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# War Neurosis and Cultural Change in England, 1914–22: The Work of the War Office Committee of Enquiry into 'Shell-Shock'

**The first world war** fundamentally challenged inherited social and cultural ideas, including traditional views of mental illness and its treatment. The hordes of English veterans who suffered from war-induced mental illness, or what was then called 'shell-shock', raised the most complex and disturbing questions. Their sufferings not only challenged long-held medical opinions about the nature and treatment of mental illness, but seemed to demand that the very well-springs of human behaviour be explored anew. Furthermore, so basic were the questions posed by the shell-shock crisis that they ultimately threatened a number of traditional moral values. New views of the mind brought in their wake ambivalence where formerly there had been certainty. An important manifestation of this transformation of values was the *Report of the War Office Committee of Enquiry into 'Shell-Shock'* which was issued in 1922.

On 28 April 1920, Lord Southborough addressed the House of Lords regarding his motion to establish a committee to investigate the nature and treatment of 'shell-shock' in the Great War.

> The subject of shell-shock cannot be referred to with any pleasure. All would desire to forget it — to forget . . . the roll of insanity, suicide, and death; to bury our recollections of the horrible disorder, and to keep on the surface nothing but the cherished memory of those who were the victims of this malignity. But, my Lords, we cannot do this, because a great number of cases of those who suffer from shell-shock and its allied disorders are still upon our hands and they deserve our sympathy and care.[1]

Two years after the Armistice, some 65,000 ex-servicemen were drawing disability pensions for neurasthenia; of these, 9000 were still undergoing hospital treatment.[2] There could scarcely have been a member of the House of Lords who had not heard of someone

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breaking down as a result of the war. Indeed, it is a signal evidence of the revolution in attitudes toward mental illness in the half-decade since 1914 that in the debate which followed Southborough's statement no one contradicted the existence or seriousness of 'shell-shock', as would likely have been the case in the first years of the war. Lord Horne, formerly a general staff officer, supported the motion, and said: 'I think every one will agree that under the novel conditions that are met with on a modern battlefield there is no man who does not suffer from fright'. Horne was 'much struck' by the possibility of training 'our soldiers to endure the nerve-shattering conditions which lead to this form of shell-shock'.[3]

The relationship between cowardice in battle and 'shell-shock' was a theme which ran all through the debate: Southborough himself had raised it dramatically in his motion. He was not alone. There was widespread fear after the Armistice that among the 3000 soldiers convicted by courts-martial for cowardice, desertion or other crimes (of whom 346 were executed) there were a considerable number who had been suffering from war-induced mental illness and thus had been unjustly sentenced.[4] Viscount Haldane, who had reviewed all court-martial sentences, surprisingly agreed with Southborough that there had been 'injustices done in the early stages of the war' before shell-shock was generally understood.[5] And he revealed that he and the War Office had been much occupied by the problem of shell-shock during the recent conflict.

This essay will discuss the work and conclusions of the Committee of Enquiry into 'Shell-Shock', the result of Southborough's motion, and attempt to demonstrate how these reflect some important changes in traditional English ideas regarding mental illness and morality between 1914 and 1922. It will begin with a brief discussion of the sometimes sharp distinctions between the mad and the sane prevalent in pre-1914 England and say something about the conditions of trench warfare on the Western Front which caused these distinctions to become blurred. It will allude to the reactions of the medical profession, the government, the army and the general public to the many mental casualties of that brutal war. The heart of the essay will be a discussion of the work of the 'Shell-Shock' Committee with particular emphasis on its final report, which reveals changing attitudes towards the origins and cure of mental illness. Finally, it will emphasize a subtle shift in English values resulting from the crisis in mental illness which the committee's report indirectly highlights.

The near unanimous sympathy and support Southborough encountered when he made his motion in the House of Lords was all the more remarkable when one considers the views of insanity held by the legal and medical professions and the public at large in the decades before 1914. Shell-shock was a legal, medical and moral half-way house in a society used to a clear division between the mad and the sane.

Legal evidence of this pre-war distinction was the M'Naghten Rules of 1843, which still served as a guide for British courts in 1914. They held that a defendant could legitimately be judged innocent on grounds of insanity only if he was completely unaware of his deeds or could not distinguish between right and wrong. There was no middle ground here — only sanity or insanity. Although there is some evidence that during and immediately after the first world war courts were seeking to modify this Manichaen measure, employment of the M'Naghten Rules remained the legal norm in the first decades of this century.[6] A further legal manifestation of this black-and-white division was that before 1930 public asylums (with the exception of the Maudsley Hospital in London) permitted no voluntary admissions unless the patient was legally certified insane, with all the social stigma that implied.[7]

The English medical profession before 1914 reflected some of the stark divisions between the mad and the sane prevalent in law and in society. Before the war, English medical opinion regarding mental illness had not changed substantially since the 1880s; a somatic interpretation was still dominant. This somatic or physiological view rested on a theory of 'psychophysical parallelism'. According to this dualistic theory, closed mental and physical systems co-existed in a healthy man in a certain relational balance, but did not normally directly interact with each other. In the sane individual, the mind was autonomous. In the mentally ill, however, the autonomy of the mind

> was severely reduced, or even lost altogether. Thought and feeling were progressively removed from the sphere of volitional control . . . and eventually reduced to the level of mere epiphenomena of underlying morbid states . . . of the brain and nervous system . . . Diseased physical processes, as it were, spilled over . . . into the normally separate and closed domain of mind, impairing or suspending the action of the normal psychological processes that were ordinarily responsible for mental phenomena.[8]

There was widespread acceptance among English psychologists 'that insanity was a disorder of mind resulting from a structural or

functional lesion of the "organ of mind" ', that is, 'the brain . . .'[9] It was thus the task of the physician to ignore irrational mental symptoms and to attend solely to diseased physical or somatic processes: only the latter were susceptible to scientific inquiry.

Such a mechanistic view of the mind led many English psychologists between 1880 and 1914 to reject 'mental' therapies, based on unconscious processes, such as psychoanalysis and hypnotism. They regarded the patient's dreams and delusions as beyond rational analysis and thus of no importance in therapy.[10] Following from this, physicians felt obliged to assert their authority over the 'deluded' and 'irresponsible' patient. Therapy, especially in the case of female hysterics, was regarded as a 'battle of wills' in which the doctor must triumph. The 'moral/pastoral' duties[11] of the psychologist demanded that he guide the patient back to the road of reason, that he encourage him to exercise his will-power for good ends and to take up his social responsibilities again.

In practice, doctors switched back and forth between their somatic theories and vague and often unexamined 'mental' categories.[12] Psychologists who treated hysterics and neurasthenics could speak of the approaching day when the location of minute brain lesions responsible for these maladies would be found, and then turn around and posit immoral behaviour and a failure of character and will-power as the prime causes of these afflictions. Such confusion of the material and the mental led physicians, for example, to refer to a 'lesion of the will'.[13]

In Victorian and Edwardian England, the medical profession espoused the values associated with what Nathan G. Hale calls 'civilized' morality,[14] among the most important of which were character and will-power. ' "Victorian" is almost synonymous with "will-power"; a genre of popular writing exhorted readers to exercise their innate mental power over thoughts and acts.'[15] For educated Englishmen, the existence of will-power confirmed the 'special dignity of man and his moral nature'.[16] It was the duty of schools to promote character in the young by 'programming' (in today's parlance) the will 'into the very structure of the nervous system, storing up through daily habit the capacity for active response in particular situations'.[17]

There are few better examples of the pre-war belief in the importance of character than in an 'anatomy of courage' written three decades after the Armistice by Lord Moran, a regimental medical officer in the Great War and subsequently Winston Churchill's

private physician. His views on war as the ultimate test of character have great relevance to the shell-shock phenomenon of the first world war.

> I contend that fortitude in war has its roots in morality; that selection is a search for character; and that war itself is but one more test — the supreme and final test if you will — of character . . . Character as Aristotle taught is a habit, the daily choice of right instead of wrong; it is a moral quality which grows to maturity in peace and is not suddenly developed on the outbreak of war . . . Man's fate in battle is worked out before war begins. For his acts in war are dictated not by courage, not by fear, but by conscience, of which war is the final test.[18]

In his study, Moran displayed ambivalence regarding the origins of war neuroses as well as sympathy for its victims. Yet he could still write that shell-shock gave 'fear a respectable name'.[19] His ambiguous responses to this phenomenon demonstrate that as late as 1945 officers and doctors were still wrestling with its troubling implications.

The decade and a half prior to the first world war was the high-water mark of the celebration of character and the will. The reformed public schools in England had for decades seen as their primary task the building of character and will-power in their élite charges: to this end, team sports and the prefect system were crucial. As late as 1917, one psychologist could maintain that products of public schools were less prone to shell-shock, for they had had the benefit of that 'atmosphere . . . in which character and manliness are developed side by side with learning', and which 'seems to prevent neurasthenia'.[20] As the quotation from Lord Moran indicates, it was widely held before 1914 that war would be the supreme test of character and will. Sir Ian Hamilton, among other staff officers, stressed the training of the will-power of the English soldier:[21] *élan vitale*, it was thought, could overcome any material obstacle.

These voluntarist values, considered so essential in late nineteenth-century English society, had their repercussions in the medical profession's views on mental illness. The physician's attitude toward the hysteric and the neurasthenic was often one of moral condemnation: they were seen as morally depraved, wilful and egoistic. These judgements led the physician to stress 'discipline, chastisement and even punishment' as part of the therapeutic process. Such attitudes would reappear in the treatment of shell-shock during the war and in the final report of the 'Shell-Shock' Committee.

Before 1914, some of the ideas of the nascent English psycho-analytic movement had begun to penetrate medical opinion, partially

through the efforts of such men as F.W.H. Myers, Havelock Ellis, Bernard Hart and Ernest Jones.[22] However, as a result of the dominant medical and social attitudes described above, many medical practitioners vehemently opposed the new 'depth' psychology of Freud and other continental theorists. The medical journal, *The Lancet*, issued regular broadsides against the parochialism of English psychology.[23]

Yet many doctors thought they had good reason to reject the ideas associated with psychoanalysis. Such therapies, based on the exploration of unconscious motivation and primary processes, seemed to them to encourage rather than alleviate the patient's 'morbid introspection' and 'deficiency of will-power'.[24] Furthermore, Freud's frank discussion of the sexual etiology of neuroses and his stress on infantile sexuality threatened prevailing moral standards, and his emphasis on the continuity between normal and abnormal mental states undermined crucial pre-war legal and medical distinctions. Thus Freud's theories aroused fierce opposition as much for relativizing traditional values and demarcations as for challenging medical orthodoxies.

Such hostile attitudes were still to be found years after the Armistice. Even a doctor sympathetic to victims of war neurosis could write in the official medical history of the war: 'Any soldier above the rank of corporal seemed possessed of too much dignity to become hysterical'.[25] And in 1914 many Englishmen still sharply differentiated between madness and sanity and placed a heavy burden of guilt and shame on those who broke down.

The war on the Western Front helped blur these distinctions. A 1916 editorial in *The Lancet* stated the problem succinctly: in the first two years of the war many 'healthy young males' had suddenly begun to experience the symptoms of neurasthenia. Such cases ought not to be labelled 'sane or insane'. The editorial declared that in medicine there is a 'no-man's-land' which 'defies definition'. 'This nebulous zone shelters many among the sad examples of nervous trouble sent home from the front . . .'[26] The popular catch-all name applied to this muddle of mental affliction arising from the war was 'shell-shock'.

Most Englishmen were utterly unprepared for the stalemate on the Western Front and the triumph of artillery, machine-guns and barbed wire over human 'valour'. For many Britons, after all, the Great War initially had promised to reassert the power of the moral over the mechanical, of the élite over the mass, of spiritual over material forces. All the disintegrative trends of the last sixty years,

from the decline of religion to the rise of Labour, would be overcome by courageous men of character who would defeat the enemy through the exertion of their implacable will-power. As an editorial in *The Times* of 25 October 1914 declared, the heroic values of Agincourt would be revived. After November 1914, it was not to be that way at all.

In the House of Lords debate, Lord Horne had referred to the 'novel' and 'nerve-shattering' conditions of the modern battlefield which had led to the breakdown of so many English soldiers. The nightmare world of the Western Front has been explored by many commentators, most eloquently by the Great War poets who captured forever the horror of that war in their verse.[27] Here it will be sufficient merely to list some of the more important factors arising from service in the trenches which, acting singly or together, were often sufficient to push seemingly healthy young officers and men into temporary or permanent mental breakdown.[28] Concussion from exploding shells was the earliest remarked cause of war neurosis, hence the name 'shell-shock'. Of far greater consequence, however, was the strain of serving in the inhuman conditions of trench warfare and the exhaustion which followed from the soldier's inability to obtain sleep in the line. The witnessing of the mutilation or annihilation of a comrade often produced cases of severe shock. This was compounded by the lingering survivor's guilt syndrome, which years after the war continued to plague veterans. Too many such sights in conditions of static warfare could produce feelings of futility and despair. Such factors could be enhanced or mitigated by unit morale, which varied from battalion to battalion. For officers especially, a crushing sense of responsibility and the fear of showing fear were additional factors which might lead to mental collapse. For all ranks the very *nature* of battle on the Western Front, a static struggle dominated by machines where the individual counted for little, contributed greatly to widespread mental illness after November 1914 when the stalemate began.

While soldiers in France were often immediately aware of how these monstrous conditions had contributed to the vast amount of war neurosis on the Western Front, for most civilians in England shell-shock remained an elusive and vaguely threatening phenomenon. They learned of it mainly through the national press, whose articles mirrored the growing English awareness of the nature and intensity of the shell-shock crisis.

In the autumn of 1914, newspapers began to write of the 'uncanny effect of shells', and *The Lancet* reported on October 31: 'More than once in the accounts of the present war reference has been made to the use of shells which on exploding' leave their victims 'in life-like groups . . . the whole suggesting a group of waxwork bodies at Madame Tussaud's'. These early references to shell-shock in the press imply a *mysterious* malady of *physiological* origin resulting from shell bursts which, without leaving a trace, somehow sucked the life out of their victims. By early 1915, however, a clearer picture of war neurosis was beginning to emerge: it soon became obvious even to civilian observers that it was not artillery shells alone which were responsible for the increasing number of breakdowns in France, but rather the general atrocious conditions of the Western Front itself. By early 1915, the English public was reading a startling variety of newspaper stories about shell-shock. A series of articles appeared in *The Times*, for example, referring to hysterical blindness (8 April), 'The Wounded Mind' (24 April), and deafness and paralysis resulting from 'Wounds of consciousness' (25 May) among soldiers in the trenches. By mid-1916, the shell-shocked soldier had become a virtual cliché in the English press.

Readers of the national press were also being exposed to new views of the mind and new methods of treatment of war neurosis. If most observers still thought of diagnosis and treatment in organic terms, some now turned to theories of the unconscious for an explanation of shell-shock. Already on 8 April 1915, *The Times*'s medical correspondent was referring to the schema of the mind loosely derived from Freud's theories and elaborating upon the role of the 'sub-conscious' in war neurosis. A number of war-time articles on shell-shock employed a terminology indebted to Freud (even if their authors rarely acknowledged him). In the last years of the war, some of the once arcane vocabulary of psychoanalysis was being casually employed by journalists.

As the war progressed and mental casualties mounted, medical journals and conferences were increasingly the venues for debates between supporters of somatic and psychological treatment for shell-shock.[29] Psychoanalysts such as M.D. Eder attacked those, such as the neurologist Sir Frederick Mott, who appeared to dismiss Freud.[30] Some psychologists delightedly declared that 'shell-shock' had disproved Freud's 'sex' theories once and for all.[31] The full heat of the debate between the rival schools could be felt in such publications as G. Elliot Smith's and T.H. Pear's *Shell-Shock and Its*

*Lessons* (1917), which attacked the somatic school and the inadequacy of English treatment and facilities for the mentally ill. Smith and Pear demanded that the 'lessons' of shell-shock be applied to civilian medicine.[32]

The disturbing implications of this new phenomenon for conventional morality were also quickly noted by the national press. *The Morning Post*, for example, reported the case of an officer, a veteran of the trenches, who, once back in England, had been accused of theft. The judge had let him off lightly on hearing he had suffered from a war neurosis.[33] And occasional word of executions for cowardice had filtered home from France: if a thief could be absolved from responsibility for his act because he had suffered from shell-shock, could it be the case that some — perhaps many — of those who paid the highest penalty were also victims of this same disease?

A further measure of the importance of this phenomenon was the reaction of the English government and the army. Two years of mental casualties culminating in the thousands of shell-shock cases from the Somme forced the army to create a chain of specialized medical treatment centres, ranging from the casualty clearing stations in France to the special army mental hospitals in England. By June 1918, there were six special neurological hospitals for officers and thirteen for other ranks. Of even more interest was that physicians employing modified psychoanalytic techniques were prominent among those who treated shell-shocked officers and men. Two of the more famous were the principal commanding medical officers at Craiglockhart War Hospital in Scotland: Dr W.H.R. Rivers and Dr William Brown. While most military mental hospitals still emphasized diet, hard work and occasional punitive 'electric shock' cures for their patients, a much simplified form of psychotherapy, with perhaps an implicit admission that shell-shock's origins might lie in unconscious processes, was also prominently employed.[34]

Thus, by the Armistice, English soldiers and civilians had been exposed for four and a half years to a profound crisis of war-induced mental breakdown on the Western Front. Many, perhaps most, soldiers had heard of or had actually witnessed such cases; the army at all levels from the company commander to the General Staff was concerned about wastage and the effect on morale of shell-shock; the government was drawn in, for it had to create and staff from scratch military mental hospitals and provide pensions for long-term cases; the medical profession was exposed to vigorous debates about the

validity of 'mental' explanations of war neurosis; finally, English civilians were bombarded with an array of stories on war neurosis in the national press for the length of the war. By 1918, as a result of the shell-shock crisis, fundamental questions were being raised not only about the origins and treatment of mental illness but also whether formerly firm lines of moral behaviour could continue to be maintained in light of this new knowledge.

The War Office Committee of Enquiry into 'Shell-Shock', under the chairmanship of Lord Southborough, met officially from 7 September 1920 to 22 June 1922. It began its work in a politically-charged atmosphere. Reflecting popular concern and claiming to speak for the other ranks, the Labour Party argued that among those men executed for cowardice were many who had been shell-shock victims and thus had been unjustly sentenced to death. Labour MPs repeatedly raised this issue in parliament and lobbied for the abolition of the military death penalty.[35] Indeed, this mandate, namely, to discover 'whether there was any reason to think that in many cases men executed for cowardice were suffering from some form of this malady', must have weighed heavily on all members of the committee.

Not only was war neurosis now a political question, it was also one of consuming popular interest, as the 'shell-shock' debate in the House of Lords attests. Southborough told his committee that he had received many letters from people desiring to testify about their own and others' experiences with shell-shock and from those labouring under the mistaken impression that the committee was sitting to amend Britain's lunacy laws.[36]

It is not unreasonable to assume that, in spite of the breadth of their official mandate, Southborough's committee may have hoped to confine themselves to specific recommendations of a military nature regarding the origin, treatment and prevention of war neuroses. But from their first meeting, committee members were aware that they were treating a problem with profound implications. Perhaps some of the occasional irritation and exasperation evident in testimony of witnesses and in the final report arose from their realization that whatever precise and limited conclusions they reached, the public would likely put a far broader interpretation on them.

Faced with such a delicate and complex task, the committee was fortunate to have as its chairman the highly-regarded career civil

servant Lord Southborough (1860–1947). Southborough had had wide experience in both government and the business community, having been a long-time member of the Board of Trade. He had held a variety of responsible government posts during the war, one of the most challenging being his secret mission to Scandinavia in February 1917, in an effort to negotiate a separate peace with Austria.[37] A respected administrator who was sensitive to the sufferings of the victims of war neurosis, Southborough seemed in many ways the ideal arbitrator for a committee treating such a delicate and complex issue.

The chairman and his secretary put together a list of fifteen members to staff the committee. Reflecting the nature of the problem, eleven out of the fifteen were medically trained and six were representatives of the armed services. Among these were medical men attached to the War Office, the Admiralty, the Air Ministry, the Board of Control, the Ministry of Pensions, the Army and the Royal Army Medical Corps. Two prominent neuropathologists were appointed to the committee: Sir Frederick W. Mott and William Aldren Turner. In addition, there were two Members of Parliament: the Liberal Major W. Waring and, bowing to Labour's proprietory interest in the matter, the Labourite Stephen Walsh.[38]

The constitution of the committee, with the notable exception of Walsh, was of a somewhat conservative cast. It was, after all, intimately linked to the War Office and to the government. Committee members were overwhelmingly from the middle and upper strata of British society. Again with the exception of Walsh, a coal-miner's son, most members (perhaps the majority of witnesses as well) were products of an élite education at a public school and ancient university. During the war, most had held responsible positions in the military or the government. Such social and educational backgrounds were likely to predispose committee members to hold a number of views antagonistic to the new tenets of Freudian psychology and especially to the moral implications of the shell-shock crisis. Furthermore, they were extremely class-conscious, as is evident in their patronizing tone when discussing the 'lower orders' and the other ranks. They expressed open scorn for the 'public mind' which had been 'contaminated' by the fallacious idea of shell-shock. They were products of an age dominated by the ideas of social Darwinism, the eugenics movement and racism; they reflected as well some of that pre-war obsession with national and racial degeneration.

Such men as these had been exposed since childhood to the tenets of 'character' and the exercise of the will.

The medical men on the committee were trained in the somatic theories of mental illness which were a mainstay of medical education before the war. Sir Frederick Mott, a leading exponent of this view, was deferred to by the committee: there are a number of references to his theories in the report as well as whole pages lifted almost verbatim from his book on war neuroses.[39]

The committee members, while displaying a number of conservative attitudes, were well aware of the demand for change in post-war England; indeed, some, Southborough most obviously, were in favour of limited reform of army and civil laws governing the mentally ill. Still, these men would not lightly have challenged medical, social or cultural orthodoxies. Yet it was just these moderate and unremarkable members of Britain's governing classes who found themselves confronted with a phenomenon which would ultimately test some of their most cherished beliefs.

The committee began its serious work by defining its 'terms of reference', drawing up an elaborate questionnaire and calling witnesses. The questionnaire provided to each witness in advance contained thirty-eight questions; most were of a specific nature and dealt with such problems as military recruiting and training, the nature of shell-shock, and so on. (The questionnaire was sufficiently daunting that some non-medical witnesses such as General Jeudwine and Lord Horne wrote to say they had had difficulty in answering it.) The kinds of questions it posed indicate the fairly limited inquiry relating mostly to matters of military medicine and discipline which the committee wished to follow, but to which it only partially succeeded in adhering.

The fifty-nine witnesses who appeared before the committee during its forty-one sittings comprised a cross-section of those most directly connected with the crisis of shell-shock in the first world war. Among those who appeared were army staff officers, regimental and battalion commanders, medical officers, neurologists and psychologists who had treated shell-shock victims at home and in France, Ministry of Pensions officials and at least six men (two officers and four other ranks) who had suffered or were still suffering from war neuroses.

The final report of the committee, issued in 1922, contains both excerpts from and a summary of the witnesses' testimony. The

extremes of testimony may be seen in the cases of Lord Gort of the Grenadier Guards and of Dr W.H.R. Rivers of St John's College, Cambridge.

While displaying some understanding of the origins of shell-shock, Lt-Col. Viscount Gort, VC, thought it was almost entirely a matter of morale: in first-class units shell-shock was scarcely to be found. He declared that shell-shock 'must be looked upon as a form of disgrace to the soldier'. As for its prevention: 'Officers must be taught much more about man mastership in the same way as horse mastership . . . It is all to a great extent a question of discipline and drill.' He thought 'that a large number of the men who two or three years after the war were still suffering from "shell-shock" symptoms were probably bordering on lunacy before'.[40]

Dr Rivers, a pioneering psychologist and anthropologist who had commanded Craiglockhart War Hospital for shell-shocked officers in Scotland, insisted, on the other hand, that there was such a thing as a mental wound arising primarily from stress. He provided a sophisticated explanation for the wide incidence of shell-shock on the Western Front. It was due to the nature of the war there: men in the trenches were often passive and helpless for long periods of time. This could be particularly disastrous to the psyches of men in the worst periods of danger, since one's natural tendency in a moment of peril was what Rivers called 'manipulative' activity. He believed the repression of terrifying experiences a normal reaction, but one which was utterly wrong for the unparalleled horrors of the recent war: the patient must unburden himself to his therapist in order to be cured.[41]

Between these extremes of sophistication and dogged ignorance, the whole spectrum of medical, military and civilian attitudes toward the shell-shock crisis appears in the committee's final report. There the committee confidently stated its 'unanimity of opinion' regarding the causes and cure of war neuroses: 'The evidence of these distinguished witnesses should remove from the public mind any doubt of the true nature of "shell-shock" '.[42] Contrary to this assertion, however, what may be most striking to the modern reader is the ambivalence, antagonism and even confusion of intelligent men confronted with a startling and ambiguous phenomenon for which little in their background or education had prepared them. In the following pages, we shall discuss the most important problems studied by the committee, its solutions to these problems and the overt and hidden ambivalences and occasional contradictions which

are contained in its final report. A close analysis of their work and conclusions will reveal a good deal about the nature and impact of the shell-shock crisis of the first world war and its wider implications both for the medical profession and English culture as a whole.

The most important problems and conclusions discussed in the committee's final report may be divided into the following general areas: (1) the nature of shell-shock; (2) who was likely to succumb to it; (3) the general treatment of shell-shock; (4) specific military measures for its prevention and treatment; and (5) cowardice in battle and its relationship to shell-shock.

As on so many other issues, witnesses and committee members were ultimately divided on the nature of shell-shock. Owing perhaps to what the report itself labelled 'the materialistic trend [before 1914] of modern scientific medicine',[43] considerable evidence was given as to the physiological basis of war neurosis. Witnesses explored the relationship of shell-shock to the endocrine glands, the vegetative nervous system, alcoholism, syphilis and other diseases. 'Lesions' of the brain, 'commotional shock', and concussion — all organic wounds stemming from high-explosives — offered opportunities for medical precision in contrast to the muddled categories of what was then called 'emotional' shell-shock.[44]

Yet the committee was fully aware of an alternative explanation of the origins of war neurosis. Perhaps its most crucial statement was that many witnesses, including such respected figures as Drs Henry Head and W.H.R. Rivers, maintained that the origin of the affliction was 'mental'.

How suspect such ideas still were in the early 1920s may be gauged by the committee's discussion of this psychogenic explanation in its 'Summary of Psychological Evidence'.[45] (It is treated, for example, as but one of a number of competing theories.) Cautious in its treatment of ideas laden with disturbing implications, the summary resembles in its circumspect language early press reports of the 'shell-shock' crisis. Inevitably, however, some of the vocabulary and ideas found in this summary were indebted to Freud's revolutionary theories. This was evident not only in its emphasis on the unconscious mind but also in the terminology it employed: 'repression' and 'conversion' hysteria, for example, were recent additions to medical and public parlance and were strongly associated with Freud's work.[46] Thus, although later explicitly rejecting his therapy, the committee was repeatedly forced to pay heed to his radical ideas. Furthermore, the committee

discovered that some of the most respected psychologists who supported the 'mental' thesis employed some of Freud's insights in their eclectic therapy. (There was, however, no self-proclaimed disciple of Freud among the fifty-nine witnesses.) Thus the tendency of some committee members to favour an organically-based theory of shell-shock was in conflict with the testimony of expert witnesses. In the section on treatment below, we shall see that the committee tried to arrive at a sort of 'half-way house' regarding the origins and treatment of shell-shock.

The report describes in some detail the treatment accorded shell-shock in the regular army at the beginning of the war. The regimental medical officer, trained to see nervous collapse as physiologically-based, either discovered an organic wound which was then treated or, failing that, forced the afflicted soldier to assume 'responsibility' for his condition and return to his unit. Such methods worked well in the regular army, whose officers could properly interpret the 'moral code of honour';[47] but they were no longer suitable for the conscript armies of 1916–18. These 'untrained men', these civilians in uniform, witnesses agreed, had neither the strength nor the endurance of the regular army. With the introduction of such troops in battle shell-shock casualties soared.

Of course, there was much truth in this view. Obviously, conscript armies were more likely to have neurotics and potential hysterics. Still, what is of interest here is the covert and in places overt disapproval of conscript soldiers; it was as if, frustrated by the slipperiness and ambiguity of the disease, witnesses and committee members blamed the victims rather than the atrocious conditions of the Western Front. Such attitudes, in conjunction with pre-war social prejudices, appeared as well when witnesses declared that certain racial, social and occupational groups were more likely to break down than others. (Jews, Irishmen, and the lower classes generally were suspect in this regard.) Given such views, however, it is immensely significant that the report ultimately declared:

> Witnesses were agreed that any type of individual might suffer from one or other form of neurosis if exposed for a sufficient length of time to the conditions of modern warfare, and that it is extremely difficult to say beforehand what type of man is most likely to break down . . .[48]

Ambivalence regarding the 'mental' explanation of shell-shock was especially evident in the section on treatment. As indicated above, some of the committee's insights into the unconscious origins of

shell-shock were ultimately traceable to Freud and his English followers. Yet many witnesses and committee members appear to have regarded Freud and his theories with hostility. The writers of the report rejected his form of therapy outright: 'They do not recommend psycho-analysis in the Freudian sense'.[49] Among the reasons for this rejection were:

> A full analysis in the Freudian sense (Psycho-analysis) was recommended by very few witnesses, while several witnesses spoke against its employment (Dr Mapother regarded it as unnecessary and impracticable, Dr Bernard Hart as hardly applicable at all, Dr Hurst as dangerous in setting up sexual ideas, etc.).[50]

Of course, strict Freudian psycho-analysis demanding daily fifty-minute sessions extending over the course of months or even years not only was 'impracticable' in military hospitals in the midst of a world war but also probably impossible.[51] But it appears that it was not so much Freud's therapy as the theory underlying it that antagonized committee members. The report, for example, explicitly rejects treatment 'based on a purely sexual view of the mind . . .'. On the other hand, many medical witnesses did recommend a kind of therapy which still bore some similarity to Freud's 'talking cure', that is, a 'modified analysis . . . such as would be necessary for the thorough cross-examination of the patient . . .'.[52]

Given the conflicting testimony of witnesses and their own divided views on the nature of mental illness, it is not surprising that the committee chose a moderate 'half-way house' between a treatment which concentrated on the somatic aspects and one which emphasized the unconscious or 'mental' origins of war neurosis. 'There is a not inconsiderable body of opinion,' the report declared, 'that the value of psycho-therapeutic treatment has been much overrated.' Instead, the committee seemed inclined to support a therapy which was 'both physical and mental in its aims'. In the course of such a therapy, the exhausted nervous system would be given rest and the 'pathological' and 'subjective outlook' of the shell-shocked patient would be replaced 'by a normal and objective one . . .'.[53] The committee was of the opinion that

> good results will be obtained in the majority [of cases] by the simplest forms of psycho-therapy, *i.e.*, explanation, persuasion and suggestion, aided by such physical methods as baths, electricity and massage. Rest of mind and body is essential in all cases.[54]

The committee's report discusses six forms of simplified 'psychotherapeutic treatment' often used in the war: (1) persuasion; (2) explanation; (3) suggestion; (4) analysis; (5) re-education; (6) occupation.[55] *Persuasion* was the method of the medical officer who used everything from 'moral suasion' (sic) to threats and even physical force to drive the shell-shocked soldier to take up his duty again. Physicians used *explanation* in the rear areas and in England: the patient was told that he did not suffer from an irreversible or mysterious illness but one which could be cured with his co-operation; he was shown the 'direction he must turn to get rid of his troubles'.[56] *Suggestion* was employed to reinforce the patient in his efforts to be cured by telling him, for example, that his 'lost function' (speech, eyesight) was 'returning to activity'. *Analysis* has been described above, i.e., a 'modified analysis' was recommended. *Re-education* was the re-awakening of the patient's sense of duty through propagandizing him in the 'military and social necessities . . .'.[57] *Occupation*, that is, keeping the patient constantly busy with sports and physical labour, was considered essential during the period of 're-education'.

As is clear from the report, those who treated shell-shock during the war occupied a position somewhere between sympathetic counsellor and military policeman, with emphasis on the latter role. This was in keeping, of course, with the 'moral/pastoral' duties of the pre-war psychologist. The regimental medical officer was entitled to use force if necessary to convince the soldier to return to the line; doctors in receiving centres behind the line employed 'every method of persuasion and suggestion', including those that could easily be seen as a mixture of coercion and punishment, such as 'electrical stimulation, forcible movements, cold douches . . .'.[58]

In the 're-education' phase, it was considered part of the doctor's duty, once the patient's symptoms were cleared away, to propagandize the patient to return to the front. (This too had its roots in Victorian psychology, which emphasized the 'social obligations' of the patient.) It

> was found necessary to submit the patient to a course of graduated experiences which could prepare him for taking on his duties again, and accompanying this it was necessary to implant a raised moral view very often with a widening of the intelligent conception of the military and social necessities, so that the patient should have sufficient stability and moral support to again face the stresses of his service.[59]

As in late nineteenth-century psychiatry, there was much coercion contained in these 'simple' therapies. According to the report, the doctor must use every means at his disposal to force the shell-shocked patient to choose between his 'selfish' and 'social' tendencies. '[T]here must be no barriers of escape between the patient and himself.'[60] Hospitals treating war neuroses must have a 'correct atmosphere of cure', wherein the patient is neither pitied nor 'molly-coddled'; discipline must be maintained at all costs, and privileges will be awarded the patient only in so far as he shows 'improvement'.[61]

Perhaps the most obvious source of ambivalence and antagonism in the committee's report arose from the fact that almost all the witnesses and committee members had been involved in the recent war effort, a titanic struggle which the nation at several points had been in danger of losing. Seven hundred and twenty-two thousand young Englishmen had perished in that conflict: the working-class mother who had lost four sons on the Western Front and the aristocratic family name which had disappeared because all the male heirs had died in the trenches were the pathetic commonplaces of the national press. In light of such sacrifices, it was difficult for many Englishmen both during the war and for years afterward to forgive those who had faltered in their duty or who had actually deserted their posts; 'shell-shock' seemed an all too easy way out for the weakling or the coward. It was only to be expected that the frustration and anger of officers and doctors involved in the shell-shock crisis would surface when discussing the military aspects of shell-shock.

A number of witnesses, for example, seemed obsessed by wartime 'malingering', by the possibility that the supposed victim of war neurosis was in reality faking his symptoms. They agreed that all cases of shell-shock 'should be viewed with suspicion'.[62] The variety of punishments thinly disguised as 'treatments' (electric shock, forcible movements) was another method of catching out the man shamming mental collapse. Witnesses were especially insistent that a major reason why 'malingering' had reached 'unprecedented proportions' during the recent war was because of the widespread use in the civilian press of such imprecise and 'woolly' terminology as 'shell-shock' and 'N.Y.D.N.' ('Not Yet Diagnosed [Nervous]').[63]

To combat shell-shock in future wars, witnesses and committee members were agreed that improved recruiting and training and the maintenance of high morale were absolutely essential. The report devoted twenty-nine pages to the crucial problem of military

recruiting.[64] It castigated the poor medical selection of the first years of the war which permitted so many 'misfits' to enter the army, men who at the front were liable to break down under stress. Competent medical screening, the committee emphasized, was the key to a healthy army: those with histories of instability or a questionable family background must not be permitted to join the services.[65]

Concluding its discussion of specific military measures, the report declared that all those factors must be combated 'by which a soldier, or even a potential soldier, is encouraged to believe that the weakening or loss of mental control provides an honourable avenue of escape from military service . . .'.[66] Ironically, in its discussion of the relationship of cowardice to shell-shock, the committee itself would provide just such a 'factor'.

There is nothing very startling in the committee's emphasis on a mixed kind of therapy for mental cases, in its periodic references to the 'moral code' and in its insistence on rigorous discipline. What is astonishing is that these certitudes were challenged only a few pages later in the section entitled 'Cowardice and Shell-Shock'.

In some ways, this aspect of the committee's investigation was the most crucial: sustained courage in combat was the most important index of a unit's morale. If the morale of an army were to be maintained, it would seem essential that the man who ran from danger be severely punished. Under the terms of the pre-war 'moral code' referred to repeatedly in the report, cowardice was simply a matter of a failure of 'character', of will-power. Surely, this conservative committee's discussion of cowardice and its relationship to war neurosis ought to be the most straightforward section of the report. That, however, was not the case, for its views on this subject are testimony not to the maintenance but rather to the dilution of the pre-war 'moral code'.

> Cowardice is a military crime for which the death penalty may be exacted.
>
> Some witnesses declined to define it and others did so with reservation.
>
> Major Dowson, a barrister of considerable court-martial experience said: 'Cowardice is showing signs of fear in the face of the enemy'. Such a definition is not helpful to the medical officer who may be called on to decide between cowardice and 'shell-shock'.
>
> Cowardice, if regarded as a lack of or failure to show requisite courage, renders discussion more feasible and assists us in comprehending how the brave after much stress may temporarily fail to show their wonted courage without deserving to be called by an opprobrious term.

> Fear is the chief factor in both cowardice and emotional 'shell-shock' and it was for this reason that cowardice in the military sense was made a subject of enquiry by the Committee . . .
>
> If the individual exercises his self-control in facing the danger he is not guilty of cowardice, if, however, being capable of doing so, he will not face the situation, he is then a coward. It is here that difficulty arises in cases of war neuroses for it becomes necessary to decide whether the individual has or has not crossed that indefinite line which divides normal emotional reaction from neurosis with impairment of volitional control.[67]

The committee's conclusions regarding cowardice were:

> That the military aspect of cowardice is justified.
>
> That seeming cowardice may be beyond the individual's control.
>
> That experienced and specialised medical opinion is required to decide in possible cases of war neurosis of doubtful character.
>
> That a man who has already proved his character should receive special consideration in cases of subsequent lapse.[68]

This section is by far the most revealing of the entire report. It displays all the ambiguities arising from the shell-shock crisis; it demonstrates how impossible it was for the committee to provide neat and tidy conclusions. Although much of their report attempts to determine proper conduct in wartime, to uphold the pre-war 'moral code', and to protect and enhance military morale, on the most important issue for military discipline — namely, cowardice and its relationship to war neurosis — the committee was forced to recognize that the shell-shock phenomenon threw into question some of the most fundamental inherited conceptions of how a man ought to act.

Whereas earlier the report was quick to advocate force to drive the patient back to his duty, here, at the most crucial point, it stressed the difficulty of distinguishing malingering and dereliction of duty from genuine mental breakdown. The report specifically states that men may be cowards one day and brave the next. As in 1916 when *The Lancet* spoke of a 'no-man's land', a 'nebulous zone' which separated sanity from insanity, so in 1922 the committee offered only an 'indefinite line' between cowardice and 'seeming cowardice' resulting from war neurosis; only an expert could determine the truth. Of necessity, the committee, with its close ties to the War Office, continued to maintain that 'the military aspect of cowardice is justified'; but the effect of its second conclusion, that 'seeming

cowardice may be beyond the individual's control', is to negate the first; indeed, it renders cowardice almost impossible to determine with certainty.

This suspension of the 'moral code' with regard to cowardice is an extraordinary demonstration of the power of the shell-shock phenomenon to undermine traditional values. In other more subtle ways, its final report indicates how the committee had arrived at conclusions which challenged some of the very values it may have wished to see upheld. The best example of this is the attention the report paid to the case of an anonymous medical officer, himself a victim of shell-shock on the Western Front. His is the only testimony of a victim of war neurosis to be reported fully. It is certainly no accident that his account was placed last of all the witnesses. Not only is its location significant, so too is the fact that it was not the testimony of some half-educated other rank which was reported at length, but rather that of a regimental medical officer, a member of the articulate classes, a man with whom the committee members could readily identify.

During the second battle of Ypres, this 'gallant officer' had seen his battalion wiped out four times in three months. The medical officer recounted how, after a series of shocks had warned him that he was near breaking-point, it was the sight of a line of horses belonging to dead comrades which had led him to crack; he hid himself and cried for a week.[69]

> Well, I think that was 'shell shock' I had. I lost control when I went into the dugout and concealed myself, and also for that week in which I could not control my tears; but after that, beyond some nightmare [sic] and dreams when I went down the line, after the six months down the line I went up the line again, and I had no difficulty whatever in controlling myself — not the slightest.[70]

By choosing to print this medical officer's eloquent testimony about his breakdown and subsequent recovery, the committee members revealed that witnesses such as Lord Gort had failed to convince them that shell-shock was all a matter of morale, discipline and especially character. Here was a volunteer, most likely of middle-class origin, who had proved his valour repeatedly in the war — and who had still cracked under the continuous strain of trench warfare.

The testimony of this anonymous officer was a rock against which many pre-war values shattered. Shell-shock could not be tamed, it could not be safely attributed solely to misfits, mental degenerates or weak men of the lower orders; rather it was an impervious leveller of

classes.[71] For a generation raised to believe in the exercise of the will, it represented a signal defeat: even the strongest man could fall victim to it. The tortured language of the section on cowardice and other parts of the report is evidence of the committee's struggle to reconcile the modern ambiguous notion of shell-shock with traditional absolutist norms for behaviour in war and peace. The case of a coward ought certainly to be clear-cut. There should be no difficulty in applying the 'moral code' to the man who hid himself during an attack or who walked away from the line. Yet it was on just the issue of cowardice that the committee's efforts to uphold traditional virtues faltered.

**The War Office Committee** of Enquiry into 'Shell-Shock' concluded its two years of work with a series of recommendations which on the whole seem predictable, even mundane: no soldier should be allowed to think that loss of 'nervous or mental control' provides an 'honourable' escape from the battlefield; if possible, slight cases of mental collapse should be prevented from leaving the front; the 'simplest forms of psycho-therapy' are adequate for the majority of cases; medical officers should be acquainted with the rudiments of psychology; proper medical screening of recruits is of the utmost importance; the term 'shell-shock' should be abolished; concussion victims should be listed as battle casualties, while other types of mental illness should not; shell-shock cases should be treated separately from those with physical wounds; officers should study the psychology of the soldier ('man mastership'); unit morale and discipline are of critical importance in preventing war neurosis; short tours of duty, frequent rotation and home leave are recommended; good sanitation, physical comfort and opportunities for rest of those under strain are encouraged; and so on.[72] Many of these conclusions defiantly reassert pre-war military values, as if the shell-shock crisis had altered nothing. Pre-war somatic theories of the origins of mental illness are intermittently reasserted and Freud and his 'sexual' theories are explicitly rejected.

The report reflects a period of flux following the Armistice when fundamental values and attitudes of the English educated classes were the target of severe questioning. British politics had undergone a basic shift which saw the decline of the Liberal Party and the rise of Labour; woman's suffrage, a faint hope in 1914, had become a reality as a result of the pressures of total war; trades unions had gained significant power during the prolonged conflict; class lines had begun

to blur as a result of the social mobility which the war had encouraged. The arts as well reflected the troubled times: the work of the Western Front painters C.R.W. Nevinson and Paul Nash and the war poetry of Siegfried Sassoon and Wilfred Owen represented profound disillusionment with and sustained attacks on pre-war values; they symbolized a revolt not only against the ideals of an earlier generation but perhaps against authority generally.

It is in this context of social and cultural flux that the investigation of the 'Shell-Shock' Committee must be understood, for in a sense one of the most threatening of all challenges to conventional attitudes was the crisis in mental illness of the recent war. The vast numbers of shell-shock casualties raised the most fundamental human questions; none more so than whether in their wake there were still firm moral laws governing a man's behaviour or whether one must now create a new ethics for each situation.

Perhaps an embattled élite saw this questioning of the pre-war 'moral code' and orthodox medical opinion as symptoms of a general loosening of social control. Such fears may explain why, for all the efforts of officers and doctors to be judicious in their testimony before the committee, their anger kept on surfacing. 'Shell-shock' was seen by many of them as an excuse for an astounding degree of moral laxity during the war and, perhaps by extension, as contributing to the relaxation of conventional morality after the Armistice. This may explain why some witnesses tried to pass off the shell-shock crisis as all a matter of social or hereditary background. Some thought it a question of race: when the going got tough Jews and Irishmen weren't worth their salt.[73] Or else those who faltered were 'artistic' types,[74] 'highly-strung',[75] or 'imaginative city-dwellers'.[76] Every pre-war English prejudice was mobilized to explain away all those crack-ups at the front.

Yet, if crude unthinking prejudices are readily apparent in the report, so too are numerous instances of genuine understanding. If some angrily pounced on shell-shock as a subterfuge for malingerers, others declared it often impossible to determine which was which. Far from being a disgrace, others said, it was the product of fear, which every man harboured. If some heaped contempt upon those who broke down, others expressed a sometimes grudging sympathy and pity, which occasionally even embraced the coward executed by the firing-squad.

In both subtle and overt ways the report of the 'Shell-Shock' Committee is an ironic cultural document. For all the conservative

medical and moral inclinations of those who conducted it, this government investigation was itself a reflection of and a contribution to increased public awareness in the 1920s of mental illness and of the new psychology of Freud and other theorists of the unconscious.[77] Repudiating Freud, the writers of the report still employed elements of his theories and his vocabulary. Trained in the somatic theories of insanity, committee members had attempted to find a 'half-way house' between the organic and 'mental' theories of 'shell-shock'; yet repeatedly they were confronted with evidence testifying to the predominantly 'mental' origins of this affliction. In a sense, the committee which had dismissed Freud may have unwittingly demonstrated how impossible it had become by the early 1920s to speak of mental illness without some recourse to his theories.

The report declares that ultimately shell-shock was no respecter of class or education: in modern warfare every man was liable to break down. Such a view had some unsettling implications for the English upper classes: did their education in leadership in the public schools make them any more capable of dealing with the challenges of modern war or of the modern world than their social inferiors? Indeed, might not the very staples of an education in these schools, that is, the conventional English ideas of character and will-power, have to be re-examined?

When the report was finally issued in the summer of 1922, the national press devoted editorials and articles to its conclusions. Most journals referred to or else reported verbatim its major recommendations; others emphasized particular aspects, such as its flat rejection of Freud; others still took special note of its conclusion that responsible soldiers might be brave one day and cowards the next.[78] In an editorial entitled 'Courage and Character' in its 2 September 1922 issue, *The Times* declared that it was 'immensely significant that the members of the "Shell-Shock" Committee failed to offer a clear definition of cowardice'. One practical long-range result of the committee's investigation was to reinforce the Labour Party's campaign against the military death penalty; by 1930, after a long struggle in parliament, the army death penalty for cowardice had been abolished.[79]

Finally, a crucial if unintended contribution of the 'Shell-Shock' Committee may have been to aid Englishmen in accepting the relativization of traditional values under the impress of revolutionary new ideas and circumstances. After the Armistice, not only members of the 'Shell-Shock' Committee but also many ordinary soldiers and

civilians would find it increasingly difficult to hold on to traditional demarcations. Nowhere perhaps would this shift in values be more poignantly demonstrated than in a debate in the House of Commons in July 1919 when an infantry officer appealed against any differentiation between the graves of those who had died in battle and of those who had been shot for cowardice.[80]

## Notes

This article is an expanded version of a paper given at the Pacific Coast Conference of the American Historical Association, Stanford, CA, in June 1985.

1. Hansard, *House of Lords*, 5th series, 39, 1095. A draft version of Southborough's speech in support of his motion, differing somewhat from Hansard, is to be found in his papers in the possession of his grandson, the current Lord Southborough. I am grateful to Lord Southborough for making these papers available to me.

2. *Report of the War Office Committee of Enquiry into 'Shell-Shock'*, Cmd. 1734 (London 1922), 189. (Hereafter referred to as the *Report.*) A further measure of the magnitude of the problem may be gauged from the fact that in March 1939 there were still some 120,000 English Great War veterans receiving pensions or who had received final awards for war-related 'primary psychiatric disability'. These 120,000 cases accounted for 15 per cent of all pensioned disabilities resulting from the first world war. (Robert H. Ahrenfeldt, *Psychiatry in the British Army in the Second World War* [New York 1958], 10.) Clearly, a major reason for government preoccupation with the shell-shock phenomenon was the financial burden of providing pensions and medical care for veterans, some of whom might never get well.

3. Hansard, op. cit., 1101–2.

4. This topic is intelligently treated in Anthony Babington, *For the Sake of Example. Capital Courts-Martial 1914–1920* (New York 1983).

5. Hansard, op. cit., 1105.

6. See Nigel Walker, *Crime and Insanity in England*, vol. I: *The Historical Perspective* (Edinburgh 1968), 104–23.

7. L.S. Hearnshaw, *A Short History of British Psychology, 1840–1940* (London 1964), 145. For the complexities of the relationship between legal and medical definitions of insanity, see Roger Smith, *Trial by Medicine. Insanity and Responsibility in Victorian Trials* (Edinburgh 1981) and his 'The Boundary Between Insanity and Criminal Responsibility in Nineteenth-Century England', in *Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia 1981).

One of the many ironies of the shell-shock phenomenon was that the same British Army responsible for the execution of 346 soldiers in the recent war also provided in some respects more humane treatment for the mentally-ill soldier than he could have expected to receive in civilian life. As the report noted, 'the legal obligations regarding insanity' were held 'in abeyance so long as the man remained in the Army . . . . This had the advantage that many men recovered without any stigma being attached to the

illness. On the other hand, in the case of those who did not recover, it became a disturbing factor to the relations when on his leaving the Army the civil law necessitated the patient's being certified as insane' (*Report*, 145).

8. Michael J. Clark, 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry', in *Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era*, op. cit., 275–6. See also Tom Brown, 'Shell-Shock in the Canadian Expeditionary Force, 1914–1918: Canadian Psychiatry in the Great War', in *Health, Disease and Medicine. Essays in Canadian History. Proceedings of the First Hannah Conference on the History of Medicine. McMaster University. June 3–5, 1982*, ed. Charles G. Roland (n.p. 1984), 308–32. (I am grateful to Robert Joy for this reference.)

9. Clark, op. cit., 276.

10. Clark, op. cit., 285 and Nathan G. Hale, *Freud and the Americans. The Beginnings of Psychoanalysis in the United States, 1876–1917* (New York 1971), 54, 167.

11. Clark, op. cit., 292.

12. Hale, op. cit., 55.

13. Roger Smith, *Trial By Medicine*, op.cit., 165: 'There was general incoherence about the mind-body relation, and alienists were among the worst offenders'.

14. Hale, op. cit., 33, 55. 'In the later nineteenth century, the norms of the "civilized" moral order were enshrined in the traditional psychological models and given a somatic base' (55).

15. Smith, *Trial By Medicine*, op. cit., 72.

16. Bruce Haley, *The Healthy Body and Victorian Culture* (Cambridge, MA, 1979), 40.

17. Ibid., 44.

18. Lord Moran, *The Anatomy of Courage* (London 1945), 170.

19. Ibid., 186–7. Yet like so many other observers of the shell-shock phenomenon, Moran was a divided man. Elsewhere in his book he declared that courage was finite: like money withdrawn from a bank and not replaced. In battle, he declared, men wear out like old clothes (69–70).

20. F.W. Burton-Fanning, 'Neurasthenia in Soldiers of the Home Forces', *The Lancet*, 16 June 1917.

21. See T.H.E. Travers, 'Technology, Tactics, and Morale: Jean de Bloch, the Boer War, and British Military Theory, 1900–1914', *Journal of Modern History*, 51 (June 1979), 264–86 and his *The Killing Ground. The British Army, The Western Front and the Emergence of Modern Warfare 1900–1918* (London 1987).

22. Hearnshaw, op. cit., 164–5. See also Ronald Clark, *Freud. The Man and the Cause* (New York 1980), 372–5 and Ernest Jones, *Free Associations. Memoirs of a Psycho-Analyst* (New York 1959).

23. See for example *The Lancet* for 6 April 1912; 8 November 1913; 6 June 1914; and 7 November 1914. See also the attacks on the English attitudes toward and treatment of the mentally ill in G. Elliot Smith and T.H. Pear, *Shell-Shock and Its Lessons* (Manchester 1917).

24. Clark, op. cit., 299.

25. *History of the Great War. Medical Services. Diseases of the War*, eds. W.G. MacPherson, W.P. Herringham, T.R. Elliott (London 1923), II, 18.

26. *The Lancet*, 18 March 1916.

27. See, for example, Wilfred Owen's wrenching poem 'Dulce et Decorum est' or his

letters to his mother in *Wilfred Owen. Collected Letters*, eds. Harold Owen and John Bell (London 1967). Owen himself was a shell-shock victim and spent the summer months of 1917 undergoing treatment at Craiglockhart War Hospital.

28. For details of soldiers' lives on the Western Front see Denis Winter, *Death's Men. Soldiers of the Great War* (London 1978) and Eric Leed, *No Man's Land. Combat and Identity in World War I* (Cambridge 1979), especially chap. 5: 'An Exit from the Labyrinth — Neuroses and War'.

29. See, for example, the 'special discussion' on shell-shock which took place at the Royal Society of Medicine in January 1916, and which was reported on in *The Lancet*, 5 February 1916.

30. 'A word as to treatment. Major F.W. Mott in his Lettsomian lectures says: "I do not find hypnosis or psycho-analysis necessary or even desirable; only common sense and interest in the welfare and amusement of these neurotic patients are necessary for their recovery." This contrast between common sense on the one hand and hypnosis and psycho-analysis on the other betrays, I fear, a survival of the medieval fear of witchcraft.' M.D. Eder, 'The Psycho-Pathology of the War Neuroses', *The Lancet*, 12 August 1916.

31. See for example Harold Wiltshire, 'A Contribution to the Etiology of Shell Shock', *The Lancet*, 17 June 1916 and E.F. Ballard, 'Some Notes on Battle Psycho-Neuroses', *Journal of Mental Science*, July 1917.

32. See page 108.

33. *The Morning Post*, 6 September 1916: 'The effects of shell-shock on the moral sense of Army men was explained yesterday in a case at London Sessions .... Witness's experience was that in the case of a good many officers affected by shell-shock their moral character was entirely altered.'

34. See *History of the Great War. Medical Services. Diseases of the War*, op. cit., for the details of the establishment and organization of military mental hospitals.

35. See Babington, op. cit., 208–10. David Englander's paper on military medicine in the two world wars, delivered before the Wellcome Unit for the Social History of Medicine Seminar, Oxford, November 1979, also gave me insights into this topic. See as well the writings of Ernest Thurtle, a Labour MP who was prominent in the struggle to abolish the military death penalty: *Military Discipline and Democracy* (London 1920) and *Shootings at Dawn. The Army Death Penalty at Work* (London, n.d.). I would like to thank Guff Puttkowski for these references.

36. Disappointingly little has survived of the unpublished minutes of the Shell-Shock Committee and of the witnesses who testified before it. What remains has mainly to do with such mundane matters as finding shorthand secretaries. The surviving minutes are located in file number WO32/4747, Public Record Office, Kew. (I learned of the existence of these minutes in P.J. Lynch, 'The Exploitation of Courage: Psychiatric Care in the British Army, 1914–18', M.Phil. thesis, University College, University of London, 1977.) Southborough's comments on the mandate of the committee and on the widespread interest in its work are taken from the PRO file.

In his letter of 18 May 1920 asking Southborough to chair the War Office Committee, Lord Peel, Undersecretary of State for War, wrote: 'As you are probably aware from the Press notices, the proposed formation of this Committee has been followed with considerable interest and on all sides the opinion is expressed that the results to be obtained from its careful deliberations are of extreme national importance'. (Located in the Southborough papers — see note 1.)

37. Information on Southborough (formerly John Hopwood) from *The Dictionary of National Biography*, *The Times* obituary of 13 January 1947, and data provided by his grandson.

38. In addition to Southborough, the other members of the Shell-Shock Committee were: T. Beaton, MD (Admiralty); J.L. Birley, MD (Air Ministry); C. Hubert Bond, MD (Board of Control); Sir Maurice Craig, MD (Ministry of Pensions); Wing-Commander Martin Flack (Air Ministry); H.W. Kaye, MD (Ministry of Pensions); Hamilton C. Marr, MD (Board of Control for Scotland); Surgeon-Captain E.T. Meagher, RN (Admiralty); Colonel J.G.S. Mellor, KC; Sir Frederick W. Mott, MD; Major A.D. Stirling, RAMC (War Office); W. Aldren Turner, MD; Stephen Walsh, MP; Major W. Waring, MP; Major W.R. Galwey, RAMC (Secretary for the Committee).

39. See Frederick W. Mott, *War Neuroses and Shell Shock* (London 1919). The most obvious example is pages 114–15 in Mott which are almost identical to pages 10–12 in the *Report*. Mott (1853–1926) was largely responsible for establishing that general paralysis of the insane was invariably the result of syphilis. He and his co-workers studied the relationship between dementia praecox and endocrine disorders, between alcohol and insanity, and the hereditary aspects of mental disease (Hearnshaw, op. cit., 149–50). Mott did not reject Freud out of hand, as M.D. Eder believed (see Note 30). He approved of certain aspects of Freud's analysis of dreams (*War Neuroses*, 117–18). Like a number of other English psychologists, however, Mott was quick to note that shell-shock seemed to call into question Freud's emphasis on the sexual origins of neurosis. (Surprisingly, this issue was not raised in the *Report*.)

By 1922, Mott seemed in general agreement with even the most controversial conclusions of his committee, as is evident in a lecture he gave on 17 January 1922 to the Eugenics Society entitled 'The Neuroses and Psychoses in Relation to Conscription and Eugenics'. He accepted, for example, that all soldiers experience fear in battle; that in general one cannot tell in advance who will break down; that trench warfare was more productive of neuroses than a war of movement; that in a future surprise war with bombs, airplanes and poison gas 'the fit and the unfit, would alike perish'. *Eugenics Review* (April 1922), 13–22.

40. The *Report*, op. cit., 50–1.

41. Ibid., 55–8.

42. Ibid., 13.

43. Ibid., 127.

44. Ibid., 98–109.

45. Ibid., 96–7.

46. The concepts of 'repression' and 'conversion' and their role in hysteria, for example, are to be found in Freud and Breuer's famous essay 'On the Psychical Mechanism of Hysterical Phenomena: Preliminary Communication' (1893) and in their *Studies on Hysteria* (1895). For Freud's views on war neuroses, see the discussion of his testimony before the Austrian committee of enquiry into the treatment of 'shell-shock' (1920) in K.R. Eissler, *Freud as an Expert Witness. The Discussion of War Neuroses between Freud and Wagner-Jauregg*, trans. C. Trollope (Madison, Connecticut 1986). For the impact of the war on the Freudian movement, see, for example, Louise E. Hoffman, 'War, Revolution and Psychoanalysis: Freudian Thought Begins to Grapple with Social Reality', *Journal of the History of the Behavioral Sciences*, 17 (1981), 251–69.

47. The *Report*, op. cit., 126–7.

48. Ibid., 92.
49. Ibid., 192.
50. Ibid., 129.
51. However impracticable long-term psychotherapy might prove under the immediate circumstances of total war, the *insights* provided by Freudian psychoanalysis were invaluable in understanding and treating war neuroses. In a paper read before the Royal Society of Medicine, Section on Psychiatry, on 9 April 1918, Ernest Jones concluded with these remarks: 'A word in conclusion as to the therapeutic aspects of psycho-analysis in the war neuroses. Even if it were possible, I see no reason whatever why a psycho-analysis should be undertaken in the majority of the cases, for they can be cured in much shorter ways. But I consider that a training in psychoanalysis is of the very highest value in treating such cases, from the understanding it gives of such matters as the symbolism of symptoms, the mechanisms of internal conflict, the nature of the forces at work, and so on, and there is certainly a considerable class of cases where psycho-analysis holds out the best, and sometimes the only, prospect of relief — namely, in those chronic cases where the war neurosis proper has, by association of current with older conflicts, passed over into a peace neurosis and become consolidated as such.' S. Ferenczi, Karl Abraham, Ernst Simmel and Ernest Jones, *Psycho-Analysis and the War Neuroses* (London, Vienna, New York 1921), 59.
52. The *Report*, op. cit., 129.
53. Ibid., 135.
54. Ibid., 192.
55. Ibid., 128–30.
56. Ibid., 129.
57. Ibid., 130.
58. Ibid., 134.
59. Ibid., 129–30.
60. Ibid., 130.
61. Ibid., 132.
62. Ibid., 121.
63. Ibid., 149.
64. Ibid., 160–89.
65. Ibid., 160–70.
66. Ibid., 149.
67. Ibid., 138–9.
68. Ibid., 140.
69. Ibid., 88–91.
70. Ibid., 91.
71. This is not to say that British class distinctions did not find their way into the diagnosis and treatment of shell-shock. On the contrary, physicians were prone to diagnose an officer's mental collapse as neurasthenia (which, before the war, was an 'educated' man's affliction) and to prescribe as treatment a rest cure. They were similarly liable to judge an other rank's mental breakdown as hysteria for which the more punitive treatments (electric shock, etc.) were recommended.
72. The *Report*, op. cit., 190–4.
73. For example, in answer to the committee's questionnaire, Captain J.C. Dunn, the former Medical Officer for the 2nd Battalion, Royal Welch Fusiliers, declared that in the South African War the Jews weren't worth their salt. So far as I can determine,

Dunn's is the only surviving questionnaire (none are in the PRO file). His is located in the Royal Welch Fusiliers Archive, Caernarvon, Wales. Also, Captain Gordon Holmes testified that among a Labour Battalion of Russian Jews at the front many 'went sick' (the *Report*, op. cit., 40).

74. The *Report*, op. cit., 26.

75. Ibid., 23.

76. Ibid., 72.

77. See Ronald Clark, *Freud*, op. cit., 415–22, for the popularization of Freud's theories in England after the war.

78. On 10 August 1922, both the *Manchester Guardian* and the *Westminster Gazette* made special note of the fact that the committee had rejected Freudian psychoanalysis; the *Morning Post* of the same date gave a thorough précis of the report and noted the difficulty in distinguishing cowardice from war neurosis; the *Daily News* also presented a summary of the report's findings. In its inimitable fashion, the *Daily Sketch* of 10 August 1922 entitled its news item: 'Shell-Shock or Funk: Difficult to Distinguish One from Other says Committee'.

79. See Babington, op. cit., for details. In contrast to the first world war, no British soldier was executed for cowardice in the second world war.

80. From Ernest Thurtle, *Military Discipline and Democracy*, op. cit., xiv–xv. The lessons of the shell-shock crisis were not easily absorbed by the British Army. As was the case with Lord Moran, ambivalence and even hostility were frequent responses to the more disturbing implications of war neurosis. As a result, some of these lessons had to be learned all over again in the second world war, particularly those regarding evacuation of mental casualties and the screening of recruits for mental impairments (see Ahrenfeldt, op. cit.). In the North African desert, psychologists once again had to convince commanding officers that fear was normal among soldiers in combat (see F.M. Richardson, *Fighting Spirit. Psychological Factors in War* [London 1978]).

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