How did class influence the diagnosis and treatment of shell-shock in Britain during the First World War?

The Great War was the largest, most industrialised and destructive war that had ever been fought. Indeed, the effect of war on the Western Front on the minds and bodies of servicemen was equally as destructive. As Wendy Holden puts it, ‘the nerve-shattering properties of new killing machines that dominated the fighting – aeroplanes, tanks, and rapid-firing heavy calibre artillery – brought mental resistance to saturation levels’.¹ The first cases of mental breakdown amongst servicemen emerged merely a month after the war had begun, and it would become one of the most widespread injuries of the war.² Physical injury and death were the expected consequences of war, but trauma to one’s mind was wholly unexpected and no arrangements had been made for such an event. These war neuroses became popularly known as ‘shell shock’.

To try make sense of this ‘mystery plague’ and, most importantly, to get suffering soldiers back to the trenches, the War Office called upon neurologists, psychoanalysts and anatomical specialists from across Britain to examine the cases returning from the front.³ Various debates emerged over the significance of psychological or organic⁴ causes, as well as the question of nature versus nurture. However, this essay will explore how their approach would be influenced and sometimes undermined by the British class system, which was the pressures of the war effort and. This will be done primarily by examining the differing approaches taken towards soldiers (almost exclusively made up of men from

⁴ ‘Organic’ in this sense refers to the theory that a physical injury had been inflicted on a man’s nerves; i.e. ‘shattered nerves’; see Bourke, J. ‘Shell Shock during World War One’, BBC History, http://www.bbc.co.uk/history/worldwars/wwone/shellshock_01.shtml [Date accessed: 15/04/2015]
working-class backgrounds) and officers (normally men of upper- and middle-class origins) who were suffering from shell shock.

Soldiers had been referring to ‘shell shock’ since the war began, as it seemed to convey ‘the drama of the modern, mechanised battlefield’. However, the term was not formalised in medical discourse until Charles Myers, the British Expeditionary Force’s consulting psychologist, used it in reference to the ‘hysterical symptoms’ displayed by men exposed to the physical damage of shell blasts. Indeed, ‘this was the first time that the technology of war had included high-velocity explosive shells, employed in frightening and seemingly endless bombardment’, so it seemed to be a sufficient explanation for such an outbreak.

This was apparently a fairly undiscriminating diagnosis, and in this respect shell-shock seemed to be a great leveller—due to its supposed organic nature, it could affect anyone regardless of their background. However, psychological arguments began to gain momentum as the war raged on, and it became apparent that many cases of shell shock were occurring in men who had never been under fire. Myers would be at the forefront of this shift, changing his view to assert that psychological disturbance could be sufficient to cause shell shock.

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As early as December 1914 it became clear that officers were suffering these mental or nervous breakdowns at a higher rate than other ranks. It was estimated that 4 per cent of ordinary soldiers suffered from some kind of war neurosis, compared to 10 per cent of officers.\(^{10}\) By April 1917, one in six of those in hospital for war neurosis were officers, compared to the 1:30 ratio of officers to men at the Front.\(^{11}\) This challenged the presumption that officers, as members of the British elite, were both mentally and genetically superior to their working-class counterparts. However, ‘it would have been politically difficult to accuse these men of cowardice’, as Joanna Bourke writes.\(^{12}\) As a result, it was common for separate diagnoses to be made to distinguish suffering officers from suffering soldiers.

Ordinary soldiers were routinely diagnosed with ‘hysteria’, and described as ‘displaying gross physical symptoms such as mutism or paralysis’,\(^{13}\) explained by a supposed conflict between the primal instincts of self-preservation and ‘the esteem of the herd’.\(^{14}\) Furthermore, to be ‘hysteric’ carried significant stigma, being considered a condition of ‘faint-hearted women’, and thus implying that the men ‘had become over-emotional and suggestible’.\(^{15}\) To be diagnosed with hysteria implied a weakness of character or

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predisposition in the patient;¹⁶ sufferers were of ‘feeble will’, and were more liable to be seen as malingerers by military authorities.¹⁷

But as Major-General Sir W. P. MacPherson and his team remarked, ‘any soldier above the rank of corporal seemed possessed of too much dignity to become hysterical’.¹⁸ Officers were far more likely to be diagnosed as suffering from ‘the more refined and socially acceptable neurasthenia’, or ‘anxiety neurosis’, for which most sympathy was reserved.¹⁹ It was alleged that officers lived under constant pressure, with ‘the lot of numerous individuals … in their hands’.²⁰ Their ‘public school training and military discipline taught them to suppress their instinct of fear’,²¹ and their possession of ‘high ethical conceptions’ meant that they could not run away, so they simply ‘cracked’.²² The famed neurologist and psychiatrist W. H. R. Rivers asserted that ‘public schoolboys tried hard, through sheer mental effort, to repress traumatic memories’ and ‘faced particular emotional demands’. In clinging to ‘the shreds of an acceptable, even heroic, male ideal’ became intolerable and caused ‘persistent anxiety’.²³ This so-called ‘repression


neurosis’— similar to Freud’s concept of ‘suppression’—allowed the sufferer ‘to operate at a high level of cognitive functioning until his mental and physical energies are depleted. Once he crosses this threshold, there is a breakdown’. These ideas very much reinforced long held view that madness in middle classes was often caused by the stresses of over-working.

Another debate during the war related to eugenicist theory and social Darwinism, which had been very popular in the decades preceding the war and seeped into the perceptions of shell shock. George L. Mosse explains how shell shock was often regarded as ‘a mental state which mirrored a social disease and national degeneration’, which had ‘haunted society and culture ever since the turn of the century’. So shell-shocked men must have been degenerates, who threatened the “fundamental pillars of society—strong nerves, will-power and the clear separation of sexes’. As Hans Binnevald has written, the idea that shell-shocked men were ‘predisposed’ to their illness was a vital element in biomedical thought at this time. ‘Many military psychiatrists traced the disorder of their patients back to a weak constitution or nervousness in the structure of their personality. Wartime experiences were merely the final straw that broke the camel's back.’ One battalion doctor, Captain J.C. Dunn of the Royal Welsh Fusiliers, asserted that no sympathy or compassion should be shown to shell-shock victims, as they were inherent ‘weaklings who never should have been inducted into the army, or tricksters who deserved


to be punished’.  So ultimately, as the prominent psychiatrist Dr. Montague Eder declared, this war neurosis must develop in just two types of people: men ‘inherently below the level of civilisation, who may be called degenerates’ or in those who were ‘ethically in advance of their age’, who suffer ‘conflict between their conscious and unconscious selves’. The latter we can assume refers to the army officer, who Eder dubbed ‘the harbingers of a new world, of the dawning civilisation which may only (or may never) materialize centuries hence’.  

As Bienevald points out, these theories opened up ‘a wide range of racial and class-based stereotypes’. Particularly prone to hysteria were the Jews, while the Irish and lowland Scots were though to be ‘not up to manly combat’ and so also especially prone to malingering. Indeed, ethnicity was used as a sign by the medical profession to identify malingers. Another sign was men who wore earrings. The War Office had ‘explicitly argued that one of the most important tasks of medical officers was to police the behaviour of servicemen. When asked if he was a doctor, one army surgeon would reply, ‘No … I am a detective.’ As Reid and Van Everbroeck have noted, ‘Just as the discourse of nineteenth and early twentieth century poverty made a clear distinction between the


deserving and the undeserving poor, the discourse of wartime nerves distinguished between the shell-shocked and the shell shy. This categorization blurred the boundary between the medical and the moral and reflected elite fears about a feckless working class as well as a military culture in which there was a widespread suspicion of scrimshanking and malingering’.35

As Hans Binnevald argues, this social distribution of symptoms and diagnoses ‘corresponded in general outline with what was observable in civilian society’, and indeed so did the treatment. Without the circumstances of war, most hysteria patients—the ‘ordinary folk’—would be confined in public institutions, whereas those diagnosed as neurasthenic—‘chiefly to be found within the better-off later of the population’—were cared for in costly private clinics.’36 Though there was some overlap in the facilities for treating both shell-shocked officers and soldiers—Maghull, for example, cared for all, but with separate quarters for treating officers—the treatment of officers was mostly privately funded and independent from the treatment of the other ranks.37

Rivers believed that hysterical soldiers should be treated through ‘suggestion, persuasion, re-education, hypnosis, and physical means’.38 In some cases, a soldier would be confined in a room—sometimes referred to as a ‘torture chamber’—where he would be subject to ‘fierce intimidation, often accompanied by hypnosis or electroconvulsive therapy in which


increasingly painful electric shocks were administered in an attempt to compel “cure” in the ‘weak privates’. He would not be permitted to leave until the doctor had ‘cured’ him. This ‘very forceful, authoritarian, swift sort of therapy’ was called the ‘quick sure’ by the British, and was undoubtably influenced by the social and ethnic stereotypes of hysterical men and the presumption of malingering that came with it. These quick treatments suited a medical profession under pressure to get soldiers back on the frontline.

On the other hand, neurasthenic officers supposedly did not need such invasive or violent treatment; instead, Rivers believed that they ‘must be helped to lift the repression in order to confront, narrate, and metabolize the memory that has been thrust out of consciousness’. According to Peter Leese, ‘the Army Medical Services believed that having led by example, worked closely with the soldiers under their command and been pressured to take trenches and win attacks, shell-shocked officers in the field and in British treatment centres should receive certain traditional privileges’, and were accommodated for in various ways.

Indeed, there was significant stigma against mental illnesses, and shell-shocked officers were not exempt from this prejudice. However, as Leese summarises, efforts were made by doctors and the military to uphold the image of the suffering officers. ‘They were shielded more than exposed to the taint of dishonour, cowardice and insanity; treated more

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than disciplined; viewed with sympathy more than suspicion. … In the eyes of the press, in politics and in Army treatment, it was officers who suffered shell shock and who were heroes willing to sacrifice their sanity for the war effort.\textsuperscript{43} Furthermore, the elite education officers had received, and more generally their social position and military function, ‘gave them a different vocabulary in which to express their feelings and thoughts’, which in ways validated their suffering in ways that the normal soldier hadn’t the words to convey.\textsuperscript{44}

Finally, however, it must not be forgotten that a great deal of the victims of shell shock faced courts martial, and many of the 306 shot for cowardice or desertion were those suffering shell shock. Though a higher proportion of officers would suffer from war neuroses, no officer would be shot for neurasthenia. As John Crossland writes, ‘Army officers could use the whisky bottle as a prop for shattered nerves; flyers no longer able to stand the strain of playing hide and seek with the Red Baron in their flying coffins could off a patrol and not be accounted cowards. But God help Tommy Atkins if he cracked.’\textsuperscript{45}

The response to shell shock over the course of the war was riddled with contradictions and an overall inconsistency in both the military’s and the medical profession’s approach, which reflects how unprepared they were for such wide-spread mental illness in war. As a result, a piecemeal approach was taken which in many ways manifested itself in social prejudices which existed before the war broke out. Fundamentally, the ‘rigidly-structured class system of Edwardian Britain’,\textsuperscript{46} combined with suspicion and hasty diagnosis due to the pressures of war, meant that one’s experience as a victim of shell-shock would


significantly be shaped by his social position, and this could ultimately mean the difference between life and death.
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