Shell-Shock and Medical Culture in First World War Britain

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This book traces trajectories of medical understanding of mind, brain and nerves from pre- to post-war Britain and analyses the impact of the First World War with its shell shock 'epidemic' on established medical ideas and practices.

Its main evidence base is a comprehensive survey of published wartime medical discourse on shell shock and related disorders, incorporating military medical journals, specialist publications on neurology, psychiatry, and psychology and textbooks authored by doctors involved in the treatment of shell-shocked soldiers. The challenge posed by shell shock to the medical profession was that traumatised servicemen presented with neurological signs and symptoms that defied an organic explanation and thus transcended the framework of functional neuroanatomy carefully built up by the founders of neurology and psychiatry in the 19th century. The term 'shell shock', coined by the British psychologist Charles Myers in 1915, hinted at a link with conventional injuries associated with explosions but many, including Myers himself, were not convinced of such a physical explanation. This conundrum, whether neurological illness could be caused by purely psychological mechanisms without any contribution of physical injury, was the topic of intense debates in the medical journals and conferences of the war, and the reconstruction of this debate is one of the main achievements of Loughran's scholarly analysis.

In chapter one ('Frameworks of understanding: reconstructing the human from Darwin to the First World War'), Loughran introduces what she calls the 'evolutionary framework' of mind. She argues that, influenced by Darwin and Darwinists, the early psychologists and psychiatrists conceptualised the mind as faculty that had evolved through natural selection, and consequently mental disorder was seen as 'regression, a slippage down the evolutionary scale of development' (p. 48). This well-established framework, which dominated medical thinking in the early 20th century, set the scene for interpretations of shell shock as 'painful failures of will' (p. 49). While psychological medicine became an integral part of medical education in the late 19th and early 20th centuries (p. 32) 'boundaries between psychology, psychiatry and neurology were porous' (p. 30). The interdependence of physical and mental processes became one of the main doctrines of psychological medicine (pp. 38–9), which reinforced the evolutionary framework. A further step towards physiological theories of mental processes was taken when the American psychologist William

James and the Danish physiologist Carl Lange posited a primacy of bodily sensations in the generation of emotions. Loughran argues that this biological approach to the mind provided the foundation for the tendency of psychiatrists of the period to regard mental disorders as signs of constitutional weakness. As I have argued in *They Called It Shell Shock* (1), it was because of this preconception that military psychiatrists and neurologists – and their superiors in the army hierarchies – were so surprised when even battle-hardened soldiers and members of their elite forces started to react to the war trauma with symptoms that could simply not be explained by conventional injuries. Was it possible that the veteran of the Boer war and the Prussian cuirassier were, after all, constitutionally so weak that they were prone to develop mental symptoms? This assumption would have challenged the very fabric of the military and wider society in Britain and Germany alike.

Before we move on to the solutions for this conundrum considered by the British military doctors, Loughran makes us pause to consider exactly what was meant by shell shock. In chapter two ('Languages of diagnosis: hysteria, neurasthenia, and changing pre-war psychological medicine'), she seeks to define the term shell shock and places it within the diagnostic system of pre-war psychological medicine. While shell shock serves as an umbrella term for all nervous and mental reactions to the trauma of war, different diagnostic labels (such as hysteria, neurasthenia, traumatic neurosis, concussion, exhaustion etc.) mirror the broad range of symptoms and aetiological models associated with this phenomenon (p. 52). This 'diagnostic messiness' of war-time psychological medicine reflects the attempt to locate shell shock on different explanatory scales that would have 'nature' versus 'nurture' or 'mental' versus 'physical' as their respective endpoints.

Loughran identifies a period of greater openness to psychological thinking in the years immediately before the war, which was partly related to the increasing influence of Freud. However, this increasing awareness of psychological disease mechanisms coincided with 'the resurgence of biological modes of explanation for mental illness' (p. 54). These seemingly antithetic models were not perceived as irreconcilable (p. 66) and 'coexisted quite happily in the thought of most doctors' (p. 54–5). Despite this co-existence of psychological and somatic models, the point of reference for functional disorders was always somatic: 'The concept of functional disorder was predicated on the notion of an organic non-event, not on the possibility of a psychological event' (pp. 61–2). This somatic frame of reference which implied an organic – yet hitherto undiscovered – basis for functional disorders (such as hysteria and neurasthenia) kept physicians and patients from exploring sophisticated psychological theories. Pre-war models of hysteria and neurasthenia also focused on biological determinism, an inborn tendency/predisposition which made individuals vulnerable to breakdown (pp. 72–4).

Thus, when doctors in base hospitals or back home in the specialist units of Netley, Maghull or Queen Square were confronted with their first cases of shell shock (*avant la lettre*) they only had a largely degenerative model of mental breakdown at their disposal. However, as mentioned above, this model faced major challenges – assuming an underlying degeneration which made soldiers prone to psychological collapse was politically dangerous – but they lacked the evidence for physical injury that could replace this explanation. Medicine clearly needed a proper debate about aetiological models of shell shock. This debate happened in great detail despite the constraints of the war, and Loughran traces it elegantly in chapter three ('Body and mind in shell shock: war and change within psychological medicine') of her book. Loughran argues that the often claimed 'linear transition from physical to psychological understandings of war neuroses' is not supported by wartime medical discourse on shell shock (p. 80). Firstly, there was no focus on physical theories of causation at the beginning of the shell shock epidemic; according to her analysis, the earliest reports referred to psychological strain and trauma rather than the physical effects of shells as trigger for shell shock symptoms (p. 81). Furthermore, Loughran describes how – in the first half of the war – medical approaches towards shell shock drew on pre-war models which emphasized an interaction and co-existence of physical and psychological factors.

Loughran identifies 1916 as a turning point in the aetiological debate when doctors started clearly to differentiate between psychological and physical aetiological models. However, purely physical

explanations – although they never quite disappeared throughout the war – were never seen as the major contributor towards shell-shock symptoms (apart from a brief flare of excitement in 1916–7) and only affected a small proportion of cases. (pp. 97–8). Thus, a ‘shell’ shock model was never quite adopted, and organic explanations were increasingly superseded by an interest in psychodynamic approaches (p. 106) and a return to the theory of inherited predispositions (pp. 107–8). One reason for the increasing acceptability of the predisposition model may have been that, with universal conscription in the major combatant countries, the army lost its elite character and special pleading for traumatised soldiers became unnecessary, with the exception of officers who were always considered separately in the diagnosis and treatment of shell shock.

Yet, these developments occurred without a major public debate: As Loughran argues in chapter four (‘Reading silences: gender and class in medical discourse on “Shell Shock”’) the published wartime medical discourse hardly ever touched on the role of class or rank and gender in shell shock (p. 129). This is remarkable because shell shock was a highly gendered (the published literature only considered soldiers, which is why we know so little about the traumatic reactions of nurses) and classed (there were separate treatment facilities for officers and men, and there were clear differences in the diagnostic labels used by doctors for soldiers of different ranks) concept. There was a tradition of separating functional disorders into male and female affections even if, in their clinical presentation, they were quite similar. Traumatic neuroses – hysterical symptoms typically developing after industrial accidents and thus largely observed in men – were the first point of reference for doctors trying to understand the newly emerging phenomenon of shell shock. With the extension of this pre-war concept, male hysteria moved from the industrial world into the combat zone, both masculine environments, taking over gender and class stereotypes (working class men, p. 128). Like traumatic neurosis, shell shock was never fully integrated into models of functional disorders. Despite an increased awareness of male hysteria in the early 20th century, it was only accepted in two particular contexts – the modern industrial environment and the warzone.

This ‘conscious, or at least partially conscious’ silence about gender and class issues in shell shock does not come as too much of a surprise. There was indirect evidence that the medical profession (male doctors) considered male hysteria as shameful. For example, they applied organic labels to symptoms which would have been classified as functional in women (p. 122). Despite the obvious silence, Loughran points out that previous scholarship (2) has focused on ‘the anomalous doctors who made class and gender central to their accounts or used overtly classed or gendered language’ (pp. 117–8). However, Loughran argues that this line of scholarship paints a misleading picture of the medical discourse of the time because wartime medical discourse hardly every touched on the role of class or rank in shell shock. There are only very few medical authors who addressed the relation of rank, symptoms and treatment in shell shock, mainly John T. MacCurdy and WHR Rivers (p. 129). The near absence of discussions on class and gender is a new observation, not analysed in previous scholarship.

Chapter five (‘Re-making men: will in medical approaches to shell shock’) introduces the concept of will as a central recurring theme in the medical literature of the time. Whereas the lack of will and self-control (or an imbalance of emotion and will) defined shell shock as an illness, treatment aimed at re-establishment of will and restoration of self-control (pp. 152–3, 157). Loughran argues that the concept of will linked medical and cultural discourses of masculinity, character and patriotism (p. 153). This chapter also provides an in-depth analysis of Lewis Ralph Yealland’s treatment approach to shell shock at the National Hospital in London. While Yealland used suggestion to remove the obvious symptoms of shell shock, he ‘saw the instillation of self-reliance and control as essential to restore both the patient’s lost function and his lost identity’ (p. 163).

Chapter six (‘Animal bodies and minds: instinct and regression in shell shock’) returns to the evolutionary framework introduced in chapter one and reflects on another theme surrounding the shell shock debates, that of instinct and regression. ‘Whether perceived as the dominance of emotion, the recrudescence of instinct, or the loss of self-control, shell shock always constituted a regression’, and both biologically and psychologically/psychoanalytically minded doctors/psychologists embraced the idea of ‘shell shock as regression to a lower level of individual or racial development’ (p. 193). I agree with this analysis, which

provides a very helpful framework for the understanding of the rather eclectic way in which many doctors combined psychodynamic, degeneration and physiological models to explain – and treat – shell shock. In fact, some of the treatments discussed by Mott in Britain and Binswanger in Germany appealed directly to the regressive elements in the presentations of the traumatised soldier. Footage of shell shocked soldiers in some of the medical films of the war gives evidence of regressive behaviour, for example soldiers playing with toy trains.

In her conclusion ('Shell shock and post-war medical culture'), Loughran reflects on the impact of the war and the shell-shock epidemic in particular on psychological medicine. Throughout the war, shell shock had ignited discussions on mental health, its integration into medical training, the improvement of treatment facilities and the deinstitutionalization of treatable mental conditions. Yet Loughran's analysis of the post-war medical literature concludes that – despite a flourishing interest in psychology and psychoanalysis – 'shell shock began to fade out of mainstream medical discourse' (p. 212). Loughran argues that although psychodynamic theories and therapies infiltrated medical culture through the conduit of shell shock, this did not involve fundamental revisions of existing theories and practices.

Based on a thorough analysis of the literature of the time, Loughran provides a fascinating account of medical discourse in Britain throughout the First World War. She traces trajectories of medical understanding in response to the newly emerging phenomenon of shell shock. This is very important work which discusses hitherto untouched topics. I only have a couple of critical remarks.

In the introduction Loughran states that '[d]octors based their knowledge of [shell shock] on the cases they treated, but viewed these cases through the lens of pre-war civilian medical culture' (p. 21). I am not sure I agree, at least for the specialist hospital at Queen Square. When I analysed the medical records of the time for *They Called it Shell Shock*, I got the impression that doctors had discarded their pre-war preconceptions about functional disease and viewed shell shock as something unconnected to civilian disease. One point of reference was traumatic neurosis of pre-war medical discourse, but this category was never really integrated into the group of functional disorders, as Loughran writes herself.

Another point is that, in chapter three, Loughran observes that at beginning of war psychological explanations dominated. Contrary to this view, I found that at the beginning of the war there were clear references to physical effects of shell explosions, for example by T. R. Elliott in his paper entitled *Transient paraplegia from shell explosions*.⁽³⁾ Furthermore, the frequent reference to traumatic hysteria in wartime medical literature and patient records in the early years of the war implies some – hidden – organic pathology. However, what seems most relevant to me is not the question if organic or psychological models dominated at the very beginning of the shell shock epidemic, but the observation that organic currents – after an intermittent recession in the middle of the war – grew stronger towards the end and after the war. This persistence of somatic models is an intriguing facet of the history of shell shock because they were favoured by patients and doctors alike. The 'taunt of having nothing to show' and the general stigma associated with mental disease, certainly contributed to this search for organic or physiological explanations. On this point I don't think I am actually in disagreement with Loughran, as evidenced by her analysis of the parallels between 'commotional shock' and present-day 'mild traumatic brain injury' (see further below).

As final point of disagreement, I have gone on record with a more positive appreciation of Lewis Yealland's work.⁽⁴⁾ My main points were that electrotherapy as such was common practice at the time and that Yealland incorporated it in a psychological treatment programme aiming at restoration of function and resilience. In fact, on this latter point Loughran seems to agree because she concludes her detailed analysis with the statement. 'Yealland ... saw the instillation of self-reliance and control as essential to restore both the patient's lost function and his lost identity' (p. 163). This is a remarkable approach which would later – through the concept of 'self-efficacy' - become well established in cognitive models and treatment approaches for depression.

Throughout the book, Loughran emphasises the importance of diagnostic terms and their implicit meaning.

This is very important, as diagnostic labels serve as valuable keys to aetiological models/beliefs about shell shock. As an enduring legacy for present discourse in medical humanities, Loughran establishes a co-production model of illness: ‘What doctors said and did influenced how patients suffered’ (p. 16). Medical knowledge is produced in encounters between patients and doctors.

Loughran also draws a link to current discussions on posttraumatic reactions in the military. From the beginning she emphasises that ‘although there is a definite historical relationship between the diagnostic constructions and experiences of shell shock and PTSD, the two syndromes are not direct equivalents or the same conditions under different names...’ (pp. 10–11). She also points out similarities between the wartime diagnostic categories of commotional shock and present-day mild traumatic brain injury (mTBI) in that both these categories comprised an organic, yet hitherto unidentified pathology (p. 97–8). This is another fascinating observation, which attests to the ongoing quest for organic explanations of traumatic syndromes, which may reflect a deep-seated need to replace the uncertainties of the mental world with seemingly more robust physical foundations.

Notes

1. S. Linden, *They called it Shell Shock* (Solihull, 2016).[Back to \(1\)](#)
2. Eric Leed, *No Man’s Land: Combat and Identity in World War I* (Cambridge, 1979); Elaine Showalter: *Elaine Showalter. The Female Malady: Women, Madness, and English Culture, 1830–1980* (Oxford, 1985).[Back to \(2\)](#)
3. T. R. Elliott, ‘Transient paraplegia from shell explosions’, *British Medical Journal*, 2 (1914), 1005–6.[Back to \(3\)](#)
4. S. Linden, E. Jones, A. Lees, ‘Shell shock at Queen Square: 100 years on’, *Brain*, 136 (2013), 1976–88.[Back to \(4\)](#)

The author declined to respond.

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