

Shell Shock and the Doctors who Defined It:  
A Study of the Medical Field's Reaction to Mental Illness  
During the First World War

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In World War I, shell shock became another feature of the traumas suffered by countries that had lost and killed millions of their young men, destroyed cities, permanently scarred the landscapes of their countryside, and created a legacy of tragedy and loss that survived for more than a century. Although shell shock did not have the same visible consequences as amputees and pockmarked fields, the effect large populations of young men with mental illnesses contributed to the concept that modern warfare was synonymous with mental trauma and strain. Through this connection, doctors all over the world rushed to understand the phenomenon that affected huge portions of their military, and attempted to alleviate the conflict that was preventing more soldiers from returning to the trenches to defend their homeland.

Shell shock and the study of warfare's impact on an individual's mental and physical health has been a popular topic of interest for historians over the last few decades. It is possible to attribute this popularity to the growing attention paid to the mental health of soldiers in the wars of the second half of the twentieth century and beginning of the twenty-first, such as the Vietnam War and the numerous wars in the Middle East. World War I has prompted copious study because to many historians, it is the first "modern" war, and in this case, it was the first time that mental trauma had been seen on as large a scale. The study of these soldiers who felt the strains of war fatigue would be one of the first major studies of mental illness and neurology that had been undertaken. These foundational works of study during the war by doctors, serve as a beginning to understanding psychology in times of trauma and as evidence of the consequences of industrial modern warfare. Throughout these studies, doctors experiment with treatments in the hopes of eradicating the mental strain and understanding the complexities of mental illnesses. These treatments sometimes seem barbaric or recognizably modern, but regardless of the

method, these doctors had limited sources to prepare them for extensive work in the fields of psychology and mental health.

For many of the British doctors that became involved in treating and researching shell shock, many historians have argued that there are only two sides to discussing treatment for shell shock. One side is the extreme physical treatment methods of shell shock, which included electro-therapy, considered a stark contrast from the sensitive and gentle treatments of psychoanalysis. Two doctors who represent these differences the best are Dr. Lewis Yealland and Dr. W.H.R. Rivers. Firstly, Dr. Yealland used physical treatments for what he believed was a physical ailment; alternatively, Dr. Rivers pursued psychoanalysis to cure what he considered were mental traumas. This argument is the “Maghull vs. Maudsley” debate, named after the two most popular hospitals for shell shock research that both Yealland and Rivers worked with, which adds to the suggestion that there was a marked difference between approaches to the treatment of shell shock.

In her book, *The Female Malady: Women, Madness, and English Culture, 1830-1980*, Elaine Showalter asserts that the first response to treating shell shock was to find “explanations for their conditions in food poisoning, noise, or “toxic conditions of the blood’.”<sup>1</sup> While this statement is not untrue, her study follows a very similar arc of the legend of shell shock treatment in the First World War, that suggests that the treatments were outdated and barbaric before psychoanalysis became a legitimate and popular form of treatment. There is a common narrative found in Showalter, as in other sources, that create a dark torturous world for shell

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<sup>1</sup> Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (Penguin Books, 1985), 170.

shock patients, until Dr. Rivers arrives, shedding a light on the possibilities of humane and sensitive treatments of psychoanalysis.

Ben Shepard continues this trope in his book, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century*, when he proposes that the differing treatments were between the “active cure,” that included light labor and exercise, and the mental cure. He argues that treatments like Dr. Yealland’s electro-therapy and doctors like Dr. Arthur Brock (doctor of the poet Wilfred Owen) and Dr. Arthur Hurst’ emphasis on quiet atmospheres and busy work were unsuccessful until “new psychological methods of treatment were...developed.”<sup>2</sup> Shepard does study numerous doctors of the period who participated in different methods, but still divides them into analytical and physical treatments.

Edgar Jones also favors this theory in his essay, “Shell Shock at Maghull and the Maudsley: Models of Psychological Medicine in the UK”, in which he divides the major doctors researching shell shock into the two categories of physical treatments and psychological treatments. He suggests that, “Although staff transferred between the two hospitals, each institution developed a distinct style.”<sup>3</sup>

The problem with defining the treatments for shell shock as two opposing forces is that it negates the fact that many of these doctors defined shell shock differently. Some viewed it as a physical consequence of the noises and conditions of war, while others viewed it as a psychological issue that stemmed from the horrors of the battlefield. A few historians have understood this issue and suggested that the treatments consisted of a variety of theories and

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<sup>2</sup> Ben Shepard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, MA; Harvard University Press, 2001), 75.

<sup>3</sup> Edgar Jones, “Shell Shock at Maghull and the Maudsley: Models of Psychological Medicine in the UK,” *Journal of the History of Medicine and Allied Sciences* 65 (July 2010): 370

methods sometimes to treat one symptom, like tremors and muteness, or all of the symptoms, physical and mental. Whether these symptoms were physical, such as tremors, muteness, blindness or paralysis, or psychological, in many cases nightmares, depression, and debilitating anxiety, historian Peter Leese reasons that these doctors represented a wide spectrum of overlapping and opposing ideas when it came to the treatment of shell shock.

In Leese's book, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War*, he suggests that shell shock was not a new phenomenon, but instead it was a consequence of the Industrial Revolution that began in England a half a century before. Industrialism introduced the public to large-scale industrial injuries, such as railroad and factory accidents, that were more violent and prevalent than workplace or transportation accidents had been in previous generations.<sup>4</sup> These incidents brought about new traumas that demanded new studies, but it was not until the First World War that the cases of the new "hysteria" grew exponentially and demanded a more thorough study. However, Leese does point out that between the American Civil War and the First World War that "military medicine responded...to the new mechanical and chemical technologies as their implications for the conduct of modern combat were played out."<sup>5</sup> The period between these two wars that presented a new casualty of war, suggested to many doctors that the different methods of "modern" warfare would increase the number of "mental casualties."<sup>6</sup> When the war began in 1914, many of the military leadership "rejected shell shock because it threatened discipline among the rank and file."<sup>7</sup> Many of the treatments to abate or dull shell shock in the trenches were through military rituals, alcohol

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<sup>4</sup> Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (New York: Palgrave Macmillan, 2002), 15- 17.

<sup>5</sup> Leese, *Shell Shock*, 18.

<sup>6</sup> Leese, *Shell Shock*, 20.

<sup>7</sup> Leese, *Shell Shock*, 30.

and repression.<sup>8</sup> When this treatment was not enough, Leese claims that the British doctors “preferred not to adhere to strict schools of thought, but to take a generalist, ‘objective’ approach to mental conditions.”<sup>9</sup> Leese describes this treatment as “improvisation” that included doctors from all aspects of British society, including psychiatrists from asylums and researchers from medical and educational institutions.<sup>10</sup> Through his study of the various treatment centers, especially focusing on one that was notorious for its physical treatment that was influenced by animal training<sup>11</sup>, Leese admits that there is great difficulty in “adhering to the disciplinary/analytic dichotomy” even within this one facility.<sup>12</sup> Leese’s argument is important because it is one of the few theories that acknowledges the complexities of the British medical field. It promotes an idea that suggests that these doctors were not isolated or dogmatic in their treatments of shell shock, and in many ways worked off one another and experimented with various treatments, contradicting many historians’ arguments that the issue of shell shock was distinctly divided between schools of thought.

In her article, “Early British Psychoanalysis and the Medico-Psychological Clinic,” historian Suzanne Raitt also acknowledges the multifaceted aspects of treatment amongst many doctors treating shell shock. In her study, she focuses mainly on the creation of psychoanalysis clinics, but while these clinics were places that emphasized psychological treatment, they also offered “occupational treatment” that included “music...dancing, games, gardening” that would “provide ‘outlets for patients’ resuscitated energies.”<sup>13</sup> Although, not as extensive a study as Leese’s work, Raitt’s study of these clinics that catered to mental illnesses and shell shock does

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<sup>8</sup> Ibid.

<sup>9</sup> Leese, *Shell Shock*, 70.

<sup>10</sup> Leese, *Shell Shock*, 71.

<sup>11</sup> Leese, *Shell Shock*, 74.

<sup>12</sup> Leese, *Shell Shock*, 78.

<sup>13</sup> Suzanne Raitt, “Early British Psychoanalysis and the Medico-Psychological Clinic,” *History Workshop Journal* 58(2004): 74.

suggest that there is not a rigid distinction between analytical or physical methods of treatment that many historians argue exists.

These broader understandings of shell shock treatments during the First World War exist within the writings of the leading doctors who applied both physical and psychological methods to cure the problem of war neuroses. Unlike many historians have suggested, there are not two distinct views of treatments, instead, in the approach to curing shell shock there are a variety of ideas that overlap and contradict each other.

In this wide spectrum of treatments, the most extreme is Dr. Lewis Yealland. Yealland was a physician at the National Hospital for Paralysis and Epilepsy and was unique in the passion he had for using electricity to treat his patients. As a treatment, the majority of doctors in this time use electricity to help alleviate physical symptoms, however the extent that Yealland uses this method goes beyond any practices by his medical colleagues. In his book, *The Hysterical Disorders of Warfare*, he catalogues his cases by physical ailment and documents his treatment methods and the amount of time it takes to cure the patient. Treatments lasting over four hours are rare, and many of them only take twenty minutes to an hour. In the preface of his book, written by Edward Farquhar Buzzard, he is applauded for throwing himself into the treatments with “characteristic energy, and soon realized that what may be called an intensive method of treatment gave better results than the more prolonged measures generally adopted.”<sup>14</sup>

Although his treatments were efficient and returned the soldiers to duty on the front quickly, throughout his writings, there is a disturbing element of megalomania and resentment towards his patients, who he believes are weaklings or malingerers. He accuses his patients of

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<sup>14</sup> Lewis R. Yealland, *The Hysterical Disorders of Warfare* (London: Macmillan, 1918), 1.

“negativism” often, implying that they are physically unable to respond to treatment quickly, and a suggestion to him that they are mentally resisting his methods, and purposefully being insubordinate. This is especially apparent when introduces the patients into the case study who he describes as “a sulky school boy”<sup>15</sup> or “obstinate and intractable.”<sup>16</sup> This condescension towards “negativistic” behavior made him question whether these poor attitudes and physical delays were the “physical manifestation of general negativism,” and if that were the case, a patient’s own behavior and personality would then be the cause of their hysteria.<sup>17</sup> Attributing shell shock symptoms to personality and character, as well as family medical history is a common method many of the doctors use to understand the background of the patient’s illness. Oftentimes, the judgments based on a patient’s character are often times moralistic and based on class and educational differences.

Yealland’s candid case studies reveal more about his behavior than the conditions of his patients. There are many instances where he continues his electro-therapy even when the patient refuses, begins to cry, collapses in exhaustion, and complain of pain. One patient faints halfway through the treatment and Yealland’s response is to continue administering electricity until the patient regained consciousness, an instance that Yealland described as “splendid.”<sup>18</sup> In one situation a patient brought in to Yealland’s care for an examination of his hand paralysis refused electro-therapy and Yealland responded by threatening the patient with an accusation of “grave military offence” that would lead to his punishment as a malingerer if he did “not accept the treatment.”<sup>19</sup> Malingerers were a bitter subject for Yealland who targeted them and studied the best methods to ensure that they would not be accepted into long-term medical treatment for

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<sup>15</sup> Yealland, *Hysterical Disorders*, 13.

<sup>16</sup> Yealland, *Hysterical Disorders*, 4.

<sup>17</sup> Yealland, *Hysterical Disorders*, 31.

<sup>18</sup> Yealland, *Hysterical Disorders*, 81.

<sup>19</sup> Yealland, *Hysterical Disorders*, 38.



pretend ailments. In his book, he dedicated an entire chapter to explain the methods he uses in exposing the “supposed sufferer,”<sup>20</sup> including giving high doses of electro-therapy until they exclaim ““You have beaten me; you have beaten me; I’ll give in to you”” and the patient admits, “he had been shamming.”<sup>21</sup>

The problem with Yealland’s writings that make it difficult to understand his place in the medical field is that every case study follows the same narrative. It begins with a doubtful patient questioning the effectiveness of Yealland’s work, Yealland smirking at their ignorance, treating them in less than an hour and being hailed by his patients as a miracle worker who turned them into heroes, and in one case, a “champion.”<sup>22</sup> It seems very unlikely that this reaction would be common, especially considering the verbal abuse he gives to his patients. This includes calling his patients “emotional Irishmen”, “stupid”, “lazy brain,” and “gloomy,” while also comparing their condition to that of a fragile and hysterical woman.<sup>23</sup> In an even more extreme method that would stun other doctors, Yealland tells his patients that he does not care about what their traumatic war experiences were, just that he will fix them, suggesting that Yealland is more of a repairman in a factory than a doctor. He also demands that one of his patients, who almost collapsed during treatment “behave as becomes the hero I expect you to be, a man...should have better control of himself.”<sup>24</sup> The use of guilt and degradation is unique to Yealland, and while many doctors try to enforce some element of military discipline, Yealland goes beyond what most medical professionals would assume to be reasonable.

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<sup>20</sup> Yealland, *Hysterical Disorders*, 97.

<sup>21</sup> Yealland, *Hysterical Disorders*, 98.

<sup>22</sup> Yealland, *Hysterical Disorders*, 9.

<sup>23</sup> Yealland, *Hysterical Disorders*, 3-100.

<sup>24</sup> Yealland, *Hysterical Disorders*, 7.

The doctor that better exemplifies physical treatment is Dr. F.W. Mott, a neurologist who worked with Yealland, but proves to be substantially more thorough in his research of shell shock. In 1919, he published his findings in his book, *War Neuroses and Shell Shock*, arguing that the family and personal medical history was vital in understanding the hereditary links that would predispose an individual to shell shock or hysteria. Like Yealland, he also believes that a person's character and emotions contribute to the likelihood of suffering from the physical effects of shell shock.<sup>25</sup> The majority of Mott's work suggests that he believes very strongly in examining all aspects of the patient for diseases and ailments to rule out additional causes that could mask themselves in the symptoms of shell shock. As a neurologist, Mott studies nerve and spinal damage, as well as disruptions of the thyroid gland that could contribute to shell shock symptoms, such as "a sudden fall of blood pressure" and "arrest of function of the vaso-motor center...followed by anemia causing loss of consciousness."<sup>26</sup> This shut down of the internal organs could lead to what Mott calls "psychic deafness, blindness, mutism and amnesia" and cause doctors and patients to believe that they have been incurably damaged by the mental strain of war.<sup>27</sup> A common ailment attributed to patients who have been labeled as suffering from shell shock, Mott believes, are actually suffering from Grave's disease, or exophthalmic goiter, indicating that "the endocrine glands are profoundly affected" by the strains of war.<sup>28</sup> Grave's disease is an extreme case of hyperthyroidism caused by lack of iodine, exertion during hot weather or in "constitutionally predisposed individuals."<sup>29</sup> This diagnosis allows Mott to be more specific when he does identify "credible" shell shock, such as those who were directly

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<sup>25</sup> Frederick W. Mott, *War Neuroses and Shell Shock* (London: Oxford University Press, 1919), 35, 107-108.

<sup>26</sup> Mott, *War Neuroses*, 22.

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.*

<sup>29</sup> Clayton L. Thomas, ed., *Taber's Cyclopedic Medical Dictionary* (Philadelphia: F.A. Davis Company, 1977), G-37.

affected by an explosion, and not over diagnose patients with shell shock. He also treats individuals who appear to have been affected by gas poisoning, that include symptoms of rapid heartbeat and severe temperature changes and other signs of physical shock caused not by mental trauma, but physical injury.<sup>30</sup>

Unlike Yealland who believed that electricity was the cure for shell shock, Mott does not believe in a complete cure. Many doctors echo this sentiment regardless of their method of treatment, and discuss shell shock treatment as being limited to controlling the symptoms. Mott suggests, “There is always a residual neurasthenic condition which persists for a long time and does not yield” to persuasive or physical treatments.<sup>31</sup> Mott’s work focuses primarily on the internal physical consequences of warfare that lead to symptoms of physical shock, such as hallucinations, “temporary irresponsibility”, mania, depression, and confusion, all symptoms that are common amongst deserters.<sup>32</sup> He also mentions the effect of explosions on the body, initially studied through animal testing, and concluded that it can causes “ruptures”<sup>33</sup>, “hemorrhages and suffusions of blood” found in the spine and brain, that would lead to changes in an individual’s body and mental state.<sup>34</sup> He also expresses an acute interest in the role of hereditary causes in cases of shell shock, suggesting that some patients have “inborn predispositions to emotivity” and that a personal or family history of nervousness or insanity, contributes to this predisposition.<sup>35</sup>

Mott’s relationship with psychology is confusing and he approaches mental health treatments with trepidation. It is unclear when he speaks of the “mind,” if he is speaking about

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<sup>30</sup> Mott, *War Neuroses*, 258.

<sup>31</sup> Mott, *War Neuroses*, 30.

<sup>32</sup> Mott, *War Neuroses*, 78-86.

<sup>33</sup> Mott, *War Neuroses*, 75.

<sup>34</sup> Mott, *War Neuroses*, 70.

<sup>35</sup> Mott, *War Neuroses*, 107.

the nervous system, and the various nerve reactions of the brain, or the psychoses. He supports psychoanalysis in cases where physical treatment has reached a limit and the physical symptoms are no longer responding to Mott's various methods. The only method of psychology that he supports fully is dream analysis, which he justifies through quotes from Shakespeare and the ancient Greeks who spoke of the revealing nature of dreams.<sup>36</sup> Although he supports dream analysis, he is uncomfortable with the emphasis placed on sex by Sigmund Freud's pre-war studies that examined nightmares and targeted sexual repression as the cause. Doctors like Rivers, who Mott references in his book, use the theory of repression and dream analysis to understand the cause of the individual's trauma.<sup>37</sup> Mott supports Rivers' de-sexualization of Freud's theory because the "merit of Freud's theory is that it provides a psychological theory of dissociation...and the process by which its effects can be overcome."<sup>38</sup> The most important distinction between Yealland and Mott is that Mott understands the impact of emotional conflict and soldiers' feelings of responsibility, fear, and guilt that exacerbate their physical symptoms. He believes that this creates a vicious circle that makes dependency on one form of treatment ineffective, especially because symptoms vary between military classes. For instance, Officers have more instances of depression related to "war responsibility."<sup>39</sup> However, it is important to remember that there was discrimination between classes, and those who held a higher rank were often treated with more sensitivity and respect.

The merging of the physical and psychological side effects of war is present in the sudden movement and "tics" commonly found in Mott's patients. Constant twitching is a defensive movement by the patient to dodge bullets, and shells, and patients who crouch or

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<sup>36</sup> Mott, *War Neuroses*, 114-116.

<sup>37</sup> Mott, *War Neuroses*, 117.

<sup>38</sup> Mott, *War Neuroses*, 118.

<sup>39</sup> Mott, *War Neuroses*, 189.

become compact and paralyzed represent a “defensive reaction of concealment by immobility.”<sup>40</sup> This response to loud noises or anxiety suggests to Mott that the fear that is present in nightmares is the same subconscious fear that creates other mobility and physical symptoms. For Mott, the existence of defensive movements suggest that there is a link between the psychological and physical, because although he argues that there could be physical causes to these tics and reactions, such as Grave’s disease and the slew of physical symptoms caused by shock, he acknowledges the continual effect of emotions on his patients.<sup>41</sup>

By examining his patients’ background and physical health, Mott also was able to hypothesize as to why there were such large numbers of shell shock cases. Mott’s main goal is to discover alternative explanations for shell shock that excludes war experiences as the cause. He identifies that many of the younger patients, late teens and early twenties, are suffering from “Dementia Praecox,” or schizophrenia, after they show signs of “petty delinquencies such as late for parade, dirty gun” and “absence without leave.”<sup>42</sup> The labeling of this behavior as schizophrenic seems extreme because the age of these soldiers could justify their behavior, especially in a conscript army. Mott also labels another category of soldiers being treated for shell shock but really suffering from “psychasthenia,” which is an obsession with phobias that causes the individual to suffer from “a mental eclipse.”<sup>43</sup> Mott contends that this illness is “inborn” and the military should discharge the patient because they are unable to adapt to new situations.<sup>44</sup> The largest proportion of misdiagnosed shell shock cases are those of the “feeble-minded” who, according to Mott, make up twenty percent of the shell shock patients.<sup>45</sup>

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<sup>40</sup> Mott, *War Neuroses*, 121.

<sup>41</sup> Ibid.

<sup>42</sup> Mott, *War Neuroses*, 205.

<sup>43</sup> Mott, *War Neuroses*, 206.

<sup>44</sup> Mott, *War Neuroses*, 207.

<sup>45</sup> Ibid.

He suggests that these patients are “imbeciles of the criminal type” and “mental defectives” making them “quite useless for active service.”<sup>46</sup> Another common occurrence among shell shock patients is the occurrence of epilepsy that had gone unnoticed before the war. Mott theorizes that the stress of the war ignites the epileptic fit, which makes these patients unfit to return to the front.<sup>47</sup> Mott also investigates manic depression amongst his patients by looking into family histories and backgrounds, and suggesting that the strains of combat exacerbate the delusions, illusions and hallucinations that, like epilepsy, had a minimal impact before the war.<sup>48</sup> He also includes alcoholism’s effect on the patients whose neuroses worsen and prevent successful treatment.<sup>49</sup> Another conclusion Mott makes is that prior mental health issues, such as depression and nervousness, predispose an individual to severe paranoia. Mott asserts that this too is a product of inborn traits and family history and suggests that it is most common amongst superior officers who feel “persecuted.”<sup>50</sup> This is especially interesting because it seems unlikely that the same person would feel the same paranoia in peacetime in a non-military occupation as they had in the military position during wartime.

This limited acceptance of psychological treatment meant that Mott relied primarily on physical treatments to assist his patients. The variety of treatments he proposes suggest that he believed in an active cure that recommended, exercise, light manual labor, such as gardening and basket-weaving, and physical therapy that included electro-therapy, massage, baths, nutrition, and rest.<sup>51</sup> Mott also recommends that atmosphere is vital in the treatment of patients; most doctors would use this theory and found treatment more successful when in an isolated and

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<sup>46</sup> Ibid.

<sup>47</sup> Mott, *War Neuroses*, 209.

<sup>48</sup> Mott, *War Neuroses*, 213.

<sup>49</sup> Mott, *War Neuroses*, 223-225.

<sup>50</sup> Mott, *War Neuroses*, 214.

<sup>51</sup> Mott, *War Neuroses*, 270-297.

peaceful area. In keeping with Yealland however, Mott believes that “all patients should be made to salute officers and stand to attention when they enter the wards,” and that maintaining military discipline is vital to preventing the patients from becoming too comfortable.<sup>52</sup>

Whether intentional or unintentional, Mott succeeds in creating a policy for the military to deny responsibility for soldiers’ shell shock. Mott includes a chapter about weeding out malingerers and individuals who imagine they are suffering, and while he does not include electro-therapy as a means to expose them, he does encourage close examination and observation. In his final argument, he makes a plan about government care and pensions arrangements once the war is over, and declares “the government, having accepted for military service, men who afterwards develop a psychosis, has recognized responsibility for their care and treatment.”<sup>53</sup> While this might seem like a commendable statement, the emphasis should be placed on the word “afterwards” that suggests that if the military can prove preexisting or inborn mental illnesses, that they are relieved from responsibility.

An element from Peter Leese’s argument attributing shell shock to industrial accidents appears in both Mott’s work, and in the work of another neurologist, Dr. H.C. Marr. Mott believes that shell shock is not a new phenomenon, and Marr concurs, arguing, “No new phenomena or symptom complex has been revealed by war psychoses.”<sup>54</sup> Marr also published his book, *Psychoses of War*, in 1919, which includes a case taking worksheet for local doctors to understand their patient’s mental and physical well-being. Although he is similar to Mott in neurological approach, he works to remove the stigma attached to mental illness. Like Mott, he believes that physical causes result in the symptoms of shell shock, such as brain hemorrhages,

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<sup>52</sup> Mott, *War Neuroses*, 277.

<sup>53</sup> Mott, *War Neuroses*, 214.

<sup>54</sup> H.C. Marr, *Psychoses of War* (London: Oxford University Press, 1919), 49.

spinal and nerve damage, as well as diseases and thyroid issues.<sup>55</sup> He also believes in the “vicious circle” of physical symptoms influences psychological symptoms, like depression and anxiety, which eventually cause nightmares that lead to insomnia, which causes the physical symptoms to worsen.<sup>56</sup> Physical symptoms also worsen when an individual believes that they might have a mental illness, the stigma attached to “degeneration,” and “hysteria” creates new physical and emotional symptoms.<sup>57</sup>

Marr also begins to depersonalize shell shock by contributing it to random and variable reactions, which could be caused by psychic or biological triggers. Marr suggests, “Mind reacts on body, and body on mind, and the signs and symptoms of mental and bodily disorder are only aspects of the same ultimate existence.”<sup>58</sup> With the connection between the previously separated elements of mind and body, Marr also begins to argue that mental trauma does not solely exist because people are weak-willed, instead he declares, “no one is free from anxiety, and, in everyone, fearful emotions exist.”<sup>59</sup> Those who do not show fear are the ones that should be of concern because they have a “grave mental defect.”<sup>60</sup> He does attribute the majority of cases to hereditary and inborn issues, but does acknowledge that the randomness of war can awaken hidden reactions within a patient; an opinion that psychologists like Rivers would share.<sup>61</sup>

By expanding on the vicious cycle theory, Marr also explains the distinctions between neurasthenia, or shell shock, and psychasthenia as well as other mental illnesses. Neurasthenia is “the result of mental stress and strain and physical ailments of manifold variety” that normally

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<sup>55</sup> Marr, *Psychoses of War*, 50-51, 106-110.

<sup>56</sup> Marr, *Psychoses of War*, 51-53, 60.

<sup>57</sup> Marr, *Psychoses of War*, 81-82.

<sup>58</sup> Marr, *Psychoses of War*, v.

<sup>59</sup> Marr, *Psychoses of War*, 47.

<sup>60</sup> Ibid.

<sup>61</sup> Marr, *Psychoses of War*, 108.



appear in persons with “inherited neurotic and neuropathic” tendencies.<sup>62</sup> Similar to Mott’s definition, psychasthenia is the “obsession and impulse, moral stigmata, and deficiency” of an individual with phobias, manias and perversions that are oftentimes hereditary or a congenital defect.<sup>63</sup> A surprising phobia that is often attributed to psychasthenia by both Mott and Marr is claustrophobia, which does not seem like an unreasonable phobia to have for a soldier who spent months in the trenches and was oftentimes buried alive after heavy shell bombardments.

The issue of class also appears in Marr who suggests that the patients with psychasthenia are degenerates, and warrant discharge from the military because they are “morally insane.”<sup>64</sup> The evidence of immorality to Marr is a history of desertion and escape from military service.<sup>65</sup> In a case study, he explains a neurasthenic patient who had grown up with abusive, neglectful, and alcoholic parents and siblings, had a juvenile police record, and had the “anatomical stigmata of Mongolian imbecility.”<sup>66</sup> He would declare the patient morally insane and a degenerate because of his background, even though he had no “tendency to suicide or homicide.”<sup>67</sup> It is also apparent that class and prejudice play a role in Marr’s definitions of psychasthenic patients, especially in his case taking worksheet that required the doctor to determine if the patient has a “Jew nose” or “Roman nose.”<sup>68</sup> He believes evidence of psychasthenia in these patients is present in behavior that is “hesitating, irresolute, timid, and fearful,” they also feel “mentally inferior to other people.”<sup>69</sup> Ignoring the reasonable feelings of “fearful” patients, it is a suspicious claim on behalf of Marr to suggest that they feel mentally inferior, especially because

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<sup>62</sup> Marr, *Psychoses of War*, 140.

<sup>63</sup> Marr, *Psychoses of War*, 125-127.

<sup>64</sup> Marr, *Psychoses of War*, 132.

<sup>65</sup> Ibid.

<sup>66</sup> Marr, *Psychoses of War*, 133.

<sup>67</sup> Ibid.

<sup>68</sup> Marr, *Psychoses of War*, Appendix, 31.

<sup>69</sup> Marr, *Psychoses of War*, 137.

the relationship between him and his patients, as is commonly found between doctors and patients, is one of authority and inferiority.

The most interesting dichotomy between condescension and sensitivity is the description of the mental deficiencies that he commonly finds amongst his patients. The first category he examines is the “infantile” deficiencies that allow an individual to be functional but with “extreme stupidity” that “arises before birth or during.”<sup>70</sup> This deficiency, Marr argues, allows the individual to be docile and mechanical in a familiar environment, allowing them to be good soldiers until their surrounding changes.<sup>71</sup> The second category is that of the “enfeebled” individuals who are usually adolescents, late teens to mid-twenties, who suffer from “mania, melancholia” and “simple loss of intellectual faculties” as a result of accessibility to drugs, alcohol, sex, dramatic life changes, and excitement.<sup>72</sup> Like Mott’s description of young adults who suffer from schizophrenia, this definition also implies the inability of either of these doctors to realize the behavior of youths, especially the behavior of young men who made a dramatic entrance into independence and adulthood.

To treat the deficiencies that Marr has examined, he encourages early, specialized treatment that removes the patient from external influences so that the illness does not progress and become uncontrollable.<sup>73</sup> Like Mott, he also suggests light activity, such as gardening, sewing, wood carving and basketwork, while also encouraging rest, massages, baths, and quiet atmospheres.<sup>74</sup> His attitude about psychoanalysis is different from Mott’s resistance in that he supports treatment to help the patient improve and control their symptoms, gain self-confidence,

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<sup>70</sup> Marr, *Psychoses of War*, 144.

<sup>71</sup> Marr, *Psychoses of War*, 145.

<sup>72</sup> Marr, *Psychoses of War*, 159-161.

<sup>73</sup> Marr, *Psychoses of War*, 119.

<sup>74</sup> Marr, *Psychoses of War*, 120-122.

and become educated about their illness.<sup>75</sup> He urges that this treatment only be given by qualified psychologists because “only is psycho-therapy of value, when the patient recovers the mastery of himself and no longer requires the services of the physician.”<sup>76</sup> Rivers and his colleagues, who believed that the only hope for treatment was in the patient’s ability to understand and control their mental illness, would share Marr’s opinion about self-cure. Although there are few differences between Mott and Marr, the differences that do exist, such as suggesting that shell shock is not always inborn and can be random, and embracing psychoanalytic treatment methods, are important in showing the diversity and complexity of psychiatric doctors in the First World War.

Another doctor who falls between reliance on physical or analytical treatments, but variety, is Sir Arthur Hurst who worked at Netley Hospital during the war. Hurst did not write about his case studies, instead he used film to record the before and after transformations of his patients. In these silent films, the introduction of the patient is followed by a slide explaining their condition and the treatment tried appears. Often the treatments for a patient who has paralysis or a tic are massage, baths, and physical therapy, which suggest that Hurst had a traditional view towards curing physical symptoms with physical cures. It appears that the physical treatment allowed the patient to feel “back to normal” and made his psychological symptoms less severe. However, there are also patients that do not fall into this category. One in particular has gone deaf, with the exception of being able to hear the word “bomb,” at which point he jumps under his bed, hides, and has a severe case of tremors. Hurst may have tried to treat both the psychological and physical ailments of his patients equally and with great interest,

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<sup>75</sup> Marr, *Psychoses of War*, 123.

<sup>76</sup> Marr, *Psychoses of War*, 124.

but on film, the dramatic change in a patient's posture and gait was better evidence of the success of his physical treatments.<sup>77</sup>

There is a common myth amongst historians that Dr. W.H.R. Rivers was the savior of shell shock patients and the doctor who gave credibility to psychoanalysis. In many ways this true, but at Craiglockhart Hospital where he spent most of war, the institution was a thriving example of both the active and atmosphere cure, and dream and psychoanalysis. Rivers began his academic career as an anthropologist, an interest he returned to before he died, but became involved in psychoneurotic research in Cambridge.<sup>78</sup> During the war, he became a psychologist at the Craiglockhart Military Hospital in Scotland, treating officers who had "dreams of a less simple kind" than the lower ranking soldiers he had treated before practicing at Craiglockhart.<sup>79</sup> He is most famous for his 1917 essay, "The Repression of War Experience", which outlines the social and personal causes of repression and suggests a treatment that involves giving the patient skills to understand and manage their trauma. He observes that upon returning home from war, the soldier meets with "continual inquiries of his relatives and friends about his experiences of the front" that "awakens painful memories."<sup>80</sup> This situation also occurs when soldiers who have "little in common except their war experiences" spend time with each other, as in a hospital setting, that leads them to only being able to discuss the war.<sup>81</sup> Rivers is one of the few doctors who place some responsibility on the civilians at home who do not understand the realities of war and trauma and act inconsiderately. He does however agree with most doctors who suggest that there is a personal motivation to repress these painful memories. He notes that soldiers often want "to banish the distressing and horrible" memories from their consciousness and by doing

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<sup>77</sup> Arthur Hurst, *War Neuroses: Netley 1917*, British Pathé, 1917.

<sup>78</sup> Showalter, *The Female Malady*, 183.

<sup>79</sup> W.H.R. Rivers, *Conflict and Dreams* (New York: Harcourt, Brace & Company, Inc., 1923), 6.

<sup>80</sup> W.H.R. Rivers, "The Repression of War Experience," *The Lancet* (February 1918) 3.

<sup>81</sup> *Ibid.*

this they confront this trauma when they are no longer able to intentionally “banish” these thoughts.<sup>82</sup> This confrontation occurs in dreams that terrorize the patient and make their recovery all the more difficult. Rivers’ treatment for this is confrontation during consciousness, so that the patient “when in place of running away from these unpleasant thoughts” he faces “them boldly and” allows “his mind to dwell on them in the day, they no longer” race “through his thoughts at night and” disturb “his sleep.”<sup>83</sup> This treatment is not a complete cure, but it uses open discussion about the war experience, and allows patients to express their fears and traumas freely in order to manage the severity of their anxieties.<sup>84</sup>

Sympathy towards Rivers probably stems from his trepidation about sending his patients back to the front, an event that most of the other doctors enjoyed as it meant they had cured another patient. He warns the Royal Society of Medicine, “a soldier can have but one result when he is again faced by the realities of war,” a prediction that relapses are inevitable amongst returning soldiers.<sup>85</sup> Rivers urges an end to the ostrich-like policy of the medical field ignoring the complexities of psychological cases and “overcome the difficulties which are put in their way be enfeebled volition and by the distortion of experience.”<sup>86</sup>

The pursuit by Rivers to begin to reform the field of military psychology reaches a climax with colleague Dr. Grafton Elliot Smith’s collaborative work with Dr. T.H. Pear, *Shell Shock and Its Lessons*, published in 1918. Smith does not limit the reform to military psychology, but instead to the entire medical field’s approach to the illness and the public’s perception of shell shock. Elliot Smith is not a military doctor, but affiliated himself with

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<sup>82</sup> Rivers, “Repression,” 2.

<sup>83</sup> Rivers, “Repression,” 4.

<sup>84</sup> Rivers, “Repression,” 6, 9-10.

<sup>85</sup> Rivers, “Repression,” 11-12.

<sup>86</sup> Rivers, “Repression,” 12.

military hospitals and patients while retaining the right to research and express controversial opinions freely.<sup>87</sup> With this freedom, he is able to place blame upon the experiences of war as the major cause of trauma without worrying about the effect that his opinions will have on the military's system of pensions. He recognizes shell shock as "war strain" and links it to the lack of sleep and nutrition offered to soldiers on the front, who then become so exhausted and anxious, that insomnia occurs, creating another example of a vicious circle.<sup>88</sup> The physical symptoms that both Mott and Marr recognized as the initial stages of shell shock are actually the result of ongoing mental issues.<sup>89</sup> Elliot Smith suggests that in the early stages of shell shock the patient is not "necessarily displaying any outward signs of his trouble" and that he may "consume his own smoke."<sup>90</sup> He also refutes doctors' accusations of patients as unreasonable and weak, arguing that cause of their behavior is from being too reasonable as a defensive reaction to their surroundings.<sup>91</sup> This suggested defensive mechanism is an instinctive reaction to trauma, not mental degeneracy, nerve damage or organic disease, but is in fact a legitimate illness caused by war strain.<sup>92</sup> He doubts strongly the idea that these patients "inherited" or are more susceptible to nervous behavior and shell shock because "the strongest man when exposed to sufficiently intense and frequent stimuli may become subject to mental derangement."<sup>93</sup>

Since Elliot Smith believes that the causes of shell shock are mental and emotional, his suggestions for treatments place heavy emphasis on psychoanalysis and the importance of a sympathetic and respectful relationship between doctor and patient. He believes that the patient

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<sup>87</sup> Jones, "Shell Shock at Maghull," 373.

<sup>88</sup> Grafton Elliot Smith and T.H. Pear, *Shell Shock and its Lessons* (Manchester: Manchester University Press, 1918), 2-7.

<sup>89</sup> Elliot Smith, *Shell Shock*, 91.

<sup>90</sup> Elliot Smith, *Shell Shock*, 7.

<sup>91</sup> Elliot Smith, *Shell Shock*, 2.

<sup>92</sup> Elliot Smith, *Shell Shock*, 71, 86, 98-99.

<sup>93</sup> Elliot Smith, *Shell Shock*, 87-89.

will learn the skills to cure himself through sympathy, respect and trust in his doctor's sincerity and discretion.<sup>94</sup> He is exceptionally opposed to military discipline within hospitals, the treatment preferred by both Mott and Yealland, and infers that the rigidity of the military causes anxieties that would not have appeared in civilian life, and by continuing this rigid system during treatment would end with "disastrous results."<sup>95</sup> Elliot Smith finds that it is "most advisable" that the patient try various methods of treatment until discovering which method works best, whether it be active cures like gardening and exercise or different psychological cures, such as psychotherapy, dream analysis and hypnotism.<sup>96</sup> He doubts the efficacy of using electricity because, in a possible insult to Yealland, the "the method savors of charlatanism."<sup>97</sup>

Although Elliot Smith is open to various cures, he is determined to make the conditions of mental hospitals as respectful and sympathetic as possible. He places emphasis on these traits because he believes that they will encourage a "rational and intelligent treatment of the disease" that mirrors the same approach to "dealing with bodily affections."<sup>98</sup> Through this rational approach, Elliot Smith reasons that the public and medical perception of shell shock as evidence of degeneracy will dissipate, and the concept of shell shock as a legitimate mental illness caused by trauma will become the norm. He does suggest various reforms to improve this system such as educating doctors and the public about the causes and treatments of shell shock, so that when either group encounters a patient they do so with sensitivity and understanding.<sup>99</sup> Elliot Smith also recommends the creation of outpatient clinics to treat shell shock patients, which would not immediately institutionalize the patient when they sought help. By avoiding the association with

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<sup>94</sup> Elliot Smith, *Shell Shock*, 29-30.

<sup>95</sup> Elliot Smith, *Shell Shock*, 28-32, 50.

<sup>96</sup> Elliot Smith, *Shell Shock*, 41-47, 66-67.

<sup>97</sup> Elliot Smith, *Shell Shock*, 43.

<sup>98</sup> Elliot Smith, *Shell Shock*, 46.

<sup>99</sup> Elliot Smith, *Shell Shock*, 100-102, 111.

asylums and mental institutions, the patient can also avoid the stigma surrounding treatment that will allow the patient to seek medical care without fear or embarrassment. While Elliot Smith's research does focus on the causes and treatments of shell shock, his deepest concern is with the system that exists once these patients are released into a civilian population that can neither care for them, understand them, nor see them as anything but mental degenerates and cowards.

These six doctors laid foundational research and organized various approaches for dealing with the mental wounds of war. Through their research, United States military officers, like Major Thomas Salmon of the Medical Officers' Reserve, was able to organize the American equivalent of the British military hospitals once the U.S. entered the war in 1917. This research would allow the Americans to avoid becoming like the European countries who "made "practically no such preparations and...fell into difficulties from which they are now only commencing to extricate themselves."<sup>100</sup> By experimenting and researching various methods of treatment, they helped establish the structure and requirements of military mental hospitals, which created a blueprint for many governments during and after the war. The causes of shell shock, although highly debated, gave Salmon the idea that "prevention" was vital in "excluding insane, feebleminded, psychopathic and neuropathic individuals" from recruitment to avoid exposing them "to the terrific stress of modern war."<sup>101</sup> Suggested in the language of Salmon's report is the new emphasis on the hardships of war, especially the consequences, which created a new and deep respect for the soldiers. This exists in the report Salmon creates of patients in British military hospitals who are either mentally insane or neuroses cases. In this detailed, and amoral, record it likes over 5,000 patients in only fifteen military hospitals in the United

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<sup>100</sup> Thomas W. Salmon, *The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army* (New York: War Work Committee of the National Committee for Mental Hygiene, Inc.), 47.

<sup>101</sup> Salmon, *Care and Treatment*, 47-48.



Kingdom.<sup>102</sup> This number does not include the various hospitals on the front in France, used to treat the early stages or minor symptoms of shell shock amongst the soldiers stationed in Europe and abroad.

Whether the world learned from this outbreak of mental illness among the young men of their countries, it is evident that doctors attempted to control the exponential growth of mental illness at home. Doctors like Mott, Marr, Rivers, Hurst, and Elliot Smith proved that any treatment method was worth trying in order to sustain some sanity amongst their patients. These doctors were suspicious of the dogmatic methods of Yealland's electro-therapy treatments, and believed they were too restrictive and would inevitably lead to failure. By the end of the war, many of these doctors quit practicing and became academics and researchers. Rivers returned to anthropology and died a few years after the war and Yealland's reputation for efficiently curing soldiers crumbled and remains demonized by historians and writers to this day. There are very few records that follow the patient's transition into civilian life back home, and because of this, it is impossible to know how successful the various treatments were. Without conclusive evidence as to the best treatments for traumatized soldiers, the research was passed on to a new generation of doctors who would be required to pick up the research and once again try to understand the complexities, causes and outcomes of mental trauma during war time.

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<sup>102</sup> Salmon, *Care and Treatment*, 93-98.

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