation of blood-pressure to the psycho-neuroses	Bousfield, P	<i>Practitioner</i>	November 1918	101:5	266-70
12	The re-education of the adult. 1. The neurasthenic in war and peace	Brock, A.J	<i>Sociological Review</i>	Summer 1918	10:1	25-40
13	The war neurasthenic: a note on methods of reintegrating him with his environment	Brock, A.J	<i>Lancet</i>	March 23 1918	(1)	436
14	The treatment of shell shock cases in an advanced neurological clearing centre	Brown, W	<i>Lancet</i>	August 17 1918	(2)	197-200
15	War neurosis: a comparison of early cases seen in the field with those seen at base	Brown, W	<i>Lancet</i>	May 7 1919	(1)	833-6
16	Hypnosis, suggestion, and dissociation	Brown, W	<i>BMJ</i>	June 14 1919	(2)	734-6
17	Neurasthenia in soldiers of the home forces	Burton-Fanning, F.W	<i>Lancet</i>	June 16 1917	(1)	907-11
18	Remarks on the pathology of the war neuroses	Bury, J.S	<i>Lancet</i>	July 27 1918	(2)	97-9
19	Warfare on the brain	Buzzard, E.F	<i>Lancet</i>	December 30 1916	(2)	1095-99
20	War neuroses	Campbell, H	<i>Practitioner</i>	May 1916	96:5	501-09
21	War neurasthenia, acute and chronic	Carmalt-Jones, D.W	<i>Brain</i>	October 1919	42:3	171-213
22	Some biological effects due to high explosives	Carver, A Dinsley, A	<i>PRSM</i> , section of neurology	March 13 1919	12 (pts 1 and 2)	36-51
23	The commotional factor in the aetiology of shell shock	Carver, A	<i>Lancet</i>	August 2 1919	(2)	193-96
24	Mental wards with the British Expeditionary Force: a review of ten months' experience	Chambers, W.D	<i>JMS</i>	July 1919	65:270	152-80
25	The cause of the physiological and abnormal conditions in "shell shock" and other allied symptoms	Churchward, A	<i>TMW</i>	August 24 1917	9	149-50

26	Some neuroses of the war	Clarke, J.M	<i>Bristol Medico-Chirurgical Journal</i>	July 1916	34:130	49-72
27	Neurasthenia: what it costs the state	Collie, J	<i>Journal of the RAMC</i>	April 1916	26:4	525-44
28	The management of neurasthenia and allied disorders contracted in the army	Collie, J	<i>Journal of State Medicine</i>	January 1918	26:1	2-17
29	Practical hints on functional disorders	Culpin, M	<i>BMJ</i>	October 21 1916	(2)	548-9
30	The early stage of hysteria	Culpin, M	<i>BMJ</i>	April 13 1918	(1)	425-6
31	Dreams and their value in treatment	Culpin, M	<i>Practitioner</i>	March 1919	102:3	156-62
32	The analysis of a composite neurosis	Dillon, F	<i>Lancet</i>	January 11 1919	(1)	57-60
33	A record of admissions to the mental section of the Lord Derby War Hospital, Warrington, from June 17 <sup>th</sup> , 1916, to June 16 <sup>th</sup> , 1917	Eager, R	<i>JMS</i>	July 1918	64:266	272-96
34	War psychoses occurring in cases with a definite history of shell shock	Eager, R	<i>BMJ</i>	April 13 1918	(1)	422-5
35	The early treatment of mental disorders	Eager, R	<i>Lancet</i>	September 27 1919	(2)	558-63
36	An address on the psychopathology of the war neuroses	Eder, M.D	<i>Lancet</i>	August 12 1916	(2)	264-8
37	Transient paraplegia from shell explosions	Elliott, T.R	<i>BMJ</i>	December 12 1914	(2)	1005-6
38	Organic lesions from shell concussion	Evans, J.J	<i>BMJ</i>	December 11 1915	(2)	848
39	Essentials of treatment of soldiers and discharged soldiers suffering from functional nervous disorders	Fearnside, E.G	<i>PRSM, section of neurology</i>	March 12 1918	11 (pts 1 and 2)	42-8
40	Loss of personality from "shell shock"	Feiling, A	<i>Lancet</i>	July 10 1915	(2)	63-6
41	Enterospasm following shell shock	Fenwick, P.C.C	<i>Practitioner</i>	April 1917	98:4	391
42	The management of neurasthenia, psychasthenia, and allied conditions	Forster, F.C	<i>Practitioner</i>	January 1918	100:1	85-90
43	Functional nerve disease and the shock of battle	Forsyth, D	<i>Lancet</i>	December 25 1915	(2)	1399-1403
44	Shell shock and its treatment by cerebro-spinal galvanism	Garton, W	<i>BMJ</i>	October 28 1916	(2)	584-6
45	Eye colour and the abnormal palate in neuroses and psychoses	Gordon, H.L	<i>Lancet</i>	July 5 1919	(2)	9-10
46	War neuroses	Gordon, R.G	<i>Practitioner</i>	November 1919	103:5	358-65
47	The cure of spinal concussion in warfare by suggestion	Grimbly, A.F	<i>Practitioner</i>	March 1918	100:3	292
48	Neuroses and psychoneuroses of the sea	Grimbly, A.F	<i>Practitioner</i>	May 1919	102:5	243-58



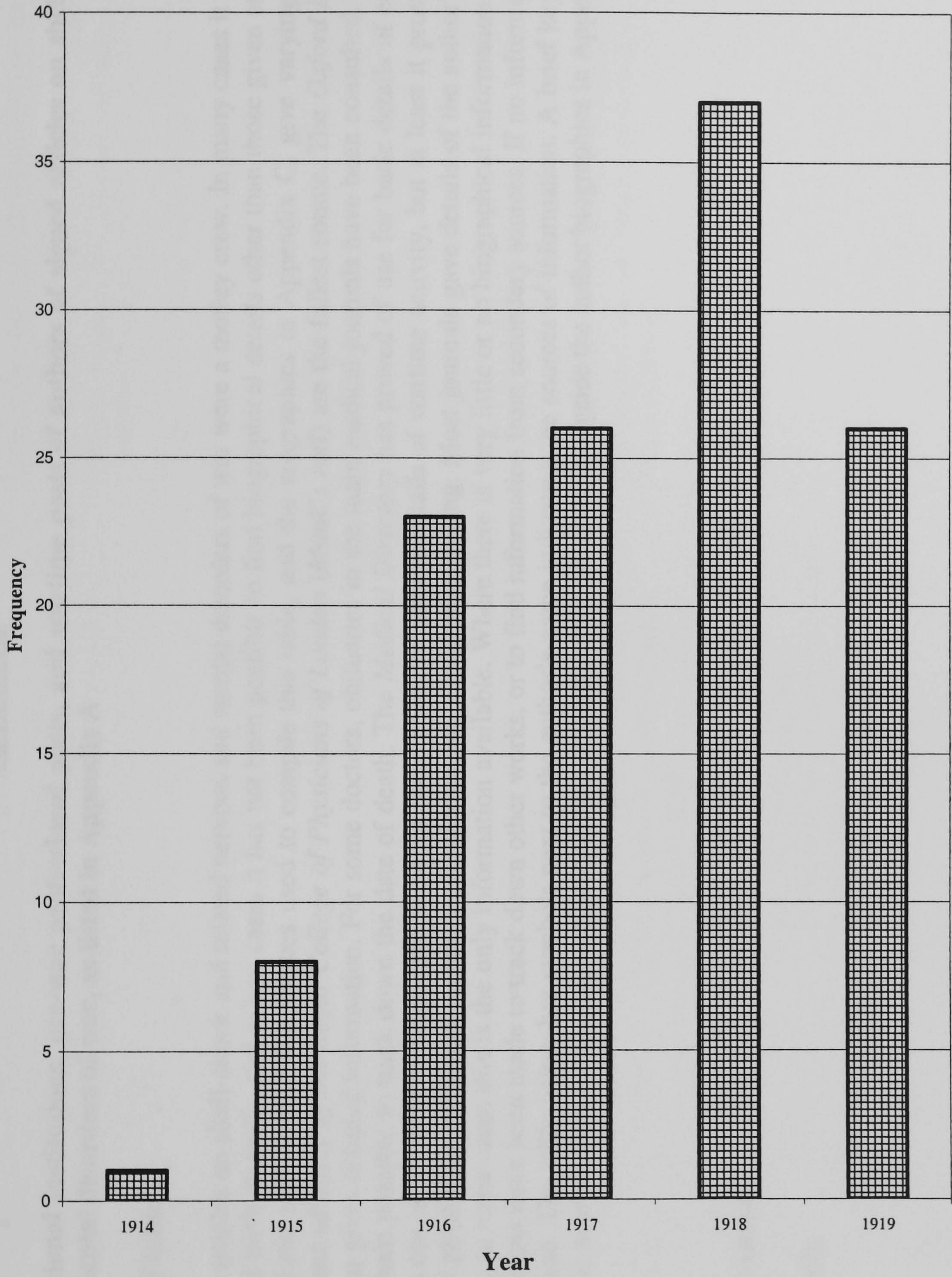
49	A preliminary note on the nature and treatment of concussion	Harwood, T.E	<i>BMJ</i>	April 15 1916	(1)	551
50	Three cases illustrating the functional consequences of head-injuries	Harwood, T.E	<i>Lancet</i>	September 2 1916	(2)	431
51	Functional conditions in the light of head injuries	Harwood, T.E	<i>Journal of the RAMC</i>	June 1917	28:6	699-707
52	War psychoses: an analysis of 202 cases of mental disorder occurring in home troops	Henderson, D.K	<i>JMS</i>	April 1918	64:265	165-89
53	Renfrew District Asylum as a war hospital for mental invalids: some contrasts in administration, with an analysis of cases admitted during the first year	Hotchkis, R.D	<i>JMS</i>	April 1917	63:261	238-49
54	Neurasthenia and emotion	Hunter, P.D	<i>Practitioner</i>	November 1919	103:5	343-57
55	Observations on the etiology and treatment of the war neuroses	Hurst, A.F	<i>BMJ</i>	September 29 1917	(2)	409-14
56	Cinematograph demonstration of the war neuroses	Hurst, A.F	<i>PRSM, neurological section</i>	March 12 1918	11 (pts 1 and 2)	39-41
57	Nerves and the men (the mental factor in the disabled soldier)	Hurst, A.F	<i>Reveille</i>	November 1918	2	409-14
58	The bent back of soldiers	Hurst, A.F	<i>BMJ</i>	December 7 1918	(2)	621-3
59	Hysteria in the light of the experience of war	Hurst, A.F	<i>ANP</i>	November 1919	2:5	562-72
60	A report on the pathology, diagnosis, and treatment of absolute hysterical deafness in soldiers	Hurst, A.F; Peters, E.A	<i>Lancet</i>	October 6 1917	(2)	517-9
61	The rapid cure of hysterical symptoms in soldiers	Hurst, A.F; Symns, J.L.M	<i>Lancet</i>	August 3 1918	(2)	139-41
62	Hysterical tremor	Johnson, W	<i>BMJ</i>	December 7 1918	(2)	627-8
63	Symptoms of hyperthyroidism observed in exhausted soldiers	Johnson, W	<i>BMJ</i>	March 22 1919	(2)	335-7
64	War shock and Freud's theory of the neuroses	Jones, E	<i>PRSM, section of psychiatry</i>	April 9 1918	11 (pt 3)	21-36
65	Functional gastric disturbance in the soldier	McDowall, C	<i>JMS</i>	January 1917	63:260	76-88
66	Mutism in the soldier and its treatment	McDowall, C	<i>JMS</i>	January 1918	64:264	54-64
67	The genesis of delusions: clinical notes	McDowall, C	<i>JMS</i>	July 1919	65:270	187-97
68	Shell shock stammering and other afflictions of voice	MacMahon, C	<i>Practitioner</i>	May 1917	98:5	427-35
69	A method of treatment of "shell shock"	Milligan, E.T.C	<i>BMJ</i>	July 15 1916	(2)	73-4

70	Opening paper and concluding response: special discussion on shell shock without visible signs of injury	Mott, F.W	<i>PRSM</i> , sections of neurology and psychiatry	January 25 and 26 1916	9 (pt 3)	i-xxiv and xli-xliv
71	The Lettsomian lectures on the effects of high explosives upon the central nervous system. I	Mott, F.W	<i>Lancet</i>	February 12 1916	(1)	331-8
72	The Lettsomian lectures on the effects of high explosives upon the central nervous system. II	Mott, F.W	<i>Lancet</i>	February 26 1916	(1)	441-9
73	The Lettsomian lectures on the effects of high explosives upon the central nervous system. III	Mott, F.W	<i>Lancet</i>	March 11 1916	(1)	545-53
74	The Chadwick lecture on mental hygiene and shell shock during and after the war	Mott, F.W	<i>BMJ</i>	July 14 1917	(2)	39-42
75	The microscopic examination of the brains of two men dead of commotio cerebri (shell shock) without visible injury	Mott, F.W	<i>Journal of the RAMC</i>	December 1917	29:6	662-78
76	Two addresses on war psycho-neurosis. (I) Neurasthenia: the disorders and disabilities of fear	Mott, F.W	<i>Lancet</i>	January 26 1918	(1)	127-9
77	Two addresses on war psycho-neurosis. (II) The psychology of soldiers' dreams	Mott, F.W	<i>Lancet</i>	February 2 1918	(1)	169-72
78	War psychoses and psychoneuroses	Mott, F.W	<i>JMS</i>	April 1918	64:265	230-38
79	Treatment by speech and song	Mott, F.W	<i>Reveille</i>	February 1919	3	432-9
80	A contribution to the study of shell shock: being an account of three cases of loss of memory, vision, smell, and taste, admitted into the Duchess of Westminster's War Hospital, Le Touquet	Myers, C.S	<i>Lancet</i>	February 13 1915	(1)	316-20
81	Contributions to the study of shell shock (II): being an account of certain cases treated by hypnosis	Myers, C.S	<i>Lancet</i>	January 8 1916	(1)	65-9
82	Contributions to the study of shell shock (III): being an account of certain disorders of cutaneous sensibility	Myers, C.S	<i>Lancet</i>	March 18 1916	(1)	608-13

83	Contributions to the study of shell shock (IV): being an account of certain disorders of speech, with special reference to their causation and their relation to malingering	Myers, C.S	<i>Lancet</i>	September 9 1916	(2)	461-7
84	A final contribution to the study of shell shock: being a consideration of unsettled points needing investigation	Myers, C.S	<i>Lancet</i>	January 11 1919	(1)	51-4
85	The treatment of "concussion blindness"	Ormond, A.W	<i>Journal of the RAMC</i>	January 1916	26:1	43-9
86	The psychology of traumatic amblyopia following the explosion of shells	Parsons, J.H	<i>PRSM</i> , section of neurology	March 25 1915	8 (pt 2)	55-68
87	Psychoses in the expeditionary forces	Pearn, O.P.N	<i>JMS</i>	April 1919	65:269	101-8
88	The psychology of traumatic amblyopia following the explosion of shells	Pemberton, H.S	<i>Lancet</i>	May 8 1915	(1)	967
89	Stammering in the war psycho-neuroses	Prideaux, E	<i>Lancet</i>	February 8 1919	(1)	217-8
90	A survey of war neuro-psychiatry	Read, C.S	<i>Mental Hygiene</i>	July 1918	2:3	359-87
91	Hysterical vomiting in soldiers	Reynell, W.R	<i>Lancet</i>	January 4 1919	(1)	18-20
92	Freud's psychology of the unconscious	Rivers, W.H.R	<i>Lancet</i>	June 16 1917	(1)	912-4
93	A case of claustrophobia	Rivers, W.H.R	<i>Lancet</i>	August 18 1917	(2)	237-40
94	An address on the repression of war experience	Rivers, W.H.R	<i>PRSM</i> , section of psychiatry	December 4 1917	11 (pt 3)	1-18
95	War neuroses and military training	Rivers, W.H.R	<i>Mental Hygiene</i>	October 1918	2:4	513-33
96	The hysterical perpetuation of symptoms	Rixon, C.H.L	<i>Lancet</i>	March 15 1919	(1)	417-9
97	The prevention of relapse of hysterical symptoms	Ross, T.A	<i>Lancet</i>	October 19 1918	(2)	516-7
98	Certain inter-relations between peace and war neuroses	Ross, T.A	<i>PRSM</i> , section of neurology	January 9 1919	12 (pts 1 and 2)	13-20
99	Mental conditions following strain and nerve shock	Rows, R.G	<i>BMJ</i>	March 25 1916	(1)	441-3
100	Mental war cripples	Savage, G.H	<i>Practitioner</i>	January 1918	100:1	1-7
101	Hysterical "paralysis" of long standing	Scott, L	<i>Practitioner</i>	August 1918	101:2	97-9
102	The anxiety state – an aspect of treatment	Scott, L	<i>Practitioner</i>	April 1919	102:4	222-24
103	Shock and the soldier. I	Smith, G.E	<i>Lancet</i>	April 15 1916	(1)	813-7
104	Shock and the soldier. II	Smith, G.E	<i>Lancet</i>	April 22 1916	(1)	853-7
105	War neuroses	Smurthwaite, H	<i>PRSM</i> , section of laryngology	June 7 1918	11 (pts 1 and 2)	182-5

106	The treatment of war neuroses	Stewart, J.P	<i>ANP</i>	January 1919	1:1	14-24
107	Hysteria as seen at a base hospital	Symns, J.L.M	<i>Practitioner</i>	August 1918	101:2	90-6
108	An account of twenty cases treated by hypnotic suggestion	Tombleson, J.B	<i>Journal of the RAMC</i>	September 1917	29:3	340-6
109	Neurasthenia and psychasthenia	Tooth, H.H	<i>Journal of the RAMC</i>	March 1917	28:3	328-45
110	Two cases for comment	Townend, R.O	<i>Practitioner</i>	July 1917	99:1	88-91
111	Neurasthenic and hysterical cases in general military hospitals	Trotter, R.H	<i>Lancet</i>	November 23 1918	(2)	703-4
112	Remarks on cases of nervous and mental shock observed in the base hospitals in France	Turner, W.A	<i>BMJ</i>	May 15 1915	(1)	833-5
113	Arrangements for the care of cases of nervous and mental shock coming from overseas	Turner, W.A	<i>Lancet</i>	May 27 1916	(1)	1073-75
114	The Bradshaw lecture on neuroses and psychoses in war	Turner, W.A	<i>Lancet</i>	November 9 1918	(2)	613-7
115	Some cases of so-called functional paresis arising out of the war and their treatment	Veale, R.A	<i>Journal of the RAMC</i>	November 1917	29:5	607-14
116	The war and neurasthenia, psychasthenia and mild mental disorders	Weatherly, L.A	<i>TMW</i>	October 4 1918	11	217
117	The war and neurasthenia, psychasthenia and mind mental disorders. Part II: treatment	Weatherly, L.A	<i>TMW</i>	October 25 1918	11	265-6
118	Observations on shell shock and neurasthenia in the hospitals in the Western Command	White, E.W	<i>BMJ</i>	April 13 1918	(1)	421-2
119	Remarks on the treatment of neurasthenia and psychasthenia following shell shock	Williamson, R.T	<i>BMJ</i>	December 1 1917	(2)	713-5
120	A contribution to the aetiology of shell shock	Wiltshire, H	<i>Lancet</i>	June 17 1916	(1)	1207-12
121	The predisposing factors of war psycho-neuroses	Wolfsohn, J.M	<i>Lancet</i>	February 2 1918	(1)	177-80

**Chronological distribution of signed articles on shell-shock and related nervous and mental disorders of war in the British medical press, 1914-19**



## Appendix B

### **Table showing educational institutions, pre-war professional posts, and wartime posts of authors of signed articles on shell-shock and related nervous and mental disorders of war, as listed in Appendix A**

#### **Note on compilation of table:**

The doctors who wrote articles on shell-shock and related nervous and mental disorders of war were a motley crew. In many cases it has not been possible to find dates of birth or death, and in two cases it has not been possible to find biographical details other than those given at the heading of articles written by these individuals. The sources used to compile this table, and the biographies in Appendix C, give varying amounts of information. The volumes of *Lives of the Royal College of Physicians of London (Munk's roll)* are the fullest source. The *Oxford Dictionary of National Biography* also gives detailed information. For some doctors, obituaries in the main medical journals have been consulted. However, in many cases it has not been possible to track down the date of death. The *Medical Directory* has proved of use for basic details of education and professional posts: it is not ideal, as it does not give dates for these posts, or usually details of wartime activity, but at least it provides a rough guide to the interests of physicians for whom biographical information is otherwise lacking. Most journals gave details of the author's post at the top of the article; again, in some cases this is the only information available. Where there is very little or no biographical information available on a particular author, attempts have been made to track down other works, or to find information from secondary sources. If no information is given here, these attempts failed. The table below has symbols next to the author's name indicating the sources of information. A brief key is provided below. Full details of the sources used for biographical information on each author are given alongside the author biographies in Appendix C.

#### **Key:**

- \* = *Munk's Roll*
- † = Wartime articles by author
- ‡ = *Medical Directory*
- § = Miscellaneous sources

No.	Name	Dates	Education	Pre-war institutions / posts	Wartime institutions / posts [year is for when item with information published]
1*†	ABRAHAM, Adolphe	1883-1967	Emmanuel College, Cambridge; St. Bartholomew's Hospital	St. Bartholomew's Hospital (house surgeon; house surgeon to ear, nose, and throat dept; chief assistant to medical out-patients); London Temperance Hospital (medical registrar)	Lieutenant, RAMC [1915]; Officer in charge of medical division, Connaught Military Hospital; Major, RAMC, Assistant Consulting Physician to Aldershot Command [1919]
2*†	ADRIAN, Edgar Douglas	1889-1977	Trinity College, Cambridge; St. Bartholomew's Hospital		Captain, RAMC, Neurologist, Connaught Military Hospital [1918]
3*†§	ARMSTRONG-JONES, Robert	1857-1943	University College of Wales, Aberystwyth; St. Bartholomew's Hospital	Royal Earlswood Institution; Colney Hatch Asylum (junior posts); Claybury Asylum, Essex (medical superintendent); Lecturer in psychological medicine, St. Bartholomew's Hospital and Westminster Hospital	Lieutenant-Colonel, RAMC, Consulting physician in mental diseases to the London and Aldershot Military Commands [1919]
4††	BALLARD, Ernest Fryer		St. Thomas' Hospital	Somerset County Asylum, Wells (assistant medical officer)	Captain, RAMC, Medical officer in charge of the observation and mental block, 2nd Eastern General Hospital, Brighton [1917/1918]
5††§	BOUSFIELD, Edward George Paul		St. Bartholomew's Hospital	Casualty surgeon, and assistant in skin department, Queen's Hospital for Children; Demonstrator of morbid anatomy, St. George's Hospital	Medical officer, American Red Cross Hospital No. 22; Physician to Lancaster Clinic of Psychotherapy (Ministry of Pensions) [1919]
6†§	BROCK, Arthur John	1879-1947	Edinburgh University	Edinburgh New Town Dispensary (physician); Woodburn Sanatorium for Consumptives, Edinburgh (resident physician); Leith Hospital (assistant house physician); Convalescent House, Royal Edinburgh Infirmary (resident medical officer)	Captain, RAMC; served on a hospital ship to India, at the Aldershot depot, and then at Craiglockhart War Hospital from 1916-1918

7*†	BROWN, William	1881-1952	Christ Church, Oxford; King's College Hospital	Reader in psychology at King's College, University of London	Neurologist to 4 <sup>th</sup> and 5 <sup>th</sup> Armies; Officer in charge of advanced neurological centre in France (Nov. 1916- Feb. 1918) [1918]; Maghull Military Hospital; Officer in command, Craiglockhart War Hospital [1918]
8*	BURTON-FANNING, Frederick William	1863-1937	University College, London; St. John's College, Cambridge	University College Hospital, London (house appointments); Norfolk and Norwich Hospital (physician); Crome Convalescent Home, Mundesley Sanatorium, Kelling Sanatorium; Jenny Lind Infirmary for Sick Children	Major, RAMC, 1st Eastern General Hospital, Cambridge; Lieutenant-Colonel, RAMC, medical officer in charge of 55th General Hospital, France
9*	BURY, Judson Sykes	1852-1944	Owens College, Manchester; University College, London	University College Hospital, London (house appointments); Children's Hospital, Pendlebury (house appointment); Royal Infirmary, Manchester (registrar; assistant physician; physician); Professor of clinical medicine, Manchester University	Major, RAMC, serving on local medical boards
10*†	BUZZARD, Edward Farquhar	1871-1945	Magdalen College, Oxford; St. Thomas' Hospital	St. Thomas' Hospital; National Hospital for the Paralysed and Epileptic; Hospital for Sick Children (junior appointments); Royal Free Hospital (lecturer on medical pathology); Belgrave Hospital for Children, and St. George's Hospital (honorary physician); National Hospital for Paralysed and Epileptic (staff post); St. Thomas' Hospital (staff post)	Captain, RAMC [1916]; Colonel, RAMC, Consultant to London Command
11*†	CAMPBELL, Harry	1860-1938	St. Bartholomew's Hospital	Royal Ophthalmic Hospital, Moorfields, and the Hospital for Sick Children (house appointments); North-West London Hospital (staff post); West End Hospital for Nervous Diseases (physician)	Physician to the West End Hospital for Nervous Diseases [1916]



12*†	CARMALT- JONES, Dudley Williams	1874- 1957	Corpus Christi College, Oxford; St. Mary's Hospital, London	St. Mary's Hospital, London; National Hospital for the Paralysed and Epileptic; Seaman's Hospital, Greenwich; Westminster Hospital (junior medical appointments); Dept. of Therapeutic Inoculation (assistant); Westminster Hospital Medical School (dean)	Served in RAMC throughout war; officer in charge of medical division, No. 4 Stationary Hospital [1917]; Consulting physician to Egyptian Expeditionary Force (latter stages)
13†‡	CARVER, Alfred Arthur		Cambridge; St. Bartholomew's Hospital	St. Bartholomew's Hospital (clinical assistant to ear, nose, and throat dept, and house physician); Victoria Park Hospital for Diseases of the Chest; Royal Chest Hospital (clinical assistant); Birmingham General Dispensary (tuberculosis officer);	Captain, RAMC [1919]; Director of Birmingham Psychoneurosis Clinic, at Birmingham and Midland Hospital for Diseases of the Nervous System [1919]
14†‡	CHAMBERS, William Duncanson		Edinburgh University	Crichton Royal Institution, Dumfries (senior assistant medical officer)	Captain, RAMC, Mental specialist to Boulogne base in charge of mental wards for that area, located at No. 8 Stationary Hospital (March 1918- January 1919) [1919]
15‡	CHURCHWARD, Albert		Guy's Hospital; University of Brussels		
16*	CLARKE, John Michell	1859- 1918	Caius College, Cambridge; St. Thomas' Hospital	St. Thomas' Hospital (house physician); Bristol General Hospital (assistant physician, physician); University College, Bristol (lecturer on physiology, professor of pathology and medicine); University of Bristol (chair of medicine, pro- vice-chancellor)	Lieutenant-Colonel, RAMC, Officer in command of Southmead section of 2nd Southern General Hospital
17‡	COLLIE, John	1860- 1935	University of Aberdeen	Member of Advisory Committee for National Insurance Act 1911; Home Officer Medical Advisor on Workmen's Compensation Act; Assistant medical officer for education, London School Board; Royal Maternity Hospital, Edinburgh (honorary surgeon); JP, County of London	Director of Medical Services, Ministry of Pensions [1919]

18§	CULPIN, Millais	1874-1952	London Hospital	London Hospital (resident posts)	Captain, RAMC, surgical member of board for sick and wounded officers, London (1914-15); surgical specialist, Alexandra Hospital, near Portsmouth (1915-16); Served in France, predominantly surgical work (1916-17); Worked in Army neurological hospitals (1917-18)
19††	DILLON, Frederick		University of Edinburgh	Dept. of skin diseases, Royal Edinburgh Infirmary (senior house physician); Northumberland House, Finsbury Park (assistant medical officer)	Captain, RAMC, Neurologist to 3rd Army, B.E.F. [1919]
20†	DINSLEY, A				Royal Army Ordnance Corps [1919]
21††	EAGER, Richard		University of Aberdeen	Devon County Asylum, Exeter (senior assistant medical officer)	Captain, RAMC, Territorial Forces, 1st Wessex Field Ambulance [1915]; Major, RAMC, Officer in command, mental division, Lord Derby War Hospital [1918/1919]
22†§	EDER, Montague David	1865-1936	University College, London; University of Bogota	Practised in South America and South Africa, and at clinics in Poplar and Deptford	Captain, RAMC; medical officer in charge of psycho-neurological department in Malta [1916]
23*†	ELLIOTT, Thomas Renton	1877-1961	Trinity College, Cambridge; University College, London	University College, London (assistant physician, 1910)	Lieutenant, RAMC; served in France
24††	EVANS, John Jameson		University of Birmingham; University of Edinburgh	Royal Institute for the Blind, Birmingham (ophthalmic surgeon); Birmingham Workhouse (ophthalmic surgeon); Birmingham and Midland Eye Hospital (resident surgical officer/ honorary surgeon); University of Birmingham (demonstrator in anatomy and lecturer in ophthalmology)	Ophthalmic surgeon to the 1st and 2nd Birmingham War Hospitals [1915]
25*	FEARNSIDES, Edwin Greaves	1883-1919	Trinity Hall, Cambridge; London Hospital	Hospital for Sick Children (clinical assistant); London Hospital (resident staff) Hospital for Paralysis and Epilepsy, Maida Vale (assistant physician)	Commissioned in RAMC in 1916; served first at Rouen then at Springfield Military Hospital; later superintended Home of Recovery at Golders Green and acted as neurologist to the R.F.C. Hospital for Officers, holding rank of major in the RFC

26*†	FEILING, Anthony	1885-1975	Pembroke College, Cambridge; St. Bartholomew's Hospital	St. Bartholomew's Hospital (casualty physician and temporary assistant physician); Metropolitan Hospital and Hospital for Paralysis and Epilepsy, Maida Vale (assistant physician)	Held posts listed opposite [1915]; served in RAMC, becoming Major [*]
27†§	FENWICK, Philip Cuthbert Collingwood		St. Thomas' Hospital	Royal Victoria Hospital (physician); West Hampshire Hospital, Boscombe (physician)	House physician to the Royal Sussex County Hospital, Brighton
28†‡	FORSTER, Frederick Cecil		St. Mary's Hospital, London	Royal United Hospital, Bath (resident medical officer); St. Mary's Hospital, London (resident surgical casualty officer); Royal Berkshire Hospital, Reading (assistant house surgeon)	Article lists first two posts opposite [1918]
29*†	FORSYTH, David	1887-1941	Guy's Hospital	Guy's Hospital (junior appointments); Hospital for Diseases of the Skin, Blackfriars (clinical assistant); Evelina Hospital for Children (assistant physician); Charing Cross Hospital (assistant physician, in charge of children's department until 1909, pathologist 1905-1914, lecturer on practical medicine and therapeutics)	Article lists as physician to out-patients, Charing Cross Hospital, and physician to Evelina Hospital [1915]
30§	GARTON, Wilfred		Westminster Hospital; St. George's Hospital; London Hospital		Captain, RAMC: first served as company officer and radiologist, then as radiologist to general hospital in France, then as radiologist to military hospital in England, then as radiologist and officer in charge of ward in hospital in India [1917]
31†‡	GORDON, Hy. Laing		Edinburgh University	Semon Convalescent Home and Children's Hospital, Ilkley, Yorkshire (assistant visiting physician and physician)	Physician to the Lancaster Clinic of Psychotherapy [1919]
32†‡	GORDON, Ronald Gray		Edinburgh University	Royal Infirmary Edinburgh and Paddington Green Children's Hospital (house physician); Hampstead General Hospital (casualty officer)	Captain, RAMC. Article lists as late house physician to the Royal Infirmary, Edinburgh [1919]

33††	GRIMBL Y, Alan Francis		Trinity College, Dublin; Rotunda Maternity Hospital, Dublin	St. Edmondsbury, Lucan, Ireland (assistant medical officer)	Temporary sergeant-lieutenant, Royal Navy [1918/1919]
34††	HARWOOD, Thomas Eustace		Christ Church College, Oxford; University of Edinburgh	Hospital for Sick Children, Great Ormond Street (clinical assistant); Hampstead General Hospital (house surgeon); St. Mary's Hospital for Women and Children, Plaistow (assistant resident medical officer); North-West London Hospital (ophthalmic assistant)	Article lists as Resident ophthalmic officer, the King George Hospital, South East [1916]
35*†	HENDERSON, David Kennedy	1884- 1965	Edinburgh University		Captain, RAMC; served in France as psychiatric specialist; listed in article as Royal Victoria Hospital, Netley and having worked at Lord Derby War Hospital, Warrington, Lancs [1918]
36††	HOTCHKIS, Robert Dunmore		University of Glasgow; University of Durham; University of Edinburgh; St. Bartholomew's Hospital	Royal Asylum, Gartnavel (senior assistant medical officer); Paddington Infirmary, London (second assistant medical officer); Renfrew District Asylum, Dykebar, Paisley (medical superintendent)	Captain, RAMC, officer in charge, Dykebar War Hospital, Paisley [1917]
37††	HUNTER, Percy Douglas		Guy's Hospital	East Sussex County Asylum (assistant medical officer); Durham County Asylum, Winterton (assistant medical officer and pathologist); Three Counties Asylum, Arlesley, Bedfordshire (senior medical officer)	Gateshead War Hospital; Maghull Military Hospital [1919]
38*†	HURST, Arthur Frederick	1879- 1944	Magdalen College, Oxford; Guy's Hospital	Guy's Hospital (junior appointments; elected assistant physician with charge of neurological department, 1907)	Major, RAMC; consultant to British forces in Salonika; lieutenant-colonel, RAMC, neurologist to the Royal Victoria Hospital, Netley, and officer in command of Seale Hayne Military Hospital, Newton Abbot

39*†	JOHNSON, William	1885-1949	London University; Guy's Hospital	Guy's Hospital (various residential posts, including house physician, Gull student in pathology, and demonstrator in morbid anatomy)	Commissioned in RAMC; served with field ambulance in France (Sept. 1914-June 1917); appointed neurologist in charge of army centre for psychoneuroses (June 1917-Nov. 1918), with rank of major [1918]
40*§	JONES, Ernest	1879-1958	Cardiff University; University College, London	University College Hospital, London (various appointments); Professor of psychiatry at Toronto and director of Ontario Clinic for Nervous Disorders	In private practice
41 ††	McDOWALL, Colin		University of Durham	Warwickshire County Asylum (assistant medical officer); Royal Infirmary Newcastle-upon-Tyne (house physician); City Asylum, Newcastle-upon-Tyne (assistant medical officer); Country Asylum, Cheedleton, Staffordshire (senior assistant medical officer)	Captain, RAMC, Maghull Military Hospital [1917]; Medical superintendent, Ticehurst House [1918]
42†§	MacMAHON, Cortlandt			St. Bartholomew's Hospital (instructor in speech and voice to the ear, nose and throat department)	Instructor for speech defects at St. Bartholomew's Hospital; staff of King Edward VII's Hospital for Officers, and Princess Henry of Battenberg's Hospital for Officers [1917]
43††	MILLIGAN, Edward Thomas Campbell		University of Melbourne; St. Bartholomew's Hospital	Melbourne General Hospital (resident surgeon); Melbourne Women's Hospital (honorary surgeon); Melbourne Women and Children's Hospital (senior resident surgeon)	Captain, RAMC, working at Casualty Clearing Station [1916]; major, RAMC, surgical specialist to British Expeditionary Forces [1921]
44*†	MOTT, Frederick Walker	1853-1926	University College, London	Liverpool University (assistant professor of physiology); Charing Cross Hospital (lecturer on physiology; lecturer on pathology; lecturer on medicine; assistant physician; physician; consulting physician); Pathologist to London County Asylums, working out of pathology laboratory, Calybury Asylum, Essex (1895-1916)	Major [1915], then Brevet Lieutenant-Colonel, RAMC, attached to Maudsley Extension, 4th London General Hospital from 1916

45§	MYERS, Charles Samuel	1873-1946	Gonville and Caius College, Cambridge; St. Bartholomew's Hospital	University of Cambridge (demonstrator and lecturer in experimental psychology, founded laboratory for experimental psychology in 1912); professor in experimental psychology, King's College, London (1906-1909)	Captain, RAMC attached first to Duchess of Westminster's War Hospital, Le Touquet (1914-March 1915); Major, RAMC, attached to staff of ADMS, Boulogne, with responsibility for selecting cases of nervous and mental shock and neurasthenia for transfer to England (March 1915-January 1916); Lieutenant-Colonel, RAMC, stationed at GHQ, St. Omer (January - August 1916); Consulting psychologist to the Army (August 1916- January 1917); Neurologist to the South Sector (January - November 1917)
46†‡	ORMOND, Arthur William		Guy's Hospital	Royal Eye Hospital, Southwark (surgeon); Royal London Ophthalmic Hospital (clinical assistant); Guy's Hospital (ophthalmic registrar, ophthalmic surgeon); Royal Asylum for the Deaf, Margate and London Orphans Asylum, Watford (consulting ophthalmic surgeon)	Captain, RAMC, Territorial Forces ; officer in charge of ophthalmic wards, No. 2 Hospital, Chelsea; ophthalmic surgeon to Guy's Hospital
47§	PARSONS, John Herbert	1868-1957	University College, Bristol; Bristol Royal Infirmary; St. Bartholomew's Hospital	University College, London (assistant to the professor of physiology); Royal London Ophthalmic Hospital, Moorfields (clinical assistant, curator and librarian, elected to staff post in 1904); University College Hospital, London (ophthalmic surgeon); Hospital for Sick Children, Great Ormond Street (ophthalmic surgeon)	Colonel, AMS, ophthalmic consultant for home troops
48†‡	PEARN, Oscar Phillips Napier		Westminster Hospital	West Hertfordshire Hospital (house surgeon); Westminster Hospital (house surgeon); Horton Asylum, Epsom, Surrey (assistant medical officer)	Captain, RAMC, Lord Derby's War Hospital, Warrington, Lancashire [1919]
49*†	PEMBERTON, Hugh Spear	1890-1956	Liverpool University	David Lewis Northern Hospital, Liverpool (resident staff; appointed clinical pathologist 1914)	Lieutenant, RAMC [1915]; served in France, and later in Russia

50††	PETERS, Edwin Arthur		Cambridge; Guy's Hospital	Guy's Hospital (house physician); Royal Eye Hospital and Throat Hospital, Golden Square (senior clinical assistant); Ear, throat and nose dept., Bolingbroke Hospital (surgeon); Paddington Green Children's Hospital (surgeon)	Captain, RAMC, surgeon to the Royal Ear Hospital, and aural surgeon to the Royal Victoria Hospital, Netley [1917]
51††	PRIDEAUX, Joseph Francis Engledue		University College, London	Banstead Asylum (assistant medical officer); Brompton Hospital for Consumptives (resident medical officer); Fiji Colonial Medical Services (Government medical officer)	Captain, RAMC. Ewell War Hospital
52††§	READ, Charles Stanford		University College, London	West End Hospital for Nervous Diseases (clinical assistant); North London Hospital for Consumption and Diseases of the Chest (resident medical officer); University College Hospital, London (assistant physician to out-patients); Fisherton House Asylum, Salisbury, Wiltshire (assistant medical officer)	Major, RAMC, officer in charge of "D Block", Royal Victoria Hospital, Netley; previous to this post was in charge of neurological wards (not stated where) [1918/1920]
53*	REYNELL, Walter Rupert	1885- 1948	Balliol College, Oxford; Guy's Hospital	Guy's Hospital (house physician and house surgeon)	Captain, RAMC; first served in France with Australian Voluntary Hospital; recalled to Coulter Hospital in London; from 1916, worked at Seale Hayne Military Hospital, Newton Abbot
54*§	RIVERS, William Halse Rivers	1864- 1922	St. Bartholomew's Hospital	St. Bartholomew's Hospital, Chichester Infirmary, National Hospital for the Paralysed and the Epileptic, Bethlem Royal Hospital (junior appointments); Guy's Hospital and University College, London (lecturer on psychology); Cambridge (University lecturer on physiological and experimental psychology)	Captain, RAMC; Maghull Military Hospital; Craiglockhart War Hospital (medical officer); Consulting psychologist to the Royal Flying Corps Central Hospital, Hampstead
55††	RIXON, Christopher Hugh Leete		St. Thomas' Hospital	St. Thomas' Hospital (house physician and casualty officer)	Captain, RAMC, neurologist, Reading War Hospital [1919]

56*†	ROSS, Thomas Arthur	1875- 1941	Edinburgh University	Royal National Hospital for Consumption (physician)	Captain, RAMC, medical officer in charge of a division at Springfield War Hospital [1918]
57‡§	ROWS, Richard Grundy	d. 1925	University College, London	University College Hospital (senior obstetrical assistant); City Asylum, Birmingham and County Asylum Prestwich, Manchester (assistant medical officer); County Asylum, Lancaster (assistant medical officer and pathologist)	Major, RAMC, medical superintendent, Maghull Military Hospital
58*†	SAVAGE, George Henry	1842- 1921	Sussex County Hospital; Guy's Hospital	Guy's Hospital and Royal Bethlem Hospital (resident appointments); Bethlem Hospital (assistant medical officer, resident physician); Royal Institution for the Mentally Deficient, Earlwood (consulting physician); Guy's Hospital (lecturer in mental diseases)	Consulting physician to Guy's Hospital, etc [1918]
59†‡	SCOTT, Frederick Gilbert Laughton		Guy's Hospital		Home of Recovery for Officers, Golders Green; Lancaster Clinic for Psychotherapy [1918]
60*†	SMITH, Grafton Elliot	1871- 1937	Sydney University	St. John's College, Cambridge (researcher on cerebral morphology, and demonstrator of anatomy); Government School of Medicine at Cairo (professor of anatomy); Manchester University (chair of anatomy)	Listed by article as professor of anatomy and dean of the faculty of medicine in the University of Manchester [1916]
61	SMURTHWAITE, Henry		Durham University		
62*	STEWART, James Purves	1869- 1949	Edinburgh University	Royal Infirmary, Edinburgh (house appointment); Edinburgh University (assistant to professors of physiology and medicine); National Hospital for the Paralysed and Epileptic (house appointment); Imperial Yeomanry Hospital (1900-01); Westminster Hospital (assistant physician, lecturer on pharmacology and therapeutics, lecturer on diseases of the nervous system);	Consulting physician in Mediterranean and Near East theatres of war



				West End Hospital for Nervous Diseases, Royal National Orthopaedic Hospital, Central London Throat and Ear Hospital (honorary appointments)	
63†‡	SYMNS, Jasper Llewellyn Montfort		Cambridge; Guy's Hospital	Guy's Hospital (out-patient officer, assistant house surgeon, house surgeon); All Hallows Country Hospital, Ditchingham (surgeon)	Captain, RAMC; served with 29 <sup>th</sup> division in the field during Gallipoli campaign (April – November 1915); neurological department, Royal Victoria Hospital, Netley [1918]
64‡	TOMBLESON, Jasper Bennett		Oxford University; St. Thomas' Hospital	West Africa Medical Staff, South Nigeria (medical officer); Hounslow Cottage Hospital (honorary physician); St. Thomas' Hospital (senior obstetric house physician); Ferrocarril Nacional de Tehuantepec, Mexico (medical director)	Lieutenant, RAMC [1917]
65*	TOOTH, Howard Henry	1856- 1925	St. John's College, Cambridge; St. Bartholomew's Hospital	St. Bartholomew's Hospital (junior appointments, elected assistant physician 1895 and full physician 1906); Metropolitan Hospital (assistant physician, physician, consulting physician); National Hospital for the Paralysed and Epileptic (assistant physician and physician); Portlant Hospital, South Africa (physician, Boer War); Commander, Medical Unit of London University O.T.C.	1914-1916: in charge of 1st London General Hospital; 1916-1918: Colonel, RAMC, consulting physician in Malta and then to forces in Italy
66†‡	TOWNEND, Robert Ockleston		London Hospital	London Hospital (clinical assistant surgeon to out-patients; house physician)	House physician at London Hospital in summer 1916; temporary surgeon, Royal Navy [1917]
67†‡	TROTTER, Robert Hale		Leeds University	General Infirmary, Leeds (house surgeon); Medical Officer of Health for combined districts of Holmfirth, Honley, and Holme	Major, RAMC, officer in charge of medical wards, Huddersfield War Hospital

68*†§	TURNER, William Aldren	1864-1945	Edinburgh University; St. Bartholomew's Hospital	Edinburgh Royal Infirmary (house physician); King's College, London (assistant to lecturer in neuro-pathology, demonstrator in neuro-pathology, and lecturer in neuro-pathology) King's College Hospital, London (assistant physician, physician in charge of neurological cases and lecturer on neurology); National Hospital for the Paralysed and Epileptic (physician)	Lieutenant-Colonel, AMS, Consulting neurologist to War Office, in France (resigned March 1915); Consulting neurologist to home forces (1915-1919); Held rank of colonel, AMS [1918]
69*	VEALE, Rawdon Augustus	1873-1954	Queen's College, Oxford; Leeds Medical School	Leeds Infirmary (house physician, resident medical officer, assistant physician)	Lieutenant-colonel, RAMC; served in France
70‡	WEATHERLY, Lionel Alexander		Bristol University; Aberdeen University	Portishead Dock Company (medical officer); Portishead Dispensary (physician); Bailbrook House, Bath, private asylum (proprietor and resident licensee);	
71†‡	WHITE, Ernest William		King's College, London	City of London Asylum near Dartford (resident superintendent); Kent County Asylum, Chartham (senior assistant medical officer); King's College, London (professor, 1905-1910, Emeritus professor of psychological medicine 1910-1915)	Lieutenant-colonel, RAMC; 1916-1918 consultant in mental diseases to Western Command and inspector of shell shock and neurasthenic patients in general, sectional, auxiliary, military, Red Cross and VAD hospitals of Western Command in Britain [1918]
72*‡	WILLIAMSON, Richard Thomas	1862-1937	Owens College, Manchester	Manchester Royal Infirmary, Birmingham School of Medicine, Royal London Ophthalmic Hospital, National Hospital for the Paralysed and Epileptic (junior appointments); Manchester Royal Infirmary (registrar, assistant physician, physician); Ancoats Hospital (staff appointment); Victorian University (assistant lecturer on medicine and on school hygiene); Medical Officer of Health, North District of Wharfedale; District Medical Officer and Public	Served neurologist in 2nd Western General Hospital, retired because of ill health in 1917

73*‡	WILTSHIRE, Harold Waterlow	1879- 1937	Clare College, Cambridge; King's College Hospital, London	Vaccinator Wharfedale Union; Wharfedale Workhouse (surgeon) Royal Northern Central Hospital (physician); King's College Hospital (medical tutor, senior medical registrar, and house physician); King's College Hospital (assistant physician); King's College Hospital Medical School (lecturer in practical medicine); Hostel of St. Luke's (physician)	Captain, RAMC, serving at base hospital in France (1916); also served in Salonika, eventually with rank of major, and was awarded DSO in 1918 and OBE in 1919
74†	WOLFSOHN, J.M			Assistant professor of nervous diseases, Leland Stanford Junior University, California	Article consists of observations made on soldiers at 4th London General Hospital, Maudsley Extension
75*	YEALLAND, Lewis Ralph	1885- 1954	Educated in Canada		Resident Medical Officer and then registrar at National Hospital for Paralysed and Epileptic, Queen Square, London

## Appendix C

### **Short biographies of authors of signed articles on shell-shock and related nervous and mental disorders of war in the British medical press, 1914-19**

See note at heading of Appendix B for details on the compilation of biographical information. The sources used for each biography are clearly indicated beneath each entry. The full name of the author is given in the heading of each biography, but thereafter he is referred to by the name under which he published (e.g. Paul Bousfield rather than Edward Bousfield, Laughton Scott rather than Frederick Scott).

#### **Abbreviations**

Bt.	Baronet
BAO	Baccalaureus Artis Obstetricae (Bachelor of Obstetric Art)
BCh	Baccalaureus Chirurgiae (Bachelor of Surgery)
BChir	Baccalaureus Chirurgiae (Bachelor of Surgery)
BM	Bachelor of Medicine
BS	Bachelor of Surgery
CB	Companion of the Order of the Bath
CBE	Commander of the Order of the British Empire
ChB	Chirurgiae Baccalaureus (Bachelor of Surgery)
ChM	Chirurgiae Magister (Master of Surgery)
CM	Chirurgiae Magister (Master of Surgery)
CMG	Companion of the Order of St. Michael and St. George
DSO	Distinguished Service Order
FRCS	Fellow of the Royal College of Physicians of London
KBE	Knight Commander of the Order of the British Empire
KCMG	Knight Commander of St. Michael and St. George
KCVO	Knight Commander of the Royal Victorian Order
LMSSA	Licentiate in Medicine and Surgery, Society of Apothecaries
LRCP	Licentiate of the Royal College of Physicians of London
LSA	Licentiate of the Society of Apothecaries
MB	Bachelor of Medicine
MD	Medicine Doctor (Doctor of Medicine)
MRCs	Member of the Royal College of Surgeons of England
OBE	Officer of the Order of the British Empire

#### **(1) ABRAHAMS, Sir Adolphe (1883-1967)**

Adolphe Abrahams was educated at Emmanuel College, Cambridge, and undertook his clinical training at St. Bartholomew's Hospital. He qualified with the Conjoint diplomas in 1909, and obtained the degrees MB and BChir two years later. After qualification he became house surgeon to St. Bartholomew's, and then house surgeon to the Ear, Nose and Throat Department, following which he undertook postgraduate

study in Vienna. He served in the RAMC, rising from lieutenant to major, from 1915-1920. He was in charge of the Medical Division of the Connaught Military Hospital, acted as Consultant Physician to the Aldershot Command, and was mentioned in despatches.

After the war he was appointed to the consultant staff of Westminster Hospital, and became Dean of Westminster Medical School in 1939, the same year he was knighted. He was also Censor to the Royal College of Physicians, examiner in medicine in the Universities of Cambridge, Liverpool, and London, and President of the British Society of Gastroenterologists, as well as of the Section of Medicine, Royal Society of Medicine. He was a general physician with a special interest in gastroenterology, and was a great admirer of Sir Arthur Hurst of Guy's Hospital. Between 1912 and 1948 he was consulting medical officer to the British Olympic team on numerous occasions. His written work was largely on gastroenterological subjects, exercise, physical fitness, and the training of athletes. He was described in Munk's roll as 'a physician of the old school to whom a detailed history and clinical examination were of basic importance, and of more importance and interest than the results of laboratory examinations, which came last to confirm or refute clinical diagnosis'.

**Sources:** *MR6*, pp. 1-3; A. Abrahams, 'A case of hysterical paraplegia', *Lancet* 1915 (2), pp. 178-9; A. Abrahams, 'The medical officer in charge of a division', *Journal of the RAMC* 33:1 (July 1919), pp. 79-94

## **(2) ADRIAN, Lord Edgar Douglas, 1st Baron Adrian of Cambridge (1889-1977)**

Edgar Adrian was educated at Trinity College Cambridge, where he became a fellow in 1913. He left the following year and qualified MB BChir from St. Bartholomew's Hospital in 1915. During the war he attained the rank of captain in the RAMC, and worked at Connaught Military Hospital. With Lewis Yealland, he developed a method of treating hysteria with suggestion via electricity, but eventually rejected this method in favour of evoking suppressed experience.

Before the war he had undertaken research with Keith Lucas on nerve conduction, and after demobilisation returned to research on nervous sensation and action. In 1932 he shared the Nobel Prize with Sir Charles Sherrington for their work into neuromuscular coordination. He made notable additions to knowledge of touch, pain, retinal activity,

and the operation of afferent and efferent fibres. He was Fullerton research professor of the Royal Society from 1929 to 1937, when he became Professor of Physiology at Cambridge. In 1951 he became master of Trinity College and retired in 1965. He was chancellor of the University of Cambridge from 1967 to 1975. He was made a hereditary peer in 1955. He was a member of 48 learned societies and was given 29 honorary degrees.

**Sources:** *MR7*, pp. 3-4; E.D. Adrian and L.R. Yealland, 'The treatment of some common war neuroses', *Lancet* 1917 (1), pp. 867-72

### **(3) ARMSTRONG-JONES, Sir Robert, CBE (1857-1943)**

Robert Jones (later Armstrong-Jones) was educated at the University College of Wales at Aberystwyth, and Grove Park School, Wrexham. He entered St. Bartholomew's Hospital as a student in 1876 and qualified MD four years later. He devoted his career to asylum psychiatry, and first obtained junior appointments at the Royal Earlswood Institution (1880-82) and the Colney Hatch Asylum (1882-88). He then returned to Earlswood as medical superintendent, and was appointed to the same post at Claybury Asylum in 1883. Under his management special training for mental nurses and occupational therapy for patients were instituted, and Claybury became the first London County Council asylum to accept private patients. The pathological laboratory at Claybury, run by Frederick Mott, also gained a prestigious reputation during these years.

Armstrong-Jones retired from Claybury in 1916 and was appointed consulting physician in mental diseases to the London and Aldershot Commands, with the rank of lieutenant-colonel. From 1921-1931 he was a Lord Chancellor's Visitor in Lunacy. He also lectured on mental diseases to the Westminster and St. Bartholomew's Hospitals.

**Sources:** *MR4*, pp. 480-1; *ODNB*, vol. 30, p. 626

### **(4) BALLARD, Ernest Fryer**

The *Medical Directory* (1915) states that Fryer Ballard undertook clinical training at St. Thomas' Hospital, and graduated MB, BS in 1908. He was a member of the Medico-

Psychological Association of Great Britain and Ireland, and assistant medical officer to the Somerset County Asylum, Wells. During the war he attained the rank of captain in the RAMC, and served as medical officer in charge of the observation and mental block to the 2nd Eastern General Hospital, Brighton. In 1917 he published *An epitome of mental disorders: a practical guide to aetiology, diagnosis, and treatment for practitioners, asylum, and R.A.M.C. medical officers*.

**Sources:** *Medical Directory* (1915), p. 482; E.F. Ballard, 'Some notes on battle psycho-neuroses', *JMS* 63:262 (July 1917), pp. 400-5; E.F. Ballard, 'The psychoneurotic temperament and its reactions to military service', *JMS* 64:267 (October 1918), pp. 365-77

#### **(5) BOUSFIELD, Edward George Paul**

Paul Bousfield graduated MRCS, LRCP from St. Bartholomew's, where he edited the hospital journal, in 1916. He had held posts as casualty surgeon, and assistant in the skin department of Queen's Hospital for Children. The heading of his 1918 article on the war neuroses described him as physician to the Lancaster Clinic of Psychotherapy (Ministry of Pensions). The professional details given in publications of 1919 and 1920 add that he is MRCS, LRCP, physician to the London Neurological Clinic (Ministry of Pensions), late demonstrator of morbid anatomy to St. George's Hospital, and late medical officer to American Red Cross Hospital 22. A Harley Street address is given at the end of the preface to the 1920 work. His posts at Ministry of Pensions clinics and publications on psychology suggest that in the immediately postwar years he continued to work in psychological medicine, although nothing more is known after 1920.

**Sources:** *Medical Directory* (1919), p. 96; P. Bousfield, 'The relation of blood-pressure to the psycho-neuroses', *Practitioner* 101:5 (November 1918), pp. 266-70; P. Bousfield, "An outline of psychotherapy": a lecture delivered before the Deputy Commissions of Medical Service, reprinted from *The Medical Press*, May 7<sup>th</sup>, 14<sup>th</sup> and 21<sup>st</sup>, 1919 (London: Bailliere, Tindall and Cox, 1919); P. Bousfield, *The elements of practical psycho-analysis* (London: Kegan Paul, Trench, Trubner & Co. Ltd, 1920)

**(6) BROCK, Arthur John (1879-1947)**

Arthur John Brock matriculated from the faculty of arts at Edinburgh University in 1894, and registered as a medical student at Edinburgh University in 1896. After spending a year in Vienna, he qualified MB, ChB in 1901. He obtained his MD in 1905. Before the war he worked as a general practitioner in Edinburgh, holding appointments as medical officer at Woodburn Sanatorium for Consumptives (c. 1902; visiting physician, 1910-1912); medical officer for the United Parishes of Killearn and Kilchenzie (c. 1903-1904); resident medical officer, Convalescent House, Royal Infirmary (1903-1904); assistant house physician at Leith Hospital (pre-1905); clinical assistant, outpatient department, Royal Infirmary (1904-1906); and physician to the New Town Dispensary (1905-[?]1919).

During the war he attained the rank of captain in the RAMC, serving on a hospital ship to India, in France, at the military depot at Aldershot, and then at Craiglockhart War Hospital (1916-1918), where he treated the poet Wilfred Owen. In 1919 he left the army and set up a private practice in Edinburgh. In 1923 he published *Health and conduct*, an analysis of postwar social breakdown based on the sociology of Patrick Geddes. In 1925 he moved to North Queensferry, a village across the Forth from Edinburgh, and established a small convalescent home for nervous patients. Brock is also remembered as a translator of ancient medical texts, notably Galen's *On the natural faculties* (1916) and *Greek medicine* (1929), a series of abstracts from the work of Galen and other ancient commentators on medicine.

**Sources:** *Medical Directory* (1915), pp. 1308-9; D. Cantor, 'Between Galen, Geddes, and the Gael: Arthur Brock, modernity, and medical humanism in early-twentieth-century Scotland', *Journal of the History of Medicine and Allied Sciences* 60:1 (2005), pp. 1-41

**(7) BROWN, William (1881-1952)**

William Brown was educated at Christ Church, Oxford. He graduated DSc Lond. in 1910, and MB, BCh from King's College Hospital in 1914. For some years before the war, as head of the psychological department at King's College, London, he conducted



research on intelligence testing. In 1914 he was appointed reader in psychology to the University of London, but then joined the RAMC and served as neurologist to the 4th and 5th armies in France and as then as the commanding officer of an advanced neurological centre. On his return to Britain he served first at Maghull Military Hospital, and then as CO of Craiglockhart War Hospital. It was not until 1921 that he returned to his pre-war post, but soon after was appointed Wilde reader in mental philosophy at Oxford, where he founded the Institute of Experimental Psychology. He was also consulting psychologist to King's College Hospital and director of research in clinical psychology at Bethlem Hospital. He was an active member of many societies, including the Mind Association, the Royal Medico-Psychological Association, the Royal Institute of Philosophy, the Society for the Study of Addiction, and the British Psychological Society. Of the last two he became president. He published prolifically, but after 1946 confined himself to consulting practice.

**Sources:** *MR5*, pp. 56-7; W. Brown, 'The treatment of cases of shell shock in an advanced neurological clearing centre', *Lancet* 1918 (2), pp. 197-200; W. Brown, 'War neurosis: a comparison of early cases seen in the field with those seen at the base', *Lancet* 1919 (1), pp. 833-6

#### **(8) BURTON-FANNING, Frederick William (1863-1937)**

Frederick Burton-Fanning studied medicine at University College London, and at St. John's College, Cambridge, where he graduated MB in 1891. In the same year he was elected physician to the Norfolk and Norwich Hospital and began to practice as a consultant in Norwich. In 1899 he opened the Mundesley Sanatorium, and in 1903 the Kelling Sanatorium for non-paying patients. He was also on the staff of the Jenny Lind Infirmary for Sick Children. During the war he served first as a major with the 1st Eastern General Hospital, and then as medical officer in charge of the 55th General Hospital in France, with the rank of lieutenant-colonel. He retired from the Norfolk and Norwich Hospital, as its consulting physician, in 1928, but continued to practise for the remainder of his life.

**Sources:** *MR4*, pp. 472-3

**(9) BURY, Judson Sykes (1852-1944)**

Judson Bury was educated at Owens College, Manchester, and University College, London, where he graduated as MB in 1877. He held house appointments at University College Hospital before returning to Manchester, where he eventually became full physician to the Royal Infirmary in 1899, and professor of clinical medicine at the University in 1911. He retired from these appointments in 1912, but served as an RAMC major on local medical boards during the war. His researches were mainly concerned with neurology.

**Sources:** *MR4*, p. 367

**(10) BUZZARD, Sir Edward Farquhar, Bt., KCVO (1871-1945)**

Farquhar Buzzard was educated at Magdalen College, Oxford, and at St. Thomas' Hospital where he graduated BM, BCh in 1898. He held junior posts at St. Thomas', the National Hospital, and the Hospital for Sick Children. In 1905 he was elected to the staff of the National Hospital, and in 1910 to the staff of St. Thomas'. During the war he served as consultant to the London Command, with the rank of colonel. He was primarily a neurologist, but excelled as a clinician in every branch of medicine. In 1924 he was appointed Physician-Extraordinary to King George V, and in 1932 Physician-in-Ordinary. In 1937 he was appointed Extra Physician to George VI. He was created KCVO in 1927 and a baronet two years later. From 1928 until 1943 he was Regius professor of medicine at Oxford University, where he was active in setting up institutions for medical research. In 1935 he stood unsuccessfully as a Conservative candidate for parliament.

**Sources:** *MR4*, pp. 473-4

**(11) CAMPBELL, Harry (1860-1(?)-1938)**

Harry Campbell qualified from St. Bartholomew's Hospital in 1881. His house appointments were at the Royal Ophthalmic Hospital, Moorfields, and the Hospital for

Sick Children. He served on the staff of the North-West London Hospital from 1886-1909, and as physician to the West End Hospital for Nervous Diseases from 1896-1924. His writings dealt with a variety of medical subjects, but his most important books were *Man's mental evolution, past and future* (1923) and *Fundamental principles in treatment* (1924). From 1918-1933 he edited the *Medical Press and Circular*.

**Sources:** *MR4*, pp. 385-6; H. Campbell, 'War neuroses', *Practitioner* 96:5 (May 1916), pp. 501-9

### **(12) CARMALT-JONES, Dudley William (1874-1957)**

Dudley Carmalt-Jones was educated at Corpus Christi College, Oxford, and St. Mary's Hospital, London, where he graduated BM, BCh in 1903. He held junior appointments at St. Mary's, at Queen Square, at the Seamen's Hospital, Greenwich, and at the Westminster Hospital. In 1912 he was appointed dean of the Westminster Hospital Medical School. He served in the RAMC throughout the war, as medical officer in charge of No. 4 Stationary Hospital (neurological centre) in France, and in the latter phases as a consulting physician to the Egyptian Expeditionary Force. In 1919 he was appointed professor of systematic medicine (part-time) at the University of Otago. He continued to work for the University and medical school after retiring from his chair in 1939, and retired to England in 1946.

**Sources:** *MR5*, p. 67; D.W. Carmalt-Jones, 'War-neurasthenia, acute and chronic', *Brain* 42:3 (October 1919), pp. 171-213

### **(13) CARVER, Alfred Edward**

Alfred Carver graduated MD from Cambridge and St. Bartholomew's Hospital in 1914. Before the war he held posts as clinical assistant to the Victoria Park Hospital for Diseases of the Chest, the Royal Chest Hospital, and the Throat and Ear Department of St. Bartholomew's Hospital. He was also house physician to the latter institution. In 1914 he published articles in the *Lancet* on the diet of the labouring classes in Birmingham, and the treatment of pulmonary tuberculosis. He attained the rank of

RAMC captain during the war, and in an article of 1919 was listed as director of the Birmingham Psychoneurosis Clinic, at the Birmingham and Midland Hospital for Diseases of the Nervous System. In 1936 he co-authored a book on *Alcoholism in general practice*, to which he contributed the section on 'Psychology and management'. In this book he was described as the Medical Director of Caldecote Hall, and the diploma in psychological medicine from Cambridge University had been added to his list of qualifications.

**Sources:** *Medical Directory* (1915), p. 555; A. Carver, 'Some observations bearing upon the commotional factor in the aetiology of shell shock', *Lancet* 1919 (2), pp. 193-6; A. Carver and A. Dinsley, 'Some biological effects due to high explosives', section of neurology, *PRSM* 12 (parts 1 and 2) (1918-1919), pp. 36-51; A. Carver, T. Hunt and W. Willcox, *Alcoholism in general practice* (London: Constable and Company Ltd., 1936)

#### **(14) CHAMBERS, William Duncanson**

William Chambers was educated at Edinburgh University, where he graduated MB, BCh in 1910, and MD in 1913. Before the war he was senior assistant medical officer at the Crichton Royal Institution, Dumfries. He attained the rank of RAMC captain during the war, and from March 1918 to January 1919 was in charge of the army mental wards in the Boulogne area.

**Sources:** *Medical Directory* (1915), p. 1318; W.D. Chambers, 'Mental wards with the British Expeditionary Force: a review of ten months' experience', *JMS* 65:270 (July 1919), pp. 152-80

#### **(15) CHURCHWARD, Albert**

Albert Churchward obtained his LSA from Guy's Hospital and the University of Brussels in 1873, and graduated MD from the University of Brussels in 1876. The *Medical Directory* of 1915 listed a series of publications on freemasonry and ancient religion, as well as articles on gynaecological surgery (1893), hermaphroditism (1909), and treatment for rodent ulcer (1911). He was also described as an inventor, and his

creations included a hygienic bicycle saddle, improved cycle pedals, and a new process of hardening and toughening steel and armour plates. No information could be obtained on his pre-war or wartime professional posts. He published books on *The origin and evolution of primitive man* (1912) and *The arcana of freemasonry* (1915), based on lectures previously published in *The Freemason*.

**Sources:** *Medical Directory* (1915), p. 126; A. Churchward, *The origin and evolution of primitive man* (London: George Allen and Company Ltd., 1912); A. Churchward, *The arcana of freemasonry* (London: George Allen and Unwin Ltd., 1915)

**(16) CLARKE, John Michell (1859-1918)**

John Michell Clarke was educated at Caius College, Cambridge, and qualified as a doctor at St. Thomas' Hospital in 1885. He served first as a house physician to this hospital, and then was elected assistant physician (1887) and physician (1893) to Bristol General Hospital. He became successively lecturer on physiology and professor of pathology and of medicine at University College, Bristol, and when Bristol University was founded was appointed to its chair of medicine. He was pro-vice-chancellor of the University from 1911 until his death. He was primarily a neurologist. During the war he was in command of the Southmead section of the 2nd Southern General Hospital, holding the rank of lieutenant-colonel.

**Sources:** *MR4*, pp. 386-7

**(17) COLLIE, Sir John (1860-1935)**

John Collie graduated MB, CM from the University of Aberdeen and the Royal College of Surgeons of Edinburgh in 1882, and obtained his MD from the University of Aberdeen in 1885. Before the war he was a Justice of the Peace for the county of London, a member of the advisory committee on the National Insurance Act 1911, the insurance committee for London, the executive committee of the Annuity and Life Insurance Company, and the Royal Commission on Venereal Disease. He was a medical examiner for the London County Council, the Metropolitan Water Board, the Shipping Federation, Sun Insurance, and other companies. He had served as the Home Office

medical referee for the Workmen's Compensation Act, the assistant medical officer for the London School Board, and as house surgeon to the Royal Maternity Hospital, Edinburgh. He was author of *Malingering and feigned sickness* (1913), and continued to publish on malingering throughout the war, when he was medical director of the Ministry of Pensions.

**Sources:** *Medical Directory* (1915), p. 131; *Medical Directory* (1919), p. 125

### **(18) CULPIN, Millais (1874-1952)**

Millais Culpin graduated MB, BS from the London Hospital in 1905, where he had held a number of resident posts. He then went to Shanghai to practise in the English settlement there, but returned to England on the outbreak of the war and joined the RAMC. He was first appointed the surgical member of a board in London for sick and wounded officers, but in 1915 was transferred to the Alexandra Hospital, near Portsmouth, as a surgical specialist. He there noticed that many patients with trench foot displayed hysterical symptoms, and although he was occupied mainly with surgical work during the early stage of his service in France (1916-17), he also fostered an interest in functional disorders. Towards the end of 1917 he gave up surgery for work in army neurological hospitals. When he obtained his MD in 1919, he wrote his thesis on war neuroses, and in 1920 published a book on *Psychoneuroses of war and peace*. After the war he was appointed lecturer in psychoneuroses to the London Hospital Medical College, and also worked as a neurological specialist to the Ministry of Pensions. From 1923 onwards he conducted research for the Industrial Health Research Board. In 1930 he became lecturer in industrial and medical psychology at the London School of Hygiene and Tropical Medicine, and the following years was appointed professor in the same subject. He retired his chair in 1939, and in 1944 was elected President of the British Psychological Society. He published books on *Spiritualism and the new psychology* (1920), *The nervous patient* (1924), *Medicine and the man* (1927), *Recent advances in the study of the psychoneuroses* (1931), and *Mental abnormality: facts and theories* (1948).

**Sources:** [Anon.], 'Obituary: Millais Culpin', *BMJ* 1952 (2) [September 27 1952], pp. 727-8

**(19) DILLON, Frederick**

Frederick Dillon graduated MB, BCh from the University of Edinburgh in 1909. He held posts at the senior house physician in the department of skin diseases at the Royal Infirmary Edinburgh (1911), and then as assistant medical officer to Northumberland House in Finsbury Park (1915). He attained the rank of RAMC captain during the war, and served as neurologist to the 3rd army of the British Expeditionary Force.

**Sources:** *Medical Directory* (1915), p. 151; F. Dillon, 'The analysis of a composite neurosis', *Lancet* 1919 (1), pp. 57-60

**(20) DINSLEY, A**

Dinsley co-authored an article on the biological effects of high explosives with Alfred Carver in 1919. At the heading of this article, he is described as a member of the Royal Army Ordnance Corps. This is the only information available on him. It is extremely unlikely that he held any medical qualifications, as he is not listed in the *Medical Directory* for 1915, 1919 or 1921. He does not appear to have published any books in Britain.

**Sources:** A. Carver and A. Dinsley, 'Some biological effects due to high explosives', section of neurology, *PRSM* 12 (parts 1 and 2) (1918-1919), pp. 36-51

**(21) EAGER, Richard**

Richard Eager obtained his MD from the University of Aberdeen in 1912. Before the war he was senior assistant medical officer to the Devon County Asylum, Exeter, and a captain in the RAMC territorial forces, 1st Wessex Field Ambulance. By 1918 he had risen to the rank of major and was officer in command of the mental division of the Lord Derby War Hospital. In 1945 he published a book on *The treatment of mental disorders*, where he is listed as consulting psychiatrist to the Royal Devon and Exeter Hospital, and as an OBE. The book also states that he served as assistant medical

officer to the Devon County Lunatic Asylum from 1906-1922, when he was appointed medical superintendent. He resigned this post in 1936.

**Sources:** *Medical Directory* (1915), p. 629; R. Eager, 'A record of admissions to the mental section of the Lord Derby War Hospital, Warrington, from June 17<sup>th</sup>, 1916, to June 16<sup>th</sup>, 1917', *JMS* 64:266 (July 1918), pp. 272-96; R. Eager, 'The early treatment of mental disorders', *Lancet* 1919 (2), pp. 558-63; R. Eager, *The treatment of mental disorders (ancient and modern)* (Exeter: W.V. Cole and Sons, 1945), pp. 50-1

## **(22) EDER, Montague David (1865-1936)**

David Eder graduated MB from University College, London in 1895, and MD from the University of Bogota in 1898. His career was characterised by strong commitments to socialism, Zionism, and psychoanalysis. From 1897-1905 he travelled widely, earning his living as a doctor in South Africa and South America, and also practised intermittently in poor industrial areas of England. In the 1890s he joined the Independent Labour Party, the Bloomsbury Socialist League, and the Fabian Society. In 1908 the Jewish Territorial Organisation sent him to Cyrenacia in north Africa. In England, he worked with children at clinics in Poplar and Deptford, and in 1910 became joint editor of the educational journal *School Hygiene*. He was also editorial consultant to the radical literary journal *New Age* from 1907 to 1915. He was an important figure in the early history of psychoanalysis, and was a founder member of the London Psycho-Analytical Society (established 1911). He initially drew on both Freud and Jung, but in the early 1920s changed his mind about the usefulness of Jung's ideas and went into Freudian analysis with Sándor Ferenczi in Budapest.

In the war he attained the rank of captain in the RAMC, and was appointed medical officer in charge of the psycho-neurological department in Malta. His book *War-shock: the psycho-neuroses in war psychology and treatment* (1917) took an eclectic approach to therapy, acknowledging the value of hypnotism, suggestion, and psychoanalysis for different cases. In 1918 he was appointed chief residential Zionist agent in Palestine under the Balfour declaration, and lived in Palestine until 1922. When he returned to London he continued to work for the Zionist cause, while also pursuing his medical and psychoanalytical career.



**Sources:** *ODNB*, vol. 17, pp. 694-5; M.D. Eder, 'An address on the psycho-pathology of the war neuroses', *Lancet* 1916 (2), pp. 264-8

**(23) ELLIOTT, Thomas Renton, CBE (1877-1961)**

Thomas Elliott was educated at Trinity College, Cambridge, and University College, London. He obtained his MD in 1908. Between 1900 and 1906 he carried out a series of brilliant physiological researches on the autonomic nervous system and the effects of adrenaline, and proposed the concept of the chemical transmission of nerve impulses. In 1910 he was appointed assistant physician to University College Hospital, London. Within a month of the outbreak of war he had travelled to France to offer his services to the RAMC, and was initially given the rank of lieutenant. On demobilisation he became a full-time clinical professor at the University of London, but never again attained the heights reached in his pre-war researches. For several years he was a member of the Medical Research Council and a trustee of the Wellcome Foundation. He was created CBE in 1919.

**Sources:** *MR5*, pp. 119-21; T.R. Elliott, 'Transient paraplegia from shell explosions', *BMJ* 1914 (2), pp. 1005-6

**(24) EVANS, John Jameson**

John Jameson Evans obtained his MD from Birmingham University in 1903. He held posts as first resident surgical officer, and then honorary surgeon, to the Birmingham and Midland Eye Hospital; ophthalmic surgeon to the Birmingham Workhouse and Marston GreenCott Homes; and was also demonstrator in anatomy and lecturer in ophthalmology at Birmingham University. He edited the *Birmingham Medical Review*, and was a member of the Ophthalmic Society of Great Britain and the Royal Institute for the Blind, Birmingham. In 1915 he was resident ophthalmic surgeon to the 1st and 2nd Birmingham War Hospitals.

**Sources:** *Medical Directory* (1915), p. 641; J.J. Evans, 'Organic lesions from shell concussion', *BMJ* 1915 (2), p. 848

**(25) FEARNSIDES, Edwin Greaves (1883-1919)**

Edwin Fearnside was educated at Trinity College, Cambridge, and studied medicine at the London Hospital and in Berlin. He graduated MB, BCh in 1908. He then served as a clinical assistant at the Hospital for Sick Children and spent several years on the resident staff of the London Hospital. He specialised in neurology and was elected assistant physician to the Hospital for Paralysis and Epilepsy, Maida Vale. He was commissioned in the RAMC in 1916 and served first at Rouen and then at the Springfield Military Hospital. He later superintended the Home of Recovery at Golders Green and acted as neurologist to the RFC Hospital for Officers, holding the rank of major in the RFC.

**Sources:** *MR4*, pp. 544-5

**(26) FEILING, Anthony (1885-1975)**

Anthony Feiling was educated at Pembroke College, Cambridge, and St. Bartholomew's Hospital. He graduated MB, BChir in 1911 and MD in 1914. He held posts as assistant physician to the Metropolitan Hospital, the Hospital for Paralysis and Epilepsy, Maida Vale, and St. Bartholomew's Hospital. He was then appointed casualty physician to the latter institution. During the war he served in the RAMC, eventually attaining the rank of major, and was mentioned in despatches. In 1923 he was appointed assistant physician to St. George's Hospital, and was also physician to the Maida Vale Hospital for Epilepsy and Nervous Diseases, and to the Royal National Orthopaedic Hospital. St. George's became the centre of his professional life: he was Dean of the Medical School from 1926-36, and later senior physician. Although he remained a general physician throughout his career, his chief interest was in neurology. He was a founder member of the Association of British Neurologists and later its President. He was also President of the neurological section of the Royal Society of Medicine, a corresponding member of the Société de Neurologie de Paris, and a member of the American Academy of Neurology, and editor of *Modern trends in neurology*. He was instrumental in securing the appointment of the first psychiatrists to the staff of St. George's, and later supported the establishment of a unit of neurology, psychiatry, and neurosurgery at Atkinson Morley's Convalescent Hospital, Wimbledon.

**Sources:** *MR6*, pp. 173-5; A. Feiling, 'Loss of personality from "shell shock"', *Lancet* 1915 (2), pp. 63-6

**(27) FENWICK, Philip Cuthbert Collingwood**

After undertaking clinical training at St. Thomas' Hospital, Philip Fenwick obtained the LMSSA in 1916. He had held posts as house surgeon to the Royal Victoria and West Hampshire Hospital, Boscombe, and in 1917 was house physician to the Royal Sussex County Hospital, Brighton. He published a book on *Insomnia and drug addiction* in 1928.

**Sources:** *Medical Directory* (1919), p. 651; P.C.C. Fenwick, 'Entero-spasm following shell shock', *Practitioner* 98:4 (April 1917), p. 391; P.C.C. Fenwick, *Insomnia and drug addiction* (London: H.K. Lewis and Co. Ltd., 1928)

**(28) FORSTER, Frederick Cecil**

After undertaking clinical training at St. Mary's Hospital, London, Frederick Forster graduated LRCP in 1899. He held posts as assistant house surgeon to the Royal Berkshire Hospital, Reading, resident medical officer to the Royal Hospital, Bath, and resident surgical casualty officer at St. Mary's Hospital. The latter two posts he still held in 1918. He published articles on rheumatic fever (1903), traumatic pneumonia (1906), and angio-neurotic oedema (1906).

**Sources:** *Medical Directory* (1915), p. 658; F.C. Forster, 'The management of neurasthenia, psychasthenia, shell-shock, and allied conditions', *Practitioner* 100:1 (January 1918), pp. 85-90

**(29), FORSYTH, David (1877-1941)**

David Forsyth qualified MD from Guy's Hospital in 1910, where he held several junior appointments. He then acted as clinical assistant to the Hospital for Diseases of the Skin, Blackfriars, before he was elected assistant physician, first to the Evelina Hospital

for Children, and then to Charing Cross Hospital (1906) where he had charge of the children's department until 1909, was pathologist from 1905-1914, and lectured on practical medicine and therapeutics. He eventually retired from both hospitals as consulting physician. In his later years he was also senior physician to the psychiatric clinic of the Ministry of Pensions. Child health and psychology were his specialities, and he published books on *Children in health and disease* (1909), *The technique of psycho-analysis* (1922), and *Psychology and religion* (1935). He took a keen interest in new theories of psychology and declared his support for Freud before the war.

**Sources:** *MR4*, pp. 507-8; D. Forsyth, 'Functional nerve disease and the shock of battle: a study of the so-called traumatic neuroses arising in connexion with the war', *Lancet* 1915 (2), pp. 1399-1403

### **(30) GARTON, Wilfred**

After undertaking clinical training at the Westminster, St. George's, and London Hospitals, Wilfred Garton graduated LRCP in 1903. He enlisted in the RAMC in 1915, and attained the rank of captain. He served as a radiologist in England for some months, then held the same post in a general hospital in France, and then again in England. The remainder of his time in the army he spent in India, where he had charge of a ward as well as holding an appointment as radiologist.

**Sources:** *Medical Directory* (1915), p. 673; W. Garton, *Electro-therapeutics for military hospitals* (London: H.K. Lewis and Co. Ltd., 1917), p. v and pp. 39-42

### **(31) GORDON, Hy. Laing**

Laing Gordon graduated MD from the University of Edinburgh in 1895. He held posts as physician to the Semon Convalescent Home, and to the Children's Hospital, Ilkley, Yorkshire. He was a member of the Society for the Study of Inebriety and the Continental-Anglo-American Medical Society. He published articles on diphtheria (1898), weights and measurements of children (1902), phthisis (1903), and alcoholism and heredity (1904). In 1919 he was physician to the Lancaster Clinic of Psychotherapy.

**Sources:** *Medical Directory* (1915), p. 187; H.L. Gordon, 'Eye-colour and the abnormal palate in neuroses and psychoses', *Lancet* 1919 (2), pp. 9-10

**(32) GORDON, Ronald Gray**

Ronald Gordon graduated MD from the University of Edinburgh in 1913. He held posts as house physician to the Royal Infirmary Edinburgh and the Paddington Green Children's Hospital, and as casualty officer to the Hampstead General Hospital. During the war he attained the rank of captain in the RAMC. The preface to a book on *Personality* he published in 1926 defended the claim of the 'practising physician', as well as the 'erudite psychologist', to write on personality. He thanked Sir Byron Bramwell, Professors Lloyd Morgan and T.H. Pear, and Drs A.F. Hurst, R.G. Rows, and Bernard Hart, as those who had taught him neurology and psychology. In 1936 he co-edited *An introduction to psychological medicine*. He was there described as physician to the Royal United Hospital, Bath, physician to Bath and Wessex Orthopaedic Hospital, Bath, associate physician to the Institute of Medical Psychology, and consulting neurologist to Stoke Park Colony, Bristol.

**Sources:** *Medical Directory* (1915), p. 685; R.G. Gordon, 'War neuroses', *Practitioner* 103:5 (November 1919), pp. 358-65; R.G. Gordon, *Personality* (London: Kegan Paul, Trench, Trubner and Co. Ltd., 1926), pp. xiii-xiv; R.G. Gordon, N.G. Harris and J.R. Rees (eds), *An introduction to psychological medicine* (London: O.U.P., 1936)

**(33), GRIMBLY, Alan Francis**

Alan Grimbly was educated at Trinity College, Dublin, where he graduated BAO, BCh, in 1916, and he also held the LM from the Rotunda Maternity Hospital, Dublin. Although his professional qualifications suggest an early interest in obstetrics, he had also held the post of assistant medical officer to St. Edmondsbury Asylum, Lucan. During the war he served as a surgeon in the Royal Navy, where he attained the rank of sergeant-lieutenant. In 1919 he was working in the Royal Naval Hospital, Gosport, Hampshire. He was also a lieutenant in the RAMC special reserve.

**Sources:** *Medical Directory* (1919), p. 702; A.F. Grimby, 'Neuroses and psychoneuroses of the sea', *Practitioner* 102:5 (May 1919), pp. 243-58

**(34) HARWOOD, Thomas Eustace**

Thomas Harwood was educated at Christ Church College, Oxford, and graduated MB. BCh from the University of Edinburgh in 1909. He held the posts of ophthalmic assistant to the North-West London Hospital, clinical assistant to the Great Ormond Street Hospital for Sick Children, house surgeon to the Hampstead General Hospital, and assistant resident medical officer to the St. Mary's Hospital for Women and Children, Plaistow. He was listed as resident ophthalmic assistant to the King George Hospital in articles of 1916 and 1917. This was a military hospital, and he published in the *Journal of the RAMC*, but it is not known whether he enlisted.

**Sources:** *Medical Directory* (1915), p. 719; T.E. Harwood, 'A preliminary note on the nature and treatment of concussion', *BMJ* 1916 (1), p. 551; T.E. Harwood, 'Functional conditions in the light of head injuries', *Journal of the RAMC* 28:6 (June 1917), pp. 699-707

**(35) HENDERSON, Sir David Kennedy (1884-1965)**

The entry for David Henderson in *Munk's roll* describes him as 'the most eminent psychiatrist in this country, and probably Europe, between the two World Wars'. He was educated at Edinburgh University, where he graduated MB, ChB in 1907. He then spent eight years in postgraduate study preparing himself for a career in psychiatry, working under Sir Thomas Clouston at Morningside Asylum, Alexander Bruce in Edinburgh, Adolf Meyer in New York, Kraepelin and Alzheimer in Munich, Mott at the London County Council Pathological Laboratory, and again with Adolf Meyer at the Phipps Psychological Clinic of the John Hopkins Hospital, Baltimore. During the war he served in France as a psychiatric specialist with the RAMC. In an article of 1918 he is listed as working at the Royal Victoria Hospital, Netley, and the article itself is based on observations whilst working at the Lord Derby War Hospital, Warrington, Lancashire. In 1918 he was appointed senior assistant to the Glasgow Royal Asylum, Gartnavel, and became physician superintendent in 1921. In the same year he was

appointed lecturer in mental diseases at Glasgow University, and he remained there until 1932 when he was made physician superintendent of the Royal Edinburgh Hospital for Nervous and Mental Disorders, and professor of psychiatry at Edinburgh University. He held both appointments until his retirement in 1954.

He gained an international reputation for his studies of the pre-senile dementias and psychopathic personalities, and for his contributions to criminal psychiatry. He believed that psychiatry should be taught as part of the medical curriculum, in order to help doctors understand the psychiatric aspects of all illnesses. He was the author of a *Textbook of psychiatry* for students and practitioners (1927) which went into nine editions in his lifetime, and was knighted in 1947. He was president of the Royal Medico-Psychological Association (1946-7), of the section of psychiatry of the Royal Society of Medicine (1947), and of the Royal College of Physicians of Edinburgh (1950-51). He was given honorary degrees by the National Universities of Ireland and the Universities of McGill and Edinburgh, and was also elected to honorary fellowships of several learned societies of Britain and Europe. He was a member of the Expert Committee on the Work of Psychologists and Psychiatrists in the Services, and was external examiner on psychiatry to the University of Durham and the National University of Ireland.

**Sources:** *MR5*, pp. 188-90; D.K. Henderson, 'War psychoses: an analysis of 202 cases of mental disorder occurring in home troops', *JMS* 64:265 (April 1918), pp. 165-89

### **(36) HOTCHKIS, Robert Dunmore**

Robert Hotchkis graduated MRCS, LRCP from St. Bartholomew's Hospital and Newcastle-upon-Tyne University in 1891, and obtained his MD from Durham University in 1899. He held posts as the assistant medical officer to the Royal Asylum, Gartnavel, and second assistant medical officer to the Paddington Infirmary, London. He was then appointed medical superintendent of Renfrew District Asylum, Dykebar, Paisley. He attained the rank of captain in the RAMC during the war, oversaw the conversion of the asylum into Dykebar War Hospital, and served as its commanding officer.

**Sources:** *Medical Directory* (1915), p. 1352; R.D. Hotchkis, 'Renfrew District Asylum as a War Hospital for mental invalids: some contrasts in administration. With an analysis of cases admitted during the first year', *JMS* 63:261 (April 1917), pp. 238-49

**(37) HUNTER, Percy Douglas**

Percy Hunter graduated MRCS, LRCP from Guy's Hospital in 1902. He held the posts of assistant medical officer to the East Sussex County Asylum, assistant medical officer and pathologist to the Durham County Asylum, Winterton, and senior medical officer to the Three Counties Asylum, Arlesley, Bedfordshire. During the war he served at the Gateshead War Hospital and Maghull Military Hospital, although it is not known whether he enlisted in the RAMC.

**Sources:** *Medical Directory* (1915), p. 756; P.D. Hunter, 'Neurasthenia and emotion', *Practitioner* 103:5 (November 1919), pp. 343-57

**(38) HURST, Sir Arthur Frederick (1879-1944)**

Arthur Hertz, who changed his surname to Hurst during the war, was educated at Magdalen College, Oxford, and at Guy's Hospital, where he graduated BM, BCh in 1904. He held a number of junior appointments at Guy's Hospital, where he was elected assistant physician with charge of the neurological department in 1907. During the war he served first as consultant to the British forces in Salonika, with the rank of lieutenant-colonel, then as neurologist to the Royal Victoria Hospital, Netley, and was finally given command of the Seale Hayne Military Hospital at Newton Abbot, where he achieved considerable fame treating the war neuroses with suggestion and persuasion. Between the wars he continued in his post at Guy's, but also practised at the private New Lodge Clinic in Windsor Forest. After he retired from Guy's in 1939 he continued to practise as temporary physician to the Radcliffe Infirmary, and as University lecturer on medicine at Oxford, and later resumed his teaching activities at Guy's. He published on many medical topics, including nervous disease, gastroenterology, the anaemias, and asthma. He was knighted in 1937.



**Sources:** *MR4*, pp. 509-10; A.F. Hurst, 'Observations on the etiology and treatment of the war neuroses', *BMJ* 1917 (2), pp. 409-14; A.F. Hurst, 'Cinematograph demonstration of war neuroses', section of neurology, *PRSM* 11: 2 (1917-1918), pp. 39-42

**(39) JOHNSON, William (1885-1949)**

William Johnson graduated MB, BS (1908), and MD (1911) from Guy's Hospital. He held several residential posts at this institution, including house physician to Dr. Arthur Hurst, Gull student of pathology, and demonstrator in morbid anatomy, which enable him to widen his knowledge of neurology, pathology, and neuropathology. In 1912-13 he worked for period of three months under Déjerine in Paris, and Edinger in Frankfurt. During the war he was commissioned in the RAMC and served with a field ambulance in France from September 1914 to June 1917. In August 1916 he was awarded the Military Cross for conspicuous gallantry and devotion to duty. He was subsequently appointed neurologist in charge of an NYDN centre in France, with the rank of major, and held this office until the end of the war. He co-authored the chapter on neurasthenia and war neuroses in the *History of the Great War, Medical services: diseases of the war, volume 2* (1923).

After the war he was appointed chief clinical assistant to the outpatient department of the National Hospital, Queen Square (1919), assistant physician and neurologist to the Royal Southern Hospital, Liverpool (1920), and assistant physician and neurologist to the Royal Liverpool Children's Hospital (1921). He held several posts at the Liverpool University Medical School, including lecturer in clinical medicine (1921-45), lecturer in clinical paediatrics (1935-45), and chairman of the faculty of medicine (1943-44). Additional posts were consulting physician to the Ministry of Pensions Hospital, Mossley Hill, physician to the Liverpool Eye and Ear Infirmary, and physician to the Birkenhead Municipal Hospital. He also served as examiner in medicine to the Universities of Durham and Liverpool, and to the Conjoint Board (London), and was an important force in the merger of the four general teaching hospitals of Liverpool into the Royal Liverpool United Hospital. In 1948 he was appointed the first chairman of the Liverpool Region Children's Hospital Management Committee, and at the time of his death he was president of the section of neurology, Royal Society of Medicine, and president-elect of the 1949 International Neurological Congress in Paris.

**Sources:** *MR5*, pp. 217-8; W. Johnson, 'Hysterical tremor', *BMJ* 1918 (2), pp. 627-8

**(40) JONES, Ernest (1879-1958)**

Ernest Jones was educated at Cardiff University, and then University College, London, where he graduated MD in 1903. He held several junior hospital appointments, and set up an unsuccessful Harley Street practice with Wilfred Trotter in 1905, but after the latter introduced him to the work of Freud in the early 1900s he made psychoanalysis his life work. He organised the first Psycho-analytical Congress in Salzburg in 1908, where he met Freud, and was a key founding member of the London Psycho-analytical Society (established 1911). He was then appointed professor of psychiatry at Toronto, and director of the Ontario Clinic for Nervous Disorders, and did not return to London until 1913. During the war he offered his services to Lord Knutsford's Hospital for Officers at Palace Green, Kensington, but was rejected because he had been asked to resign from the West End Hospital some years previously. However, he treated several officers suffering from war neuroses in his private practice. He was the main proponent of psychoanalysis in England until the end of his life, and founded the *International Journal of Psychoanalysis* and the *International Psycho-Analytical Library* series. He half-retired to Sussex in 1940, although he continued a restricted psychoanalytic and psychiatric practice, and there wrote his acclaimed life of Freud.

**Sources:** *MR5*, pp. 219-20; E. Jones, *Free associations: memories of a psycho-analyst* (London: The Hogarth Press, 1959), pp. 244-8

**(41) McDOWALL, Colin Francis Frederick**

Colin McDowall graduated MD from the University of Durham in 1908. He held posts as assistant medical officer to the City Asylum of Newcastle-upon-Tyne, house physician to the Royal Infirmary of Newcastle-upon-Tyne, and assistant medical officer to the Warwickshire County Asylum, before being appointed senior assistant medical officer to the County Asylum, Cheedleton, Staffordshire. Before the war he published articles on leucocytosis in the insane, and bacteriological investigations of the blood in insanity. During the war he attained the rank of captain in the RAMC and served at

Maghull Military Hospital. By 1918 he had left the RAMC and been appointed superintendent of Ticehurst House, a private home for the insane.

**Sources:** *Medical Directory* (1915), p. 824; C. McDowall, 'Functional gastric disturbance in the soldier', *JMS* 63:260 (January 1917), pp. 76-88; C. McDowall, 'Mutism in the soldier and its treatment', *JMS* 64:264 (January 1918), pp. 54-64

#### **(42) MacMAHON, Cortlandt**

Cortlandt MacMahon, a teacher of voice production and public speaking, was the director of the first hospital speech clinic opened in Britain at St. Bartholomew's Hospital, London, in 1911. His title was 'Instructor in Voice to the Ear, Nose and Throat Department'. He had no medical qualifications. Students remembered him as 'a handsome, dominant man whose powerful personality was an important factor in "curing" many of his patients, especially those suffering from problems of emotional origin'. The heading of his 1917 article on affections of speech and voice in shell-shock listed the St. Bartholomew's post, and added that he was on the staff of the King Edward VII Hospital for Officers and the Princess Henry of Battenberg Hospital for Officers.

**Sources:** M. Eldridge, *A history of the treatment of speech disorders* (Edinburgh and London: E & S Livingstone, 1968), pp. 60-1; C. MacMahon, 'Shell shock stammering and other affections of voice and speech', *Practitioner* 98:5 (May 1917), pp. 427-35

#### **(43) MILLIGAN, Edward Thomas Campbell, OBE**

Edward Milligan qualified MD from the University of Melbourne in 1912, and FRCS from St. Bartholomew's Hospital in 1919. He held posts as resident surgeon to Melbourne General Hospital, honorary surgeon to the Melbourne Women's Hospital, and senior resident surgeon to the Melbourne Women and Children's Hospital. At the heading of a 1916 article he was listed as a captain in the RAMC, and at the time of its publication he was working in a Casualty Clearing Station in France. The *Medical Directory* for 1921 also lists him as a major in the RAMC, and a surgical specialist to the British Expeditionary Forces. He was also listed here as assistant surgeon to the

Dreadnought Seaman's Hospital, joint lecturer and demonstrator in anatomy to the Dreadnought Hospital, consulting surgeon to the Weir Hospital Balham, and clinical assistant to St. Peter's Hospital and St. Mark's Hospital.

**Sources:** *Medical Directory* (1921), p. 243; E.T.C. Milligan, 'A method of treatment of "shell shock"', *BMJ* 1916 (2), pp. 73-4

**(44) MOTT, Sir Frederick Walker, KBE (1853-1926)**

Frederick Mott studied medicine at University College, London, where he graduated MB, BSc in 1881, and MD in 1886. In 1883, he was appointed assistant professor of physiology at Liverpool University, but returned to London a year later to become lecturer in physiology at Charing Cross Hospital. This post he retained until 1895, afterwards holding lectureships on pathology (1900-03) and medicine (1907-13). He was elected assistant physician in 1890, physician in 1903, and consulting physician in 1913. In 1895 he was accepted the post of pathologist to the London County Council, but stipulated that he would retain his clinical appointment at Charing Cross Hospital, considering it essential that the study of diseased conditions should be combined with clinical observation. At the pathological laboratory of Claybury Asylum, he carried out and supervised world-class research. He established that general paralysis of the insane was a manifestation of syphilis, demonstrated the close relation between the nervous system and the sexual organs manifested in dementia praecox, and showed that thyroid deficiency and other endocrine disturbances could lead to deficient mental activity. On the outbreak of war he joined the RAMC with the rank of major, eventually becoming brevet lieutenant-colonel. In 1916 the Claybury laboratory was moved to the newly opened Maudsley Hospital, an institution which he had helped to plan from 1907, attached to the 4th London General Hospital. Mott here worked with shell-shocked men. In 1919 he was created KBE for his wartime services. In 1923 he retired from the post of pathologist, although he continued to teach at the Maudsley, and also accepted the post of lecturer in morbid psychology at the University of Birmingham. He held this position until the time of his death.

**Sources:** *MR4*, pp. 358-9; *ODNB*, vol. 39, pp. 498-9; F.W. Mott, 'The psychic mechanism of the voice in relation to the emotions', *BMJ* 1915 (2), pp. 845-7

**(45) MYERS, Charles Samuel (1873-1946)**

Charles Myers was educated at Gonville and Caius College, Cambridge, and proceeded MB at St. Bartholomew's Hospital in 1898. He was disinclined to medical practice and instead joined the 1898 Cambridge anthropological expedition to the Torres Strait, which also included W.H.R. Rivers and William McDougall. In 1902 he returned to Cambridge to help Rivers teach the physiology of the special senses. He remained in Cambridge to become, in succession, lecturer, demonstrator, and, in 1921, reader in experimental psychology. From 1906-1909 he was also professor in experimental psychology at King's College, London. On the outbreak of war he went to France, at first serving with a volunteer medical unit but eventually receiving a commission in 1915, and ending the war with the rank of lieutenant-colonel. In March 1915 he became attached to the staff of the Assistant Director of Medical Services at Boulogne, with responsibility for selecting cases of nervous and mental shock and neurasthenia for transfer to England. In August 1916 he was appointed Consulting Psychologist to the Army, but in January 1917 his duties were changed and restricted when he was made Neurologist to the South Sector. He had no special training in neurology, and believed the move had been largely political. He remained in the post until November 1917, when he returned to England. After the war he became dissatisfied with his post at Cambridge, believing that it offered few opportunities for the development of his practical interests, and feeling that official and academic circles showed little genuine interest in psychology. In 1922 he left Cambridge for London, thereafter devoting himself to the development of the National Institute of Industrial Psychology, which he had founded with Henry John Welch in 1921. He was also involved in what became the industrial health research board, and was the first president of the British Psychological Society. Although he wrote some extremely well-received books which went into several editions, including his *Text-book of experimental psychology* (1909), *Introduction to experimental psychology* (1911), and *Industrial psychology in Great Britain* (1926), his main contribution to psychology was to help establish pioneering institutions and to promote the science internationally.

**Sources:** *ODNB*, vol. 40, pp. 56-7; C.S. Myers, 'Contributions to the study of shell shock (II): being an account of certain cases treated by hypnosis', *Lancet* 1916 (1), pp.

65-9; C.S. Myers, 'A final contribution to the study of shell shock: being a consideration of unsettled points needing investigation', *Lancet* 1919 (1), pp. 51-4; C.S. Myers, *Shell shock in France 1914-1918: based on a war diary* (Cambridge: C.U.P., 1940)

**(46) ORMOND, Arthur William**

Arthur Ormond qualified MRCS, LRCP from Guy's Hospital in 1896. He held posts as surgeon to the Royal Eye Hospital, Southwark; ophthalmic registrar to Guy's Hospital; clinical assistant to the Royal London Ophthalmic Hospital; consulting ophthalmic surgeon to the Royal Asylum for the Deaf, Margate and to the London Orphan Asylum, Watford; and finally, ophthalmic surgeon to Guy's Hospital. During the war he attained the rank of captain in the RAMC, and served as officer in charge of ophthalmic wards, No. 2 General Hospital, Chelsea, and continued as ophthalmic surgeon to Guy's Hospital.

**Sources:** *Medical Directory* (1915), p. 283; A.W. Ormond, 'Ophthalmic injuries of warfare', *Practitioner* 96:5 (May 1916), pp. 491-500

**(47) PARSONS, Sir John Herbert, CBE (1868-1957)**

John Herbert Parsons was educated at University College Bristol and St. Bartholomew's Hospital, where he qualified in medicine in 1892 and graduated MB in 1902. After qualification he was appointed assistant professor of physiology at University College, London. For five or so years he was also in general practice, and during this time he began to concentrate his interest on ophthalmology, working as clinical assistant at the Royal London Ophthalmic Hospital, Moorfields. He was awarded the FRCS in 1900, and gave up general practice to begin the study of ophthalmology in its widest aspects. In 1904 he was elected to the staff of Moorfields, where he had previously been librarian and curator. He also became ophthalmic surgeon to University College Hospital, and remained on the staff of both these hospitals under the age fixed for retirement, when he joined the consulting staff. By 1914 he had acquired a prestigious reputation as an ophthalmologist, and had published

several books on the subject, including a textbook *Diseases of the Eye* (1907), which reached its twelfth impression in 1954.

During the war he was appointed ophthalmic consultant for the home troops, with the rank of colonel. The study of vision led him onto the overlapping territory of psychology, and he published *Mind and the nation: a study of applied psychology* in 1918. In 1919 he was appointed to the Advisory Council of the Air Ministry and three years later to the similar council of the Admiralty. In 1920 he was appointed to the Ministry of Health Committee on the Causes and Prevention of Blindness: he had served on committees dealing with the industrial aspects of ophthalmology before the war, but his interest had been particularly stimulated by accidental injuries among munitions workers. He was appointed CBE in 1919 and knighted in 1922. He was elected a Fellow of the Royal Society in 1921, was president of the Ophthalmological Society in 1925, president of the section of ophthalmology of the British Medical Association in 1923 and 1932, and president of the Royal Society of Medicine in 1936-8. At the time of the Munich crisis in 1938 he was made civil consultant to the RAF, and just before the Second World War he was appointed by the Secretary of State for Air as the only ophthalmic member of a committee to investigate and advise the Minister on the medical aspects of flying.

**Sources:** [Anon.], 'Obituary: Sir John Herbert Parsons', *BMJ* 1957 (2) [October 19 1957], pp. 945-6

#### **(48) PEARN, Oscar Phillips Napier**

Oscar Pearn graduated MRSC, LRCP, and LSA from the Westminster Hospital in 1907. He held posts as house surgeon to the West Hertfordshire Hospital, house surgeon to the Westminster Hospital, and then assistant medical officer to the Horton Asylum, Epsom. During the war he attained the rank of captain in the RAMC, and served at the Lord Derby War Hospital, Warrington, Lancashire. He published a book on *Mental deficiency nursing (simplified)* in 1931, at which time he was deputy medical superintendent to the Cane Hill Mental Hospital.

**Sources:** *Medical Directory* (1915), p. 910; O.P.N. Pearn, 'Psychoses in the Expeditionary Forces', *JMS* 65:269 (April 1919), pp.101-8; O.P.N. Pearn, *Mental deficiency nursing (simplified)* (London: Balliere, Tindall and Cox, 1931)

**(49) PEMBERTON, Hugh Spear (1890-1956)**

Hugh Pemberton qualified MB, ChB from Liverpool University in 1913, and joined the resident staff of the David Lewis Northern Hospital, Liverpool. The following year he was appointed clinical pathologist to the Hospital. He served throughout the war in the RAMC in France and later in Russia, and was mentioned in despatches in 1915 for gallant and distinguished services. On demobilisation in 1918 he was appointed assistant to the David Lewis Northern Hospital and reached senior consultant status in 1924. Though he was attached to the Liverpool Hospital for Women, the Liverpool Radium Institute, and the Neston and Hoylake and West Kirby Cottage Hospitals, all his time and interest throughout his life from the time he qualified were devoted to the Northern Hospital. From 1947-50 he was chairman of the Birkenhead and Wirral division of the British Medical Association, and was vice-president of the section of medicine at the annual meeting of the Association in 1950.

**Sources:** *MR5*, pp. 327-8; H.S. Pemberton, 'The psychology of traumatic amblyopia following the explosion of shells', *Lancet* 1915 (1), p. 967

**(50) PETERS, Edwin Arthur**

Edwin Peters graduated LRCP from Cambridge and Guy's Hospital in 1894, and MD in 1900. He held posts as house physician to Guy's Hospital, senior clinical assistant to the Royal Eye Hospital and Throat Hospital, Golden Square, and as surgeon to the Ear, Nose and Throat Department at Bolingbroke Hospital, to Paddington Green Children's Hospital, and to the Royal Ear Hospital. Before the war he published several articles on disorders of the ear, nose and throat. During the war he attained the rank of captain in the RAMC and served as surgeon to the Royal Ear Hospital, and aural surgeon to the Royal Victoria Hospital, Netley. In 1935 he published a book on *Tonsils and nasopharyngeal sepsis*, in which he was listed as consulting surgeon to the Royal Ear



Hospital, University College Hospital, London, and as president to the otological section of the Royal Society of Medicine.

**Sources:** *Medical Directory* (1915), p. 294; A.F. Hurst and E.A. Peters, 'A report on the pathology, diagnosis, and treatment of absolute hysterical deafness in soldiers', *Lancet* 1917 (2), pp. 517-9; E.A. Peters, *Tonsils and naso-pharyngeal sepsis* (London: Balliere, Tindall and Cox, 1935)

**(51) PRIDEAUX, Joseph Francis Engledue**

Engledue Prideaux graduated MRCS, LRCP from University College, London in 1908. He held posts as assistant medical officer to Banstead Asylum, assistant resident medical officer to the Brompton Hospital for Consumptives, and as Government medical officer in the Fiji Colonial Medical Services. During the war he attained the rank of captain in the RAMC, and served at Ewell War Hospital. In 1921 he was listed in the *Medical Directory* as physician in charge of the psychological department, Addenbrooke's Hospital, Cambridge, and as a Fellow of the Royal Society of Medicine, a member of the British Psychological Association, and a member of the Medico-Psychological Association.

**Sources:** *Medical Directory* (1921), p. 948; E. Prideaux, 'Stammering in the war psycho-neuroses', *Lancet* 1919 (1), pp. 217-8

**(52) READ, Charles Stanford**

Charles Stanford Read graduated MRCS, LRCP from University College, London, in 1896, MB in 1898, and MD in 1914. He held posts as clinical assistant to the West End Hospital for Nervous Diseases, resident medical officer to the North London Hospital for Consumptives and Diseases of the Chest, and assistant out-patient physician to University College Hospital. In 1907 he published a book on *How to keep well: practical hints on common ailments*, in which he was listed as a London County Council Lecturer. Immediately before the war he was employed as assistant medical officer to Fisherton House Asylum, Salisbury, Wiltshire. During the war he attained the rank of major, and was in charge of 'D' Block, Royal Victoria Hospital, Netley. In his

*Military psychiatry in peace and war* (1920) he stated that he had charge of neurological wards prior to this post, but did not state where, and claimed to have since visited all the war mental hospitals in France and Great Britain. He was here listed as physician to Fisherton House Mental Hospital, Salisbury.

**Sources:** *Medical Directory* (1915), p. 942; C.S. Read, *How to keep well: practical home hints on common ailments* (London: T. Fisher Unwin, 1907); C.S. Read, 'A survey of war neuro-psychiatry', *Mental Hygiene* 2:3 (July 1918), pp. 359-87; C.S. Read, *Military psychiatry in peace and war* (London: H.K. Lewis and Co., 1920)

**(53) REYNELL, Walter Rupert (1885-1948)**

Walter Reynell was educated at St. Peter's College, Adelaide (the place of his birth), and Balliol College, Oxford. In 1910 he entered Guy's Hospital where he was later house physician and house surgeon, and in 1913 he graduated BM, BCh. On the outbreak of war he joined the RAMC with the rank of captain and served in France with the Australian Voluntary Hospital, before he was recalled to the Coulter Hospital in London. From 1916 he worked at the military hospital at Seale Hayne, under his old teacher Arthur Hurst. He wrote his DM thesis (he obtained the qualification in 1918) on the treatment of shell-shock by suggestion, and subsequently specialised in psychiatry. After the war he became neurological specialist to the Ministry of Pensions. He was appointed to the honorary staff of the West End Hospital for Nervous Diseases in 1919, and later to the staff of the Royal Northern Hospital. He also operated a busy private psychiatric practice. Shortly after the outbreak of the Second World War he became a specialist in neuropsychiatry at the Military Hospital for Head Injuries at Oxford, where he carried out research on the value of psychometric tests in assessment and prognosis. After demobilisation he resumed practice in London.

**Sources:** *MR5*, pp. 345-6

**(54) RIVERS, William Halse Rivers (1864-1922)**

William Rivers graduated MB, MRCS from St. Bartholomew's Hospital in 1886, the youngest medical graduate in the history of the hospital to this date. In 1887 he

travelled to Japan and North America as a ship's surgeon, and passed the next few years in junior appointments at St. Bartholomew's, the Chichester Infirmary, the National Hospital for the Paralysed and Epileptic, and the Bethlem Royal Hospital. He obtained the MD in 1888 and FRCP in 1899. In 1892 he studied insanity and psychology at Jena with Ewald Hering. In 1893 he lectured on psychology at Guy's Hospital and University College, and spent the summer in Heidelberg working with Emil Kraepelin on the effects of fatigue. In the same year he was invited to work and lecture on the physiology of the sense organs at Cambridge, where he was later appointed University lecturer in psychology (1897), a fellow of St. John's College (1902), and lecturer in physiology and experimental psychology (1907). In 1898 he accompanied the Cambridge anthropological expedition to the Torres Straits, from which he returned a keen ethnologist. He undertook further anthropological expeditions to Southern India (1902), and Melanesia (1908 and 1914). From 1903-1908 he was also involved with Henry Head on research on protopathic and epicritic sensation. He was made a Fellow of the Royal Society in 1908 and awarded its gold medal in 1915.

In July 1915 he joined the Maghull Military Hospital as a physician, and in 1916 was commissioned as a captain in the RAMC. In October that year he was posted to Craiglockhart War Hospital, and in 1917 he became consulting psychologist to the Royal Flying Corps Central Hospital, Hampstead. Between 1918 and 1919 he was also on the staff of the Empire Hospital for Officers, Vincent Square, London. He returned to St. John's as praelector in natural sciences after the war, and published *Instinct and the unconscious: a contribution to a biological theory of the psycho-neuroses* in 1920. The universities of Manchester, St. Andrews and Cambridge awarded him honorary degrees in 1919. At the time of his death he was president of the Royal Anthropological Institute and the Folklore Society.

**Sources:** *MR4*, pp. 413-4; *ODNB*, vol. 47, pp. 48-9

**(55) RIXON, Christopher Hugh Leete**

Christopher Rixon graduated MRCS, LRCP from St. Thomas' Hospital in 1911, and MD from the University of Brussels in 1920. Before the war he held posts as house physician and as casualty officer at St. Thomas' Hospital. He attained the rank of captain in the RAMC during the war and served as neurologist to the Reading War

Hospital. In 1921 he was employed as senior neurologist to the Ministry of Pensions Neurological Hospital, Exeter.

**Sources:** *Medical Directory* (1915), p. 309; *Medical Directory* (1921), p. 970; C.H.L. Rixon, 'The hysterical perpetuation of symptoms', *Lancet* 1919 (1), pp. 417-9

**(56) ROSS, Thomas Arthur (1875-1941)**

Thomas Ross was educated at the University of Edinburgh, where he graduated MB, CM (1897) and MD (1901). After appointments as house physician and house surgeon at the Royal Infirmary, Edinburgh, he joined a general practice on the Isle of Wight. He was later appointed physician to the Royal National Hospital, and also worked at a nursing home for patients with nervous diseases. He became convinced that in treatment the patient must be persuaded that his illness was the solution for a difficult personal problem which could be resolved only by a readjustment to his environment. He found support for this idea in the writings of Dubois and Déjerine. During the war he attained the rank of captain in the RAMC, and was in charge of a division of Springfield War Hospital. In 1919 he was appointed medical director to the Cassel Hospital in Kent, and remained in this post until a coronary thrombosis forced his retirement in 1934. He then settled in private practice in London, but was persuaded in 1939 to act as psychotherapist to the Woodside Hospital and to give lectures to medical officers of the Armed Forces. He served on three special BMA committees – on research in mental disease, mental health, and psychoanalysis – and was president of the psychiatric section of the Royal Society of Medicine in 1936.

**Sources:** *MR5*, pp. 359-60; T.A. Ross, 'The prevention of relapse of hysterical manifestations', *Lancet* 1918 (2), pp. 516-7

**(57) ROWS, Richard Grundy (d. 1925)**

Richard (known as Ronald) Rows proceeded MD from University College, London in 1892. He held posts as senior obstetric assistant at University College Hospital, assistant medical officer at the City Asylum, Birmingham, and at the County Asylum, Prestwich, Manchester, and as assistant medical officer and pathologist to the County

Asylum, Lancaster. He was a member of the Medico-Psychological Association and the Pathological Society of Great Britain. In 1904 he translated, with David Orr, Lugaro's *Modern problems in psychiatry*. Before the war he was a keen campaigner for the early treatment of mental disorders and the institution of psychiatric training. During the war he was medical superintendent to Maghull Military Hospital, with the rank of major in the RAMC. In 1926 his book on epilepsy was posthumously published. He was there listed as pathologist and medical officer to the County Mental Hospital, Prestwich, Manchester.

**Sources:** *Medical Directory* (1915), p. 967; E. Lugaro, *Modern problems in psychiatry*, translated by David Orr, M.D., and R.G. Rows, M.D. (Manchester: Victoria University, 1904); R.G. Rows, 'Mental conditions following strain and nerve shock', *BMJ* 1916 (1), pp. 441-3; R.G. Rows and W.E. Bond, *Epilepsy, a functional mental illness: its treatment* (London: H.K. Lewis & Co., 1926); B. Shephard, "The early treatment of mental disorders": R.G. Rows and Maghull 1914-1918', in H. Freeman and G.E. Berrios (eds), *150 years of British psychiatry, volume 2: the aftermath* (London and New Jersey: Athlone, 1996), pp. 434-64

#### **(58) SAVAGE, Sir George Henry (1842-1921)**

George Savage received his medical training at the Sussex County Hospital and Guy's Hospital, and qualified MD in 1864. He held resident appointments at Guy's and at the Bethlem Royal Hospital, and then passed a few years in general practice in Cumberland. He returned to Bethlem as assistant medical officer in 1872, and in 1878 succeeded to the post of resident physician, which he retained until 1888. He was also consulting physician to the Royal Institution for the Mentally Deficient, Earlswood, for twenty years, and lecturer on mental diseases at Guy's. He examined in mental pathology for London University, and was elected to the presidency of the Medico-Psychological Association in 1886. He was joint editor of the *Journal of Mental Science* with Daniel Hack Tuke for some years, and also wrote a popular textbook on *Insanity and allied neuroses* (1894). He was knighted in 1912. During the war he was consulting physician to Guy's Hospital.

**Sources:** *MR4*, pp. 306-7; G.H. Savage, 'Mental war cripples', *Practitioner* 100:1 (January 1918), pp. 1-7

**(59) SCOTT, Frederick Gilbert Laughton**

Laughton Scott graduated MRCS, LRCP from Guy's Hospital in 1914, where he also held the post of senior assistant to the neurological department. During the war he was medical superintendent to the Home of Recovery for Officers, Golders Green, and in its later years also worked at the Lancaster Clinic for Psychotherapy. In 1921 he was employed as senior physician to the London Neurological Clinic, and was also honorary secretary to the Lancaster Medical Society for the Study of Psychotherapy.

**Sources:** *Medical Directory* (1921), p. 304; L. Scott, 'Hysterical "paralysis" of long standing', *Practitioner* 101:2 (August 1918), pp. 97-9; L. Scott, 'The anxiety state – an aspect of treatment', *Practitioner* 102:4 (April 1919), pp. 222-4

**(60) SMITH, Sir Grafton Elliot (1871-1937)**

Grafton Elliot Smith graduated MB, ChM from Sydney University in 1893. He held posts as demonstrator of anatomy at Sydney University, and as a resident at the Prince Albert Hospital. In 1896 he won a travelling fellowship and gained admittance to St. John's College, Cambridge, where he was appointed a demonstrator of anatomy and elected a fellow in 1899. A year later he left Cambridge to become the first professor of anatomy in the new Government School of Medicine at Cairo. He there became interested in anthropology and published his observations on the life-history of the inhabitants of the Nile Valley during the tenure of next appointment, the chair of anatomy at Manchester University (1909-1919). He received the Royal Medal of the Royal Society in 1912. His work on shell-shock during the war was based on observations made at Maghull Military Hospital. He also represented Manchester University on the General Medical Council from 1913-1919. His last post was professor of anatomy at University College, London (1919-1936). He was knighted in 1934.

**Sources:** *MR4*, pp. 545-6; G.E. Smith, 'Shock and the soldier. I', *Lancet* 1916 (1), pp. 813-7

**(61) SMURTHWAITE, Henry**

Henry Smurthwaite qualified MD from Durham University in 1902. He was listed in the *Medical Directory* of 1915 simply as 'travelling'.

**Sources:** *Medical Directory* (1915), p. 1003

**(62) STEWART, Sir James Purves, KCMG, CB (1869-1949)**

James Purves Stewart graduated MB, CM from the University of Edinburgh in 1894. He held house appointments at the Royal Infirmary, Edinburgh, and was assistant to the professors of physiology and medicine at Edinburgh University. He then held a house appointment at the National Hospital for the Paralysed and Epileptic, where he laid the foundations of his career as a neurologist. In the South African campaign he served in the Imperial Yeomanry Hospital from 1900-1. On his return to London, after visits to the Jena and Frankfurt medical schools, he became assistant physician to the Westminster Hospital, where he also lectured on pharmacology, therapeutics, and diseases of the nervous system. When he retired in 1931 he was made a consulting physician. He also held honorary appointments at the West End Hospital and the Central London Throat and Ear Hospital. In 1906 he published *Diagnosis of nervous diseases*, which had reached its tenth edition by 1947 and was translated into French, German, Spanish, and Arabic. During the war he served as consulting physician in the Mediterranean and Near East theatres. He was created CB in 1916 and KCMG in 1918.

**Sources:** *MR4*, pp. 477-8

**(63) SYMNS, Jasper Llewellyn Montfort**

Jasper Symns undertook clinical training at Guy's Hospital and graduated MRCS, LRCP (1911) and MB, BC (1913). He held posts as assistant house surgeon, house surgeon, and out-patient officer at Guy's Hospital, and surgeon to All Hallows Country

Hospital, Ditchingham. During the war he attained the rank of captain in the RAMC. He served first with the 29th division in the field during the Gallipoli campaign (April-November 1915), and then in the neurological department at the Royal Victoria Hospital, Netley.

**Sources:** *Medical Directory* (1915), p. 1030; A.F. Hurst and J.L.M. Symns, 'The rapid cure of hysterical symptoms in soldiers', *Lancet* 1918 (2), pp. 139-41; J.L.M. Symns, 'Hysteria as seen at a base hospital', *Practitioner* 101:2 (August 1918), pp. 90-6

#### **(64) TOMBLESON, Jasper Bennett**

Jasper Tombleson graduated MB, BCh from Oxford University and St. Thomas' Hospital in 1896. He held posts as medical officer in the West African Medical Staff, South Nigeria, honorary physician to Hounslow Cottage Hospital, senior obstetrician and honorary physician to St. Thomas' Hospital, and medical director of a hospital in Mexico. No information has been found on his wartime posts, although he was a lieutenant in the RAMC. In 1928 he published *As above, so below: being a study of consciousness and form with an attempt at synthesis*, a lengthy argument that there was no real conflict between 'real religion' and 'true science'.

**Sources:** *Medical Directory* (1915), p. 1048; J.B. Tombleson, 'An account of twenty cases treated by hypnotic suggestion', *Journal of the RAMC* 29:3 (September 1917), pp. 340-6; J.B. Tombleson, *As above, so below: being a study of consciousness and form with an attempt at synthesis* (London: William and Norgate Ltd., 1928)

#### **(65) TOOTH, Howard Henry, CB, CMG (1856-1925)**

Howard Tooth was educated at St. John's College, Cambridge, and St. Bartholomew's Hospital, where he qualified MD in 1888. He held a number of junior appointments at St. Bartholomew's before his election as assistant physician in 1895. He became full physician in 1906 and consulting physician in 1921. He was also connected throughout his career with the Metropolitan Hospital, to which he was appointed assistant physician in 1881, physician in 1891, and consulting physician in 1896, and with the National Hospital for the Paralysed and Epileptic, where he became assistant physician



in 1887, physician in 1907, and consulting physician in 1921. During the Boer War he served as physician to the Portland Hospital in South Africa, and after his return he commanded the Medical Unit of the London University Officer Training Corps. During the first half of the 1914-1918 war he was in charge of the 1st London General Hospital, and after 1916 he acted as consulting physician, with the rank of colonel, firstly at Malta and latterly with the forces in Italy. He was created CMG in 1901 and CB in 1918. His writings dealt mainly with neurology. He was a Censor of the Royal College of Physicians, and examiner on medicine for the Universities of Cambridge and Durham.

**Sources:** *MR4*, p. 331

**(66) TOWNEND, Robert Ockleston**

Robert Townend graduated MRCS, LRCP from the London Hospital in 1916. He held post as clinical assistant surgeon to outpatients, and house physician, to the London Hospital. In July 1917 he was serving as a temporary surgeon in the Royal Navy; the same position was given in his entry in the *Medical Directory* for 1919.

**Sources:** *Medical Directory* (1919), p. 360; R.O. Townend, 'Two cases for comment', *Practitioner* 99:1 (July 1917), pp. 88-91

**(67) TROTTER, Robert Hale**

Robert Trotter graduated MRCS, LRCP from Leeds University in 1895, and qualified MD in 1901. He held the post of house surgeon to the Leeds General Infirmary. He was then employed as a Medical Officer of Health for the combined districts of Holmfirth, Honley and Holme. During the war he attained the rank of major in the RAMC and served as officer in charge of medical wards at Huddersfield War Hospital.

**Sources:** *Medical Directory* (1915), p. 1052; R.H. Trotter, 'Neurasthenic and hysterical cases in general military hospitals', *Lancet* 1918 (2), pp. 703-4

**(68) TURNER, William Aldren, CB (1864-1945)**

William Aldren Turner graduated MB, CM from Edinburgh University in 1887. He completed a term as house physician at the Edinburgh Royal Infirmary, and then made postgraduate studies at Berlin and St. Bartholomew's Hospital. In 1892 he was appointed assistant and demonstrator, and then lecturer, in neuro-pathology at King's College, London. In 1899 he was elected assistant physician to King's College Hospital, and nine years later physician in charge of neurological cases and lecturer on neurology. For six years he was also on the staff of the National Hospital for the Paralysed and Epileptic. In 1907 he published *Epilepsy: a study of the idiopathic disease*, and in 1910, with Grainger Stewart, a *Textbook of nervous diseases*. On the outbreak of war he went to France as consulting neurologist to the War Office, with the rank of lieutenant-colonel. He resigned from the post in March 1915, and for the rest of the war served as consulting neurologist to the home forces, eventually with the rank of major. In 1917 he was created CB. From 1919 to 1943 he acted as neurologist to the War Office Medical Board, and from 1930 to 1943 as consultant advisor to the Ministry of Pensions.

**Sources:** *MR4*, pp. 390-1; W.A. Turner, 'The Bradshaw lecture on neuroses and psychoses of war', *Lancet* 1918 (2), pp. 613-7; C.S. Myers, *Shell shock in France 1914-1918: based on a war diary* (Cambridge: C.U.P., 1940), p. 15

**(69) VEALE, Rawdon Augustus (1873-1954)**

Rawdon Veale was educated at Queen's College, Oxford and Leeds Medical School. He qualified MB, BS in 1906, and MD in 1910. He held a series of resident appointments at the Leeds General Infirmary, and was appointed resident medical officer in 1909. In 1912 he was elected an assistant physician, in 1922 physician-in-charge of out-patients, and in 1925 full physician. He retired in 1933. During the war he served with the RAMC in France, ultimately holding the rank of lieutenant-colonel. On his return to Leeds he was appointed lecturer in clinical medicine and diseases of the skin, and was responsible for organising the dermatological department. In 1925 he was appointed to the part-time chair of therapeutics which he held until 1932, and in the year prior to his retirement he held the chair of clinical medicine. In addition to his

appointment at the Infirmary, he held appointments at the Leeds Maternity Hospital, the Leeds Public Dispensary, and the St. James' Hospital. After his retirement he continued to practise, and during the Second World War took up the duties of some of his younger colleagues who were on active service, and taught therapeutics. He was extremely interested in the training and welfare of nurses, and was an active member of the Nursing Committee, responsible for the interviewing and medical examination of all applicants.

**Sources:** *MR4*, pp. 431-2

#### **(70) WEATHERLY, Lionel Alexander**

Lionel Weatherly qualified MD from Aberdeen University in 1877. He held posts as medical officer to the Portishead Dock Company and as physician to the Portishead Dispensary. He was president of the Bath and Bristol branch of the British Medical Association in 1898-99. In the Medical Directory for 1915, he was listed as the proprietor and resident licensee of Bailbrook House, a private asylum. In 1918 he published *A plea for the insane: the case for reform in the care and treatment of mental diseases*. Here he explained that for the first thirteen years of his medical career, while employed as 'a large country practice', he became interested in the treatment of mental diseases. For several years his own house was 'a licensed house for the reception of two ladies', and he also frequently visited the Bristol City Asylum for the purpose of study.

**Sources:** *Medical Directory* (1915), p. 1080; L.A. Weatherly, *A plea for the insane: the case for reform in the care and treatment of mental diseases* (London: Grant Richards Ltd., 1918), p. 103 and p. 120

#### **(71) WHITE, Ernest William**

Ernest White qualified MB from King's College, London, in 1884. He held posts as senior assistant medical officer to the Kent County Asylum at Chartham, and as resident superintendent of the London Asylum near Dartford (1887-1905). He was professor of medicine at King's College, London from 1890-1910, and Emeritus

Professor from 1910 until at least 1915. He was also president of the Medico-Psychological Association, and honorary secretary of its south-eastern division. The *Medical Directory* of 1915 lists a series of articles on insanity and its treatment he published between 1884 and 1907. From 1916-1918 he held the rank of lieutenant-colonel in the RAMC, serving as consultant in mental diseases to the Western Command and inspector of shell-shock and neurasthenic patients in general, sectional, auxiliary, military, Red Cross and VAD hospitals in Britain.

**Sources:** *Medical Directory* (1915), p. 375; E.W. White, 'Observations on shell shock and neurasthenia in the hospitals in the Western Command', *BMJ* 1918 (1), pp. 421-2

**(72) WILLIAMSON, Richard Thomas (1862-1937)**

Richard Thomas studied medicine at Owen College, Manchester, qualifying in 1884 and afterwards visiting Vienna. He held junior appointments at the Manchester Royal Infirmary, the Birmingham School of Medicine, the Royal Ophthalmic Hospital, and the National Hospital for the Paralysed and Epileptic. In 1892 he returned to Manchester to become registrar at the Royal Infirmary, where after ten years he was appointed assistant physician and subsequently physician. He also belonged to the staff of the Ancoats Hospital for a period. He made neurology and diabetes mellitus his special interests, and for many years lectured on neurological subjects at Victoria University, in the capacity of assistant lecturer on medicine; in due course, he became lecturer on medicine and on school hygiene. His book on *Diseases of the spinal cord* (1908) confirmed his reputation as a leading neurologist. During the war he served as neurologist in the 2nd Western General Hospital, but failing health obliged him to retire in 1917. He devoted himself to general and medical history for the rest of his life.

**Sources:** *MR4*, p. 425

**(73) WILTSHIRE, Harold Waterlow, DSO, OBE (1879-1937)**

Harold Wiltshire was educated at Clare College, Cambridge and undertook clinical training at King's College Hospital, London. After he qualified in 1904, he was given a series of junior appointments in King's College Hospital and in 1910 was appointed to

the staff as assistant physician, becoming full physician seven years later. He was also physician to the Royal Northern Hospital for a brief period. During the war he served in France and Salonika, reaching the rank of major and being awarded the DSO in 1918 and the OBE a year later. He returned to King's in 1919 to take charge of the cardiological department. In 1922 he gave up his private practice in order to devote his whole energy to teaching and administration, adding the work of demonstrator in morbid anatomy to his lectures on the practice of medicine. In 1925 he was forced by ill health to retire and was appointed consulting physician to the hospital.

**Sources:** *MR4*, pp. 549-50; *Medical Directory* (1915), p. 382; H. Wiltshire, 'A contribution to the etiology of shell shock', *Lancet* 1916 (1), pp. 1207-12

#### **(74) WOLFSOHN, J.M.**

At the heading of the article he published in 1918, Wolfsohn was listed as assistant professor of nervous diseases, Leland Stanford Junior University, California. The article was based on observations made at the Maudsley extension of the 4th London General Hospital. No further biographical information could be found.

**Sources:** J.M. Wolfsohn, 'The predisposing factors of war psycho-neuroses', *Lancet* 1918 (1) [February 2 1918], pp. 177-80

#### **(75) YEALLAND, Lewis Ralph (1885-1954)**

Lewis Yealland was born and educated in Canada. During the First World War he was resident medical officer and then registrar at the National Hospital, Queen Square. Shortly afterwards he was appointed to the staff of the West End and the Prince of Wales Hospitals, and lecturer at the North-East London Post-Graduate College and the Bethlem Royal Hospital. For his work as Canadian representative on the Executive Committee of the Universities Bureau of the British Empire his parent university granted him an honorary DSc. He had a special interest in epilepsy, and in his later years devoted much time to trying to reform alcoholics.

**Sources:** *MR5*, p. 465

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'Discussion: war psychoses and psychoneuroses', *JMS* 64:265 (April 1918), pp. 234-8

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[Anon.], 'Medical societies: Liverpool Medical Institution', *Lancet* 1910 (1) [April 9 1910], pp. 1001-2

[Anon.], 'Freud's theory of hysteria and other psychoneuroses', *Lancet* 1910 (1) [May 21 1910], pp. 1424-25

[Anon.], 'The nerves of a telephone operator', *Lancet* 1910 (2) [July 9 1910], p. 114

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