The Great War was a revolutionary moment in the history of the disabled and of disability as a social, economic and political problem. The sheer number of disabled men in combatant nations meant that the treatment and post-war entitlements of those wounded in war became a permanent and highly visible part of the reckoning societies made of the costs of the war.

Among these costs was the care of men whose wounds were either neurological or psychological in character. The distinction between the two mattered, since there were roughly two schools of opinion on those who manifested symptoms of injury without visible wounds. On the one hand, there were those who believed that such individuals suffered from lesions we cannot see: thus all such injuries were physiological in character, and could be treated as such. On the other hand, some physicians and psychologists took the view that there were disabilities which were psychogenetic in character, and they had to be treated in a different way. On balance, the neurologists were prone to scepticism about some claims to war-related disability without evident physical injury; at times they believed such men were malingerers pretending to be disabled. Psychologists were more likely to accept that perfectly healthy men, without a trace of mental illness in their family histories, could be severely damaged without a scratch being visible on them. The psychological effects of heavy bombardment or the enormous stress of combat could produce disabilities even without physical injury to the soldier in question.

Most physicians and serving officers believed that the entire category of psychogenic disability was a cover for fraud. They were reluctant to consider that men who had no detectable traumatic injury could be disabled through military service and not due to a pre-existing condition. To such sceptics, a more likely explanation of paralysis or muteness without injury was cowardice or dissimulation; in short, acting disabled was a tactic to avoid facing the enemy. Such opinions did not disappear at the end of the war. The stigmatisation of psychologically disabled men continues to this day.
This chapter examines, therefore, the contested medical, political, social and cultural terrain surrounding injuries which came to be known as ‘shell shock’. Here is an instance in which we can see the transnational history of the war in very sharp terms. These debates took place in every combatant army, with each looking over its collective shoulder to see how the others approached the phenomenon. There was no consensus on diagnosis, treatment or definitions of levels of disability or cure. Above all, this chapter on wartime medical history shows that the only way to understand medical and scientific opinion, however ‘fact’-based it was, is through the language in which it was expressed at the time.

Linguistically, there was a great difference between ‘shell shock’, the English neologism for psychological or neurological injury, and words used in other languages for the same set of conditions. In all cases, language mattered; and attention to language enables us to see how it was that in Britain the term ‘shell shock’ escaped from medical discourse to become a metaphor for the damage the war inflicted tout court. This was not the case in other countries, and the reasons for such cultural differences are important. In the interwar years, it was not only bodies and minds that were shell-shocked, artists, poets, novelists and film-makers insisted, but so were the societies in which they lived.

Symptoms and diagnoses

Already in the Russo-Japanese War of 1904–5 there was considerable discussion of the need for military physicians to prepare for handling the psychological casualties of war. Ten years later, the problem occurred, but on a scale which turned differences in degree into differences in kind.

From early on in the war, physicians on active military service had to deal with thousands of men presenting a range of disorders which did not seem to have visible or measurable physical origins in wounds or other injuries. There were six groups of such disorders which were reported in the medical literature in the first year of the war. Let us consider these in terms of individual cases.

*Stupor*

F. S., a German wreath-binder before the war, fell unconscious under bombardment after only two days at the front. In hospital he was said to have been in a ‘deep stupor’. He had no idea where he was and suffered from amnesia. Within a month he began to recover his memory. A similar case was
that of a Russian lieutenant who suffered delusions after combat in 1914. He said that Germans ‘had to be burned and then fought with’. He thought he was the chief of staff, heard shots and shells, and ‘would shudder and turn away’. He remained apathetic on evacuation. There were similar cases in all combatant armies. To a French physician ‘stupor is probably the most frequent of the mental symptoms of shell shock’. Those in this state suffered from disorientation, delusions, and amnesia. Relapses were frequent.¹

Doctors treated many soldiers who were either completely unresponsive or who reacted only to certain trigger words or sounds. A British soldier buried alive on the Western Front reacted to nothing other than to the word ‘bomb’. On hearing it in hospital, he immediately hurled himself under his bed, and would not emerge until reassured that there was no imminent danger. Many other soldiers responded immediately and automatically to loud noises by seeking shelter, long after their discharge from military service.² A French soldier was the only survivor of a direct hit to a blockhouse; ten other men had been killed. Vertigo, tremors and amnesia afflicted this man, who ‘would sit hours in a chair or on a bed silent and inactive’. ‘Catatonic dementia praecox’ was the diagnosis.³

**Paralysis**

A German soldier aged 18 injured his skull in a fall just before the outbreak of the war. On active service he hurt his left forearm, which remained paralysed in a bent position. Here was, a physician remarked, a ‘typical case of hysterical paralysis’. A similar case was that of a German soldier on the Eastern Front. In late December 1914,

while engaged in transport service, on the way back with his horse, he fell into a bog and gradually sank to his neck. Attempts to get the man and his horse out failed. All that saved him from drowning was the freezing of the bog surface. After four hours he was freed by his comrades, apparently frozen stiff, but with consciousness completely preserved.

A day later he collapsed, and awoke paralysed on his right side. The right side of his mouth was frozen in an awkward position, and his right arm and leg

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were immobile. Doctors thought that refrigeration and terror combined to produce the paralysis, though they were puzzled by the fact that the onset of paralysis was delayed for a day.\textsuperscript{4}

\textit{Tremors}

A British sergeant aged 32, with eleven years of service, fainted on the retreat from Mons. He contracted dysentery, and while he was in an ambulance a shell knocked him into a ditch. He then suffered from a tremor when in company; when alone, it subsided.\textsuperscript{5} A similar case of tremors was reported by a French physician. A French soldier was thrown against a wall by a bursting shell. He was not wounded, though several of his company were killed by the explosion. He started trembling on the way back to his lines, and continued to tremble for a fortnight. His appetite was gone. He was treated behind the lines for ‘hysterical chorea’, or purposeless and involuntary movement.\textsuperscript{6} His trembling continued after his medical discharge from the army. Any ‘sharp noise or sharp command, or recalling to mind of trench service’ precipitated general tremors, which deeply ‘chagrined’ this man. His shame at his condition was evident.\textsuperscript{7}

A subaltern in the German army in 1915 was lucky to survive a direct hit on his unit. A few steps from him six of his comrades were killed. He remained with his detachment, and then on his return to base tremors set in and he lost consciousness. The tremors continued thereafter. He suffered from amnesia, ‘inhibitions, anxiety and insomnia’ for a lengthy period. His physicians stated: ‘Here is a case of psychic shock with many traits, such as inhibitions and hallucinations, suggestive of dementia praecox’. It is evident that many soldiers suffered from these variants of what was termed shell shock at the time.

\textit{Nervous collapse}

An Australian gunner aged 35 was terrified and depressed under shell-fire in France in 1916. He felt his soul was leaving his body and he had nightmares and recurrent thoughts of suicide. In May 1917 he was blown off his feet by a shell, and he began to feel that shells were aimed solely at him. He had tremors and difficulties in breathing. The physician who cared for him termed him ‘neurotic’, a condition of exaggerated fear that antedated the war. Nonetheless he was incapable of serving, screaming on being aroused from his dreams. He was discharged as unfit for service.\textsuperscript{8}

\begin{flushright}
\textsuperscript{4} Ibid., p. 424. \textsuperscript{5} Ibid., p. 642. \textsuperscript{6} Ibid., p. 421. \textsuperscript{7} Ibid., pp. 422–3. \textsuperscript{8} Ibid., p. 640.
\end{flushright}
Psoriasis

In July 1915, a French soldier was ‘bowled over’ by a marmite (heavy shell) and wounded by shell fragments. Shortly afterwards he developed psoriasis on his trunk, arms, elbow and leg. This skin condition persisted, and the physicians who treated him said that ‘the trauma provoked eczema; the emotion, psoriasis’. Vignolo-Nutati reported fifty-two similar cases of psoriasis due to ‘nervous shock’ among Italian troops.9

Delusional states

A Russian soldier presented delusions of all kinds in a divisional field hospital to which he was sent. He had been wounded in his left shoulder by fragments of a heavy shell. He heard voices accusing him of being a spy, and he thought he had been caught and was about to be shot by the Germans. He refused to touch anything or even look at German lines lest a message go directly to the enemy, which would then shell the hospital. His explanation was that the shell fragment which hit his shoulder had been ‘poisoned and charmed’. This kind of ‘paranoia’ afflicted a 21-year-old German soldier, an Iron Cross winner, who feared the approach of a Gurkha with a mallet in his hand. The day before, the German soldier had stabbed the Gurkha in the chest, and now awaited revenge.10

Other delusions were religious in character. A French soldier treated at Salpêtrière hospital in Paris had visions following a wound to his face near his right eye. A rainbow-coloured bird followed him; on examining the bird’s face, he found it to be that of the Virgin Mary. He later told his physician he was to be King of France and, like Joan of Arc, he would save the country.

Aggravated underlying or latent conditions

This brief catalogue of some of the symptoms shell-shocked men presented to doctors tells part of the story of the difficulty medical men had in identifying the nature and origin of the disabilities they had to treat. It is evident that many men suffered from more than one ailment, and in addition some physicians were prone to see the problem as arising from a latent or underlying condition.

This was a major problem, as we shall see below, for many disabled men who sought pensions for their war-related conditions. Physicians responded

9 Ibid., p. 429. 10 Ibid., pp. 213–19.
time and again that their problem, however precipitated by military service, was a worsening of a prior disorder, or the transformation of a latent to an active disability. The war thus was not the source of the problem; either pre-war behaviour or heredity was to blame. Alcoholism was believed to be the source of some psychological disorders; so was syphilis, epilepsy and cardiac disease, or ‘soldier’s heart’. We have noted how some physicians saw ‘dementia’ as being accelerated, rather than caused, by injury or by exposure to the violent death of men nearby. This tendency to resist the view that terror could cripple a perfectly healthy, sober, God-fearing man, either temporarily or permanently, had significant consequences for the treatment of psychologically disabled men and for the status of their claims for pensions for war-related disability.

The birth of a phrase: ‘shell shock’

A Cambridge-educated physician, psychologist, and anthropologist, C. S. Myers, was the first to draw attention to a new category of battlefield injury. He did so in an article in the premier British medical journal, The Lancet. In a four-page clinical report, Myers produced the first published discussion of shell shock – identified as such – by a serving physician. Myers later claimed that the term arose from the ranks and he merely had adopted it. He gave it a medical imprimatur and inadvertently launched a debate about psychological injury in war that is still alive today.

The article had the virtue of presenting the story of three injured men in their own words. They were all disabled, though not physically injured, by artillery fire. The first man was a private, aged 20, injured on 31 October 1914. He told Myers that as he was struggling to disentangle himself from barbed wire, shells burst behind and in front of him, damaging his vision. It hurt to open his eyes, he said, ‘and they “burned” when closed’. Crying and shivering, he was brought to hospital, where he told physicians he had lost his sense of taste and smell too; his hearing was unaffected. Myers tried hypnosis and suggestion, with a slight restoration of sense reactions, both there and in London, where he regained some, though not all, of his vision.

12 C. S. Myers, Shell Shock in France 1914–1918: Based on a War Diary (Cambridge University Press, 1940), p. 11.
The second man Myers treated was a corporal aged 25 who had had his trench blown in by a bomb. He said he had been buried for eighteen hours, and when he was dug out he could not see. He had hallucinations, which were not relieved by hypnosis and suggestion, but his sight and memory of having been buried and rescued gradually returned under light hypnosis. He recalled ‘saying a prayer or two’ while under the rubble, and offered other details of his remarkable survival. Myers was careful to report that the man’s account seemed either exaggerated or inaccurate. One of the man’s mates reported that no one could have survived burial for eighteen hours; one hour, though, could have seemed to last a lifetime.

The third man, a private aged 23, was blown off a heap of bricks fifteen feet high by a shell burst. The next thing he remembered was waking up in a cellar, drenched. He speculated that he must have fallen into a pool of water. Myers noted that ‘obviously he was in an extremely nervous condition’; ‘the slightest noise makes him start’. His sight and sense of taste were impaired and his hands trembled. When examined, his muscles would spasm. He recovered fragments of memory, and recalled an encounter with a physician who had told him he had had a concussion.

‘Comment on these cases appears superfluous’, Myers concluded. ‘They seem to constitute a definite class among others arising from the effects of shell-shock.’ Hearing was unaffected, but the other senses and memory were altered by the explosions these men had endured. ‘The close relation of these cases to those of “hysteria”’, Myers laconically remarked in closing, ‘appears certain.’

Comment was anything but superfluous thereafter. It appeared that some kind of commotion had disordered the memory and senses of these three men, but none of them had a physical wound or other injury. Their own accounts suggest that the terrifying nature of their experiences at the front produced conversion symptoms: that is, physical disabilities the origins of which were primarily emotional in character. That was what ‘hysteria’ signified at the time: a physical expression of an emotional state. Furthermore, there was little indication in these three cases that these men were dissimulating; their physical distress was real enough. And there was no indication that they had suffered from mental illness of any kind before the war. In sum, the extreme conditions of the war on the Western Front, even in its early months, could and did produce a new kind of injury which Myers termed ‘shell shock’. Thus the term was born.

Shell shock

To Myers the aetiology of this new cluster of conditions called shell shock lay in the artillery war, which produced ‘functional’ disorders of either physiological or of psychological origin, or both. By claiming that some symptoms of shell shock resembled ‘hysteria’, Myers let loose a two-word characterisation of war-related psychological injury whose echoes were loud enough to propel it entirely outside the medical landscape.

There was another reason why the term stuck. It is quintessentially English in its verticality: two single syllables captured what was new about the war and some of the damage it caused. Shell-fire, on a scale never seen before, produced conditions never classified before by the medical profession. ‘Soldiers’ heart’ was a nineteenth-century term, but it was too limited to describe the cases Myers and others treated. The equivalents in French or German or Italian – *choc traumatique*, *Kriegsneurose*, *psicosi traumatica* – did not share the economy of expression of the term Myers used, and therefore were less likely to achieve metaphorical or metonymical status. Shell shock said something about individual men, at the same time as it said something about the terrible newness of the war as a whole. As the fully industrialised character of the war unfolded over the next two years, the power of the term ‘shell shock’ to describe the dreadfulness of fighting in that war only increased. And this was so despite the fact that Myers was a careful physician who described a syndrome without being able to say precisely what caused the symptoms he had observed. ‘Shell shock’ was the triumph of language over science; after all, language has a life of its own.

The location of this set of conditions in the domain of ‘shock’ helped embed it in medical terminology, alongside other secondary effects of injury and surgery. To be sure, some physicians resisted the term, and preferred more opaque terminology, less likely to find a place in the soldiers’ vernacular.14

Once in the public domain, the term was uncontainable. When Myers came to see patients who had the symptoms of shell shock without having been exposed to artillery fire in close proximity to the front, he tried to qualify his first publication. But he found that, try as he might to shut the stable door, the term had already bolted out of his reach. ‘Shell shock’ came to signify a mixed bag of imperfectly understood but real disorders, the physiological or psychological character of which were disputed not only between different specialists but within the work of individual specialists like Myers himself. Shell shock

14 I am grateful to Anne Rasmussen for this point, and for references to the work of Thomas Salmon in the American Expeditionary Force in finding alternatives to the term ‘shell shock’ in clinical nomenclature.
was not what we term ‘trauma’ today, but rather was a category taken at the
time to be analogous to surgical shock, a life-threatening condition: both could
be treated. Shell shock was a metaphor and a linguistic gambit to help doctors
deal with the disabled men whom they treated under the chaotic conditions
at the time.  

The history of shell shock during the Great War is, therefore, not the
progression from a physical to a psychological approach to war disabilities, but
a mixed story of attempts to use both in caring for the disabled. Myers knew
that his diagnosis was resisted by most of his colleagues, but he persisted in
advancing his view nonetheless. His opponents were also trying to cope with a
rash of breakdowns among serving soldiers. Doctors tried their best to read
the illness from the body and the words of the damaged man: some did better
than others, then as now.

Treatment

Psychiatric services were organised in different ways in different armies. Only
in the American army was there an established independent department of
neuro-psychiatry; in the French army and elsewhere, specialists in this field
were simply part of the overall medical service, and suffered from a relative
absence of professional autonomy. To be sure, the Americans were latecom-
ers to the war, but that fact may have helped them develop a more sophisti-
cated approach to the treatment of psychologically or neurologically damaged
soldiers. In the American army there was even an attempt to screen out
‘fragile’ recruits, to prevent them from tying up able-bodied men if they
broke down under combat conditions. The manpower constraints of all
other major combatants precluded similar practices elsewhere. In all armies
there was provision for treatment near the front, and for more difficult cases
there was hospital care remote from the combat zones. As in all other aspects
of the medical history of the Great War, it is evident that in 1914–15 no one had
the slightest idea as to the scale of casualties doctors would have to treat.
Planning for the carnage of industrial war was a matter for later conflicts,
not for 1914–18.

Physicians from all combatant forces were interested in what other medical
men in other forces on both sides said and did about similar cases. The

15 Tracey Loughran, ‘Shell shock, trauma, and the First World War: the making of a
diagnosis and its histories’, Journal of the History of Medicine and Allied Sciences, 67:1
American physician E. E. Southard presented a summary list of methods of psychotherapy used in 589 wartime cases discussed in the international medical literature. In 1919 he published this list and brief summaries of cases in the hopes of improving the treatment of shell-shocked men in future. From the following list we can get a sense of the options physicians had at their disposal in treating shell-shocked men:

Hypnosis
  Verbal suggestion
  Fixation
  Fascination
  Various
Suggestion (Waking)
  Verbal
  Drug
  Apparatus
Auto suggestion
Distraction
Terrorism
Infliction of pain
Persuasion
Will training
Occupation therapy
Isolation
Psychoanalysis. 16

The choice of treatment depended on the symptoms of the patient and the predisposition of the physicians treating him. Many men found their symptoms diminished or vanished without medical intervention. One was reported to have been cured by seeing Charlie Chaplin’s ‘antics’ in the cinema; two other mute men started speaking when they heard that Romania had entered the war. 17 F. W. Mott, the distinguished London neurologist at the Maudsley Hospital, who had a strongly physiological view of the origins of mental illness in general and shell shock in particular, was sceptical of Myers’s views about hysteria. He reported that one man regained his speech when he fell out of a punt, another when told by a friend that he had spoken in his sleep, and a third when overhearing a doctor’s discussion of his case. 18

16 Southard, Shell-shock, p. 673. 17 Ibid., p. 672. 18 Ibid., p. 674.
Mott championed what was termed the ‘physicalist’ approach to neuro-pathy, meaning a belief that conditions of the kind grouped under the new heading of ‘shell shock’ were acquired as a result of concussion or a pre-existing ‘neurotic predisposition’ or ‘disease or aberrant behaviour’, like syphilis or epilepsy. Some motor injuries unaccompanied by physical wounds were, in his mind, due to internal damage to the inner ear or brain, but to him other cases were simply theatrical in character, and would vanish soon enough.

Those who believed in recovery through benign neglect, though, had to cope with problems of relapse. Men supposedly cured broke down again, tying up able-bodied soldiers who had to evacuate them, so that they could start on the hard road to physical and emotional stability once again. This was the case whether physicians caring for such men adopted a ‘physicalist’ approach or if they saw hysteria as the underlying source of the problem. In 1916, during the period of high British casualties during the Battle of the Somme, there was an increasing incidence of men reporting unfit for front-line service with emotional or psychomotor disturbances. This led administrators in the British army to reconsider diagnoses and treatment.

The two lines followed the division of opinion among serving physicians. The army was prepared to see shell shock as either ‘commotional’ in the sense of being the result of lesions or damage to the inner ear or brain, as Mott believed, or as a mix of the ‘commotional’ in Mott’s sense, and the ‘emotional’, as C. S. Myers believed.

Consequently, Arthur Sloggett, director general of British Army Medical Services, authorised the designation of two new categories of injury: ‘effects of explosion (wound)’ for men who had been exposed to explosions yielding anxiety and other disorders ‘without producing a visible wound’, or as the result of an internal injury; and ‘nervousness’ for those who suffered from post-explosion states of anxiety of various kinds.

Sloggett’s directive did not put an end to the internal disputes and difficulties in classifying shell-shocked men. His office added the general label ‘not yet diagnosed, nervous’ to the nomenclature of classification for those who puzzled or exasperated their physicians. Later on, this category was reduced to ‘neurasthenia’, which, as we shall see, was applied more to officers than to men in the ranks. And yet even this category had its doubters. To leave room

for these differences of opinion, the Royal Army Medical Corps created yet another distinction, this time between men suffering from ‘shell shock W’ as having wounds arising from enemy action, and ‘shell shock S’ for sickness.  

This latter category was evidently suspect to many, though not all, physicians in the army.

Confusion and error were inevitable, and mistakes could have serious consequences. Those who were seen as dissimulators, men trying to avoid the risks of service by acting their illness, could face court-martial and execution. Clarifying the meaning of shell shock therefore was a life and death matter, in more than one sense, and thus a potentially explosive issue. The sensitivities of the War Office were evident in their denial of C. S. Myers’s request in 1916 for permission to publish an article on shell shock in the British Medical Journal on the grounds that ‘nothing regarding the disorder should be released’ to the press.

Shell shock was a transnational condition. Doctors in all armies consulted the publications of the enemy to equip themselves better to handle what became an epidemic of breakdown of men under fire. They were all familiar with the use of electrical current to treat different forms of shell shock. In the pre-war period ‘electrotherapy’ was a well-established option to treat the mentally ill. Many psychiatrists believed in the therapeutic value of ‘persuasion’, and took this term to mean encouragement rather than punishment. Others adopted a more coercive approach which resembled what today is termed aversion therapy.

In wartime some doctors swore by the practice. In Germany this treatment was termed the ‘Kaufmann method’, after Dr Fritz Kaufmann, who would place an electrode on the inert limb of a patient and leave the current on for variable periods of time, even up to several minutes. After exercises, the electric current was turned on again, to the accompaniment of emphatic orders to the patient to move previously inert limbs. One physician termed such therapy as a ‘highly logical and brutal method’, but it seemed to work. The intention was to induce ‘sharp pain’ through what Kaufmann termed a kind of ‘surprise

attack.’ After German physicians tried to restore function to a paralysed leg for sixty-four weeks without effect, the regular application of discipline and electrodes produced a complete cure in six weeks. Unfortunately, two disabled men died under this treatment. The Kaufmann method, in various forms, was also used in the Austrian army and in Britain.

The French physician Clovis Vincent followed a similar pattern of persuading disabled men to break through what he took to be their wilful resistance to recovery from various psychomotor or neurasthenic ailments. In his clinic in Tours, he provided a ‘psychoelectric and re-educative treatment’, of the kind Kaufman had pioneered in Germany. After ‘persuasive talk’, isolation and rest for a few days, the patient was treated by electric current to the affected limb. Then he was ‘re-educated’ by physiotherapy and psychotherapy, reinforcing the positive virtues of overcoming his disability.

One patient refused to play along. Baptiste Duchamp, a man suffering from deformation of the spine, was sent to Vincent’s clinic but wanted nothing to do with electric shock treatment: ‘I was terrified. Some buddies [camarades] told me that the “torpilles” were extremely painful and that some men had even died because of them.’ But the authority of the doctor, an officer, was at stake. Vincent told Duchamp: ‘Here it is not the soldier who gives the orders, it is I.’ When faced with Vincent’s insistence on using electrodes, Duchamp punched the doctor, who responded by punching him back.

At his subsequent court-martial, the soldier said, ‘I acted without intention, given that I had been electrified [tormillé] in the jaw by Dr Vincent. I panicked. I acted involuntarily and without knowing what was happening inside me.’ Vincent presented himself as a man of honour, disgracefully set upon by a man of lesser rank. Duchamp’s defenders stated that he was the victim of an assault by Vincent. The case reached the popular press, which made Duchamp into a hero. Given the publicity, the tribunal hearing the case worked out a compromise. Duchamp was convicted of striking an officer, but he was given a suspended sentence of six months’ imprisonment.

Immediately after the Armistice, the Austrian medical profession’s use of electric current to treat hysterical patients in the armed forces came under scrutiny too. This occurred within the broader framework of an enquiry into

‘the gross mismanagement in the command of military bodies, or of other serious violations of their duties’, set up as early as 19 December 1918 by the new provisional National Assembly of Austria.

A week earlier, a Social Democratic newspaper Die Freie Soldat had published an article on ‘Die elektrische Folter’ or torture by electricity in army hospitals. In later articles the newspaper followed up the accusation against two physicians, Dr Wagner-Jauregg and Dr Kozlowski, and based its charges in part on the diary of one patient, Walter Kauders. He had been an officer who, early in the war, was disabled by artillery fire. His medical record was unclear as to the nature of the wound to the head he said he had suffered, but he was still placed on indefinite leave as medically unfit for service. In late 1917 he was still disabled and had difficulty walking. He was sent to Wagner-Jauregg’s clinic for further treatment and remained there from 24 November 1917 to 8 March 1918. He was given electric shock treatment on 1 and 24 December by Kozlowski, Wagner-Jauregg’s assistant, and further treated by Wagner-Jauregg himself. The doctor walked briskly with him around the room, persuaded, like Kozlowski, that he was malingering. Kauders was ultimately discharged from the clinic and improved slowly.

It was Kauders who provided the commission on military failures with his diary and accused Wagner-Jauregg of having ignored his wounded condition, having treated him with electric shock, and isolating him in a cell for seventy-seven days without contact with his family. In sum ‘The whole treatment was a system of torture whose purpose was to compel as many people as possible to return to the front.’

The commission reviewed these charges on 14 October 1920. Wagner-Jauregg, a distinguished physician, later to win the Nobel Prize for medicine, rejected them vehemently. He had examined Kauders and could find not the slightest trace of a head wound or any other injury. He came to the conclusion that he was hysterical, and probably malingering. After delegating shock treatment to his subordinate Kozlowski, he himself tried to talk Kauders out of his broken gait and other hysterical symptoms. He even took Kauders on a brisk march around the surgery, but to no avail. He discharged Kauders from his hospital, convinced he was a malingerer.

The only witness who challenged Wagner-Jauregg was Sigmund Freud, who had known him for thirty-five years. The challenge was indirect. Freud said there was not the slightest evidence that Wagner-Jauregg had failed in his duty or mistreated the patient. ‘I know that the motivating force in his

treatment of patients is his humaneness’, Freud stated emphatically.\textsuperscript{30}
He helped ensure that the charges against his colleague would be dismissed.

But there was a sting in the tail of his defence of a colleague. Freud claimed that Wagner-Jauregg was too quick to see malingering when there was a more complex story to tell — the story of neurotic hysteria. Whatever the nature of Kauder’s injury, ‘it was a grain of sand; a neurosis later developed from the small injury, and at the time he was at the Wagner Clinic, he was evidently neurotic. That this was taken as malingering did him an injustice . . . All neurotics are malingerers; they simulate without knowing it, and this is their sickness.’ Being told he was not sick, the patient was offended, and he consequently developed ‘a hostility’ to the physician ‘and a misconception of the latter’s intentions’. Wagner-Jauregg’s treatment had failed; had he himself treated Kauders, Freud said, the patient would have had a better chance of a full recovery.

Wagner-Jauregg would not let matters rest there. He and other colleagues pointed out that psychoanalysis was too protracted a treatment and too expensive to use in a war crisis. To this Freud responded that the source of the problem was the conflict between the doctors’ commitment to the state to cure patients in wartime and their commitment to the patients themselves. They took short cuts which were based on incomplete diagnoses and on the need to get men back to the front. Here is the essential point: an ‘inner contradiction; a contradiction between expediency and a physician’s humanity’. Yes, men like Kauders had fled from the war: that is what neurotic people do, they flee from an intolerable reality into illness. The problem for Wagner-Jauregg and all other physicians was that they ‘had to play a role somewhat like that of a machine gun behind the front line, that of driving back those who fled. Certainly, this was the intent’, Freud said, ‘of the war administration’. And such a task was ‘irreconcilable’ with the physicians’ charge to do the sick no harm.\textsuperscript{31}

Wagner-Jauregg was duly exonerated, but that was hardly the end of the argument. This exceptional public hearing caught the essential elements of the medical dilemma about shell shock. There was no consensus as to whether it had a solely physiological or a mixed physiological and psychological origin, and there was no consensus as to what constituted either effective treatment or malingering. Doctors and patients both groped their way towards an understanding of conditions more complex and numerous than anyone had anticipated.

\textsuperscript{30} Ibid., p. 60. \textsuperscript{31} Ibid., pp. 61–72.
The fear of ‘pension neuroses’ preoccupied the more conservative members of the medical profession, in particular in Germany, who saw cunning in the way some men dissimulated war-related disability.\textsuperscript{32} Others were less immediately suspicious of the ulterior motives of the men they treated, but had very variable success in relieving or removing their conditions or symptoms. On balance, doctors did the best they could, which many times was simply to put patients in a quiet environment, where some spent the rest of their lives.\textsuperscript{33}

Aftermaths

The day after the opening of the Viennese commission examining the case of Walter Kauders and Julius Wagner-Jauregg’s treatment of him, a film opened in Berlin. It was entitled \textit{The Cabinet of Dr Caligari}, directed by Robert Wiene. As Anton Kaes has remarked, it told the story of ‘the powerful director of an insane asylum who may be crazy or evil, and a shell-shocked patient who may be hallucinating’.\textsuperscript{34} The teller of the story has fragments of memory, and a sense of a terrible experience he has to relive again and again. At the end of the film the doctor says ‘at last I understand the nature of his madness’.

A year earlier, the French film-maker Abel Gance directed a film entitled \textit{J’accuse} about a soldier who goes mad. The hero, Jean Diaz, a soldier-poet with a head wound, begins to lose his mind. He escapes from hospital and reaches his village. There he summons the villagers and tells them of a dream. The dream as we see it starts in a battlefield graveyard with wooden crosses all askew. A huge black cloud rises behind it, and magically, ghostlike figures emerge from the ground. They are wrapped in tattered bandages, some limping, some blind walking with upraised arms, some stumbling like Frankenstein’s monster. They leave the battlefield and walk down the rural lanes of France to their villages. Their aim is to see if their sacrifices have been in vain. What they find is the pettiness of civilian life, the advantage being taken of soldiers’ wives and businesses. The sight of the fallen so terrifies the townspeople that they immediately mend their ways, and the dead return to their graves, their mission fulfilled. After recounting this dream, the poet,

\textsuperscript{33} I saw such men in Warwick General Hospital in 1978. Some had been in general care — that is, parked there — for sixty years.
now totally mad, accuses the sun above of standing idly by and watching the war go on. Then he dies.

This sequence of the dead rising from their graves is one of the great scenes of early cinema. Its force is made even more poignant when we realise that most of the men we see on the screen were actual French soldiers lent to Gance by the French army to play in this film. Gance’s assistant in the film was the poet Blaise Cendrars, a Swiss-born veteran of the Foreign Legion who had lost his right arm fighting with the Moroccan Division in Champagne in September 1915. He played one of the dead being carried on the back of a comrade in the parade of the fallen.

When Gance edited the film in 1920, he incorporated the march of the victorious armies through the Arc de Triomphe on 11 November 1919, but put an ethereal track of the dead marching home at the top of the screen.

I cite these two examples to suggest that shell shock entered the cinema, then coming into its own as the centrepiece of mass entertainment. Here were delusions of such dimensions that silent film, shown to a public in the dark, captured the drama and the visionary quality of the insane. Caligari was more restricted in its appeal than J’accuse, though Wiene’s film has lasted much longer and is recognised as a cinematic landmark.

Gance’s scene of the rising of the dead, imagined by Jean Diaz, was a visual masterpiece, emerging out of a romantic melodrama about war, poetry and madness. Losing his mind, Jean Diaz sees more clearly than anyone else the moral issues of the day. His accusations extend to war itself as an abomination that must be proscribed forever.

The motif of the mad soldier and his visions came into the cinema right at the end of the Great War. In subsequent generations, the same theme returned to the screen with different emphases, but with the same pathos. In the context of war, madness had a clear origin in the terrors of war, further legitimating the standing of the unfortunate men who suffered from this condition in the world outside the cinema.

The same naturalisation of shell shock occurred in fiction. Rebecca West’s Return of the Soldier was one of the first to address the problem of amnesia. The story is told from the viewpoint of Jenny, the cousin of an officer, Chris Baldry, who has lost his memory on active service. He has no knowledge whatsoever of his marriage, and on his return from the front he is full of his love for Margaret, a woman he had known fifteen years before. To restore him to the present, a psychoanalyst suggests that his wife confront him with the clothes and toys of their dead son. That brings him back to his senses, but that recovery means he can return to the war. No such luck befell Virginia.
Woolf’s character Septimus Smith in her 1924 novel *Mrs Dalloway*. He imagines he is pursued by a soldier who died under his command, and to avoid being taken to hospital he jumps out of a window to his death.

Less dramatic is the characterisation of Lord Peter Wimsey, the classic sleuth in Dorothy Sayers’s detective novels. A man of all the talents, he has been an artillery officer, wounded by shell-fire in 1918 and suffering from shell shock. He is said to have been unable to give orders to his servants after the war, recalling the deadly effect of his orders under fire to the men in his command. He has relapses, during which he is faithfully cared for by his former sergeant, and now servant, Bunter.

These references do no more than suggest the infiltration via popular literature of shell shock into the British vernacular of the post-war years. In France, two instances of very different prose may be cited to show the same phenomenon. The French diplomat and playwright Jean Giraudoux told of a man from the Limousin region of central France, Forestier, who is wounded and loses his mind during the war. He has lost all his papers, and is nursed back to health in German hospitals. His amnesia remains, though, and he constructs an entirely new life as a German intellectual and politician, rising to become German Chancellor. A shell-shocked French soldier leading France’s sworn enemy in 1922 was Giraudoux’s notion of a wry witticism.

More vicious, but no less wry in character, is the French writer Louis-Ferdinand Céline’s central character Bardamu, who pretends to go mad to get out of the war. He and his friend (and the other side of his fractured mind) Robinson make their way to safety, and ultimately Bardamu winds up as director of a hospital for shell-shocked soldiers. The book’s title *Voyage au bout de la nuit* (‘Journey to the End of the Night’) describes Bardamu’s efforts to find the hospital for shell-shocked men hidden away from public view in a Paris suburb. The boundaries between madness and malingering are entirely erased in this tour de force, published in 1932, but which remains a classic to this day. I cite these few references to fiction, not because they are the only ones to deal with psychological injury in the Great War, but rather to show the presence of the war’s psychological casualties in different cultural forms.

The blurring of the boundaries between the rational and the irrational was at the heart of two movements which grew out of the war: Dada and Surrealism. And the grotesque features of damaged veterans was a leitmotif of the work of German artists like Otto Dix and Max Beckmann, practising the ‘new sobriety’, a kind of cold clinical stare at the inhabitants of the post-war world.
A range of artistic innovation gave shell shock a visual home in which it has resided to this day. Very recently, the French genre of the bande dessinée or illustrated book for adults, has been used to tell the history of *Les soldats fous de la Grande Guerre*. Hubert Bieser, a retired psychiatric nurse, turned to the archives of the hospital at Ville-Evrard, where shell-shocked soldiers had been treated. Bieser tells the story of fifteen such men, the real unknown soldiers of the Great War, through graphic illustrations by Jean David Morvan and Yann Le Gal. The popular romantic film *A Very Long Engagement*, directed by Jean-Pierre Jeunet, which appeared in 2004, is a detective story with an unusual detective: a young woman in a wheelchair searching for her fiancé; she finds him, having entirely lost his memory after a series of horrors in the trenches.

And in a similarly popular vein, BBC television left millions with images of soldiers trying to simulate madness to get out of the trenches, and of the clearly mad officers who refused to let them go. *Blackadder Goes Forth* was aired on BBC television between 28 September and 2 November 1989, and has become a television classic. Pat Barker’s ‘Regeneration’ trilogy took up the story of shell shock through the lives of prominent writers Siegfried Sassoon and Wilfred Owen, together with the physician who treated them, W. H. R. Rivers. Barker’s genius was to add to the company an entirely fictional officer, Billy Prior, definitely not a gentleman, but rather a working-class bisexual man whose presence helped break down the notion that shell shock was for educated public schoolboys only. The success of her novels, and the cinematic version of them, show the enduring fascination with shell shock in the Anglo-Saxon world.

How far we have come from the brief article C. S. Myers published in *The Lancet* in 1915. And yet there is a cultural continuity here too, a sense of a past shared by these contemporary audiences, in which the soldier driven mad by war stands for the madness of war itself.

### Conclusion

The extent and significance of psychological injury in the Great War is still a matter of controversy. There was then and is now no consensus as to the order of magnitude of the incidence of shell shock, nor as to the most effective way to treat it. The stigmatisation of the mentally ill has not disappeared, even with respect to those whose disabilities are war-related.

After the Armistice there were many efforts to consider the extent and the meaning of shell shock. In 1922 the Southborough Commission, set up by the British War Office two years before, reported on its enquiries into the nature of shell shock and the ways it could be treated. In the preface to the report it issued, one officer opined that shell shock was a ‘most desirable’ condition ‘from which to suffer’; it elicited sympathy and seemed to provide a way out of the trenches. That practice could not be tolerated in future. The term ‘shell shock’ should be suppressed, the report recommended, and those suffering from concussion should be classified among those with head wounds. C. S. Myers refused to offer testimony to the commission, whose views (hostile to his own) were evident even before it had begun its work. And yet, in its reiteration of older truths, the Southborough Commission still had to engage with newer truths — ones that disclosed that even the bravest soldier could break down when pushed too far. In the evidence produced with the report, there is the moving case of a man referred to as a ‘gallant officer’ who, sighting the riderless horses of all his friends who had been killed in battle, wept and could go no further. The testimony of many veterans showed that old notions of heroism had to be refashioned: that courage and cowardice and breakdown mingled in a single mind. Stereotypes about stiff upper lips and manliness under fire could be shored up for a time, but they were in the process of unravelling, a remnant of a culture blown to pieces by the Great War. Shell shock survived these official attempts at damage control; it simply outlived the old guard.

The degree of under-reporting of psychiatric morbidity among serving soldiers in the Great War is unknown but is almost certainly high. The reasons for under-reporting are multiple: cultural codes of manliness and courage stigmatised breakdown; officers were reluctant to expose themselves to charges of failing to maintain morale; soldiers themselves were unaware of the mixture of symptoms they manifested during and after battle. A generation later, during the Second World War, cultural codes and medical practices had changed. If 30–50 per cent of all British casualties in the bloody and difficult Monte Cassino campaign were deemed to be psychiatric in character, and some estimates put at similar levels psychiatric casualties as a proportion of all casualties suffered by Israeli forces in the Yom Kippur War,

then the reported total of 2–4 per cent of all admissions to British military hospitals in the Great War is wildly inaccurate as a measure of the incidence of ‘shell shock’ or other disorders suffered at the time.\textsuperscript{38}

The difficulty is in finding a less than arbitrary way to increase the official figures to offer a better representation of this important part of the medical history of the war. A band of probability described at its lower end at 4 per cent of all casualties and at its upper end at 40 per cent of all casualties in the two world wars may be the best we can do. A mid point could be the best approximation we can offer. Thus if we are correct in assuming that the stress men underwent in battle was comparable in different wars, but that medical standards and cultural codes changed to enable later generations to report more fully and accurately psychiatric casualties, then to say that roughly 20 per cent of all First World War casualties were psychiatric in character may provide a rough guide to the true incidence of such war-related morbidity in the 1914–18 conflict. Another way of putting the same point is to say that, in the British case, 20 per cent of all soldiers who were unable to return to active service suffered from psychiatric disabilities of one form or another. In the Canadian case, the figure is lower – 10 per cent – suggesting that we should consider the figure of 20 per cent of all casualties merely an approximation of the risks soldiers faced of war-related psychological injury during the Great War.\textsuperscript{39}

Medical historians argue that there is a rough balance between psychiatric and physical casualties in different wars, but that that balance is hidden by medical conventions and prejudices. And yet broader cultural and political distinctions make a difference too. Russian doctors wanted to imitate the strategies their Western colleagues were using, but after the Bolshevik Revolution psychologically damaged veterans slowly disappeared from sight. Instead a much more stoical ‘collective’ approach to suffering for the motherland emerged, full of contempt for Western individualism. The outcome was the astounding claim that there was no shell shock among Soviet soldiers in the Second World War. This is under-reporting with a vengeance, but it warns us to treat with great care comparisons of casualty levels over time.


\textsuperscript{39} Thomas W. Salmon, ‘War neuroses (“shell-shock”),’ \textit{The Military Surgeon} (Washington DC), 51 (1917), p. 675. I am grateful to Anne Rasmussen for drawing my attention to this reference.
In the West there were other pathways to under-reporting. There is the claim, made (among others) by Mott in 1919, that in the British forces officers were more likely to suffer from neurasthenia, and the men in the ranks from hysterical disorders.\(^40\) Why should this be so? The additional burdens of command may have left officers with a sense of guilt for the losses suffered by men under their leadership. The origin of the term ‘hysteria’ in the constrained circumstances of Victorian women has moved other commentators to see trench warfare as a kind of ‘emasculisation’, a paralysis of mind corresponding to the paralysis of movement in a war which was supposed to go differently: from attack to breakthrough to cavalry advances and mass movement. Nothing of the kind took place on the Western Front, or at Gallipoli, or in other sectors of the war. Thus breakdown was the inevitable outcome of masses of men being bound up in the barbed-wire confines of the front. Mental illness, as Freud put it, was an escape from intolerable conditions.

The problems with this argument are multiple. First, officers suffered from the same absence of movement in battle as the men in the ranks. They led from the front, and suffered casualty rates twice those of their men. Terror, fear, nightmares, dissociation and sleep deprivation were not defined by rank, but were shared by everybody. It is more likely that this distinction is entirely cultural in character, and that it gave the more honourable ‘cerebral’ title of neurasthenia to psychiatric casualties in the officer corps, and the less honourable ‘physical’ title of hysteria to psychiatric casualties in the ranks. Thus private soldiers who had nervous breakdowns were violating cultural codes in trespassing into the officers’ realm of disability. That may have been one reason why many private soldiers who had what we now see as nervous breakdowns were deemed to have been malingering. They were behaving out of their place in the socially defined medical hierarchy of disabilities. We will never know how many enlisted men suffered from psychiatric conditions that were ignored because of their rank.

A final reason why we need to be liberal in our estimates of psychiatric casualties is the fact that those with physical wounds are rarely, if ever, listed as having psychiatric disorders too. Some doctors took this to be a matter of fact: a physical wound made other disorders appear trivial at the time. But what about the psychiatric consequences of severe disfigurement, to choose but one example? Or of amputation, or of genital wounds, or blindness? All these conditions wind up on one side of the physical wounds/psychiatric wounds divide. For this reason alone, it is reasonable to estimate in a

necessarily imprecise way that up to 20 per cent of all Great War casualties were partially or fully psychiatric in character.

Another reason for the widespread underestimation of the psychiatric toll of war is that no one in power wanted to accept the financial costs of recognising the full extent of such disabilities. In Germany the conversation about ‘pension neuroses’ was not at all hidden, though in other countries such comments were more muted, out of respect for the men who had served at the front. Whatever the rhetoric, there is hardly any doubt that pensions tribunals pinched pennies and reduced or eliminated benefits to those whose injuries were not visible and taken by many to be not creditable either. Thus, whenever you find an estimate of the psychological toll of the Great War, take it as a minimum estimate, superseded in reality by an unspecifiable but substantially greater proportion or number.

There is a dimension to the story of the psychiatric history of the war which is rarely mentioned in the literature. There is no reason whatsoever to assume that women were immune from the same pressures that operated on many men in wartime. Nurses confronted the horrors of war in searing ways, and so did those civilians trapped in war zones or unfortunate enough to live under occupation. Because they were not soldiers, their war-related psychological injuries never get into the statistics. But terror stalked them as surely as it did trench soldiers. Women facing the pogroms which followed the Russian retreat of 1915 in Galicia or the Armenian genocide of the same year knew cruelty and butchery at its worst. Who can possibly claim that the survivors were psychologically unscathed? Restricting the history of ‘shell shock’ to the story of the men at the front may make sense in terms of a reckoning of how armies treated their own casualties, but it must be avoided at all costs in any attempt to provide a realistic account of the psychological toll of the Great War.

Cruelty to civilians is as old as war itself. But between 1914 and 1918 something new appeared in the language people used to describe the ravages of war. The First World War was the moment when the category of shell shock, or psychological injury, came into public view in many parts of the world, and when it received grudging but undeniable public recognition. This extension of state responsibility for the care of the war disabled was palpable and limited. On the one hand, pensions were granted, but the care of both mentally and physically disabled veterans was undertaken primarily by families, and in particular by women, and with their own meagre resources. On the other hand, psychiatric care of damaged men became a charge on the state which could be minimised but not eliminated,
and such a charge had to be borne by polities economically burdened by war debt and by the downward economic spiral of the interwar years. The right to care expanded while the financial capacity to provide that care shrank. The outcome was suffering, misery and the burdening of families who had to live with the men exposed to and damaged by the psychological and physical risks of industrialised warfare.