Shell shocked

During World War I, some people saw shell shock as cowardice or malingering, but Charles S. Myers convinced the British military to take it seriously and developed approaches that still guide treatment today.

By Dr. Edgar Jones

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By the winter of 1914–15, "shell shock" had become a pressing medical and military problem. Not only did it affect increasing numbers of frontline troops serving in World War I, British Army doctors were struggling to understand and treat the disorder.

The term "shell shock" was coined by the soldiers themselves. Symptoms included fatigue, tremor, confusion, nightmares and impaired sight and hearing. It was often diagnosed when a soldier was unable to function and no obvious cause could be identified. Because many of the symptoms were physical, it bore little overt resemblance to the modern diagnosis of posttraumatic stress disorder.

Shell shock took the British Army by surprise. In an effort to better understand and treat the condition, the Army appointed Charles S. Myers, a medically trained psychologist, as consulting psychologist to the British Expeditionary Force to offer opinions on cases of shell shock and gather data for a policy to address the burgeoning issue of psychiatric battle casualties.

Myers had been educated at Caius College Cambridge and trained in medicine at St. Bartholomew's Hospital, London. Shortly after qualifying as a physician, he took an academic post at Cambridge, running an experimental psychology laboratory. However, at the outbreak of the war, Myers felt compelled to return to clinical practice to assist the war effort. The War Office had turned him down for overseas service because of his age (he was 42), but undeterred, he crossed to France on his own initiative and secured a post at a hospital opened by the Duchess of Westminster in the casino at Le Touquet. Once Myers was there, his research credentials made him a natural choice to study the mysteries of shell shock in France.

The first cases Myers described exhibited a range of perceptual abnormalities, such as loss of or impaired hearing, sight and sensation, along with other common physical symptoms, such as tremor, loss of balance, headache and fatigue. He concluded that these were psychological rather than physical casualties, and believed that the symptoms were overt manifestations of repressed trauma.

Along with William McDougall, another psychologist with a medical background, Myers argued that shell shock could be cured through cognitive and affective reintegration. The shell-shocked soldier, they thought, had attempted to manage a traumatic experience by repressing or splitting off any memory of a traumatic event. Symptoms, such as tremor or contracture, were the product of an unconscious process designed to maintain the dissociation. Myers and McDougall believed a patient could only be cured if his memory were revived and integrated within his consciousness, a process that might require a number of sessions.

While Myers believed that he could treat individual patients, the greater problem was how to manage the mass psychiatric casualties that followed major offensives. Drawing on ideas developed by French military neuropsychiatrists, Myers identified three essentials in the treatment of shell shock: "promptness of action, suitable environment and psychotherapeutic measures," though those measures were often limited to encouragement and reassurance. Myers argued that the military should set up specialist units "as remote from the sounds of warfare as is compatible with the preservation of the ‘atmosphere' of the front." The army took his advice and allowed him to set up four specialist units in December 1916. They were designed to manage acute or mild cases, while chronic and severe cases were referred to base hospitals for more intensive therapy. During 1917, the battles of Arras, Messines and Passchendaele produced a flood of shell-shock cases, overwhelming the four units.

Inevitably, Myers was criticized by those who believed that shell shock was simply cowardice or malingering. Some thought the condition would be better addressed by military discipline. Myers became increasingly demoralized and requested a posting back to the United Kingdom. In October 1917, the War Office in London held an emergency conference to discuss ways to improve the treatment of shell shock as large numbers of patients were being discharged from general hospitals as invalids incapable of regular employment, because physicians lacked expertise and understanding. Myers proposed a system by which doctors would refer severe cases of shell shock directly from the base hospitals in France to specialist treatment centers in the United Kingdom. He argued that effective treatment required individual attention, which in turn demanded higher staffing ratios — ideally one doctor to 50 patients. To meet this demand, he persuaded the War Office to set up training courses in the principles and practice of military psychiatry and, in particular, the treatment of shell shock.

After the war, Myers left his post at Cambridge to set up the National Institute of Industrial Psychology to facilitate the application of psychological research in the workplace. In 1922, the War Office appointed a Committee of Inquiry into Shell Shock, but Myers was so disillusioned by some of his wartime experiences that he refused to give evidence.

Only in 1940, with Britain again at war, did he write his memoirs, which detailed his theories about shell shock and its treatment. His account was not well received by the military reviewer in

the *Journal of the Royal Army Medical Corps*, who argued that the book revealed a "lack of understanding and conviction." Written at a time when the U.K. faced the threat of invasion, the author may have felt that Myers's criticisms of the army's medical services were unpatriotic and defeatist. In truth, they revealed the inability of a mass, hierarchical organization to accommodate the nuanced policy recommendations of an innovative clinician.

Nevertheless, the principles of forward psychiatry that Myers identified — prompt treatment as close to the fighting as is safe, with an expectation of recovery and return to unit — were widely adopted during World War II by both the U.S. and U.K. military, and they continue to be practiced by Western armed forces today in Afghanistan and Iraq.

Edgar Jones, PhD, is professor of the history of medicine and psychiatry at the Institute of Psychiatry, King's College London. Katharine S. Milar, PhD, of Earlham College, is historical editor for "Time Capsule."

Suggested reading

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