W. H. R. RIVERS: A PSYCHOANALYTICAL APPROACH TO
“SHELL SHOCK” IN THE FIRST WORLD WAR

A Thesis
Presented
to the Faculty of
California State University, Chico

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Social Science

by
Jason Race
Fall 2011
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DEDICATION

I wish to dedicate this to my wife and daughter for their patience, support, and love.
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ABSTRACT

W. H. R. RIVERS: A PSYCHOANALYTICAL APPROACH TO
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The Great War marked a point in history where the psychological effects of modern warfare could no longer be ignored by the medical authorities of all the combating nations. Continuous and protracted exposure to the extremely stressful conditions of trench warfare led to an epidemic of various mental neuroses commonly known as ‘shell shock.’ In Britain, one psychiatrist, William Halse Rivers Rivers, used his experiences in anthropology, neurology, and Freudian psychology to pioneer the first British psychoanalytical approach that effectively explained the etiology and epidemiology of war neuroses. Unlike most of the ideas presented by his British colleagues, Rivers’s theory allowed him to sympathetically and humanely diagnose and treat victims of “shell shock.”

The main objective of this thesis is to understand how W. H. R. Rivers’s psychoanalytical approach explained the nature of “shell shock.” Then by comparing his
theory to those of his colleagues we can determine how sympathetic and humane his methods of diagnosis and treatment were for the time period. It is also of some interest to know if any of Rivers’s ideas foreshadowed our current understanding of war related mental neuroses. The methodology used to complete these goals will be a literature review of the primary documents written by Rivers and other popular British medical professionals of the war.

Following a brief introduction to W.H.R. Rivers and the new combat environment found in World War I, this thesis will explore what was already known about war related neuroses before the war. Then attention will be given to the education and experiences that Rivers had prior to the war to better understand why he was able to develop a complete and working psychoanalytical theory. Next, Rivers’s psychoanalytical approach to the etiology and diagnosis of “shell shock” will be summarized and then compared to the approaches presented by other British psychiatrists. Following this will be a description of Rivers’s treatment method which will also be juxtaposed to those of his peers. Finally, the concluding chapter provides summarizing statements and describes any relevant implications that this study may have for current psychiatrists working with patients suffering from war related mental neuroses.
CHAPTER I

INTRODUCTION

World War I marked the dawning of full-scale modern warfare as armies for the first time clashed with a large array of technologically advanced weaponry including long range artillery, machine-guns, sharp shooting rifles, chemicals, and early model tanks and planes. The war’s architects—trained in past ideologies—initially attempted to employ strategies that were now outdated and futile. Field-Marshall Viscount Montgomery, the famous British general in World War II, served as a captain in the Great War, and he quickly became convinced that high command on both sides of the trenches did not fully appreciate the defensive capabilities that the new and improved weapons provided. There were still too many proud generals from the old-school of thought that firmly believed the only way to defeat "the great power of the defensive given by machine-guns, barbed wire, entrenchments, and artillery [was] to attack with infantry in close formations in a direct charge across no-man’s-land." The generals quickly learned from early mistakes, but even with careful and experienced planning they could not find any offensive edge that would allow them to take enemy territory without enduring heavy casualties.

The most extreme example of a well intentioned but unsuccessful strategy took place on the first day of the Somme offensive (July 1, 1916) when British

Expeditionary Forces suffered 60,000 casualties in less than three hours of action.

General Douglas Haig had reassured his army that a week-long preliminary bombardment of high explosive artillery shells would completely cripple the enemy. However, as the British soldiers crossed “no man’s land” the German troops and machine guns came out from the protection of their deep dug-outs and began to systematically slaughter their surprised enemy. The small advances into enemy lines were repelled in a German counter-attack, and the position of British and German forces remained nearly the same.² Blunders of this type happened on both sides of the trenches because all the fighting nations could equally defend themselves. In, *The Middle Parts of Fortune*, WWI British veteran and writer Frederic Manning states that “[generals] as a rule didn’t understand the new armies…and it never occurred to them that if one [machine-gun] could do the work of ten men, it was rather foolish not to prefer it, since it offered a smaller target.”³

On the other hand, war historian John Keegan contends that the level of incompetence often attributed to World War I generals is undue because they “were trapped within the iron fetters of a technology all too adequate for mass destruction of life but quite inadequate to restore to them the flexibilities of control that would have kept the destruction of life within bearable limits.”⁴ For instance, the portable two-way radio would have solved the communication problems that prohibited high command from making crucial adjustments in the battlefield once an attack had commenced. The

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absence of a reliable tank that could easily traverse through the thick mud and deep
craters of “no-man’s land” represented another missing piece of technology that hindered
generals from all the belligerent nations. Unfortunately, the soldiers in the trenches did
not have the advantage of hindsight, and many of them lost faith in the decision making
of their leaders. While leading a British battalion, Robert Graves once protested against
orders from high command because “everyone believed that the attack was unnecessary,
foolish, and impossible.” Generals on both sides of the conflict quickly discovered they
lacked any clear offensive edge that would allow them to gain ground, and therefore, the
battle developed into a grinding act of attrition.

Caught in the middle of this bloody menagerie many soldiers began to feel a
great sense of helplessness as they waited for orders to go “over the top.” The dominance
of lethal defensive weapons had immobilized combat and prompted troops to develop a
passive stance toward the forces of mechanized slaughter. Exposed to this environment
for a prolonged period of time, an epidemic proportion of men in the trenches developed
mental neuroses that attempted to alleviate their stressful situation. Although there
appeared to be more than one type of psychological disorder emerging from the trenches,
they were all commonly referred to as “shell shock.” It is estimated that by war’s end
80,000 British troops were afflicted by some form of “shell shock.”

War related mental neuroses were nothing new in 1914, but the severity of the
symptoms and the sheer number of troops inflicted was new. No longer, as in past wars,

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5 Ibid.
7 Martin Gilbert, The First World War: A Complete History. (New York: Henry Holt and
Company, 1994), 541-542.
could psychological casualties be ignored or simply brushed aside as strange anomalies. Unfortunately, in Britain, as well as in all the combating nations, the public and military medical communities knew very little about human psychology and were almost completely unprepared to deal with the problem. This resulted in many “shell shocked” patients never receiving proper diagnosing or treatment. As early British psychologists struggled to understand the nature of “shell shock” Rivers offered an approach that thoroughly explained the etiology of war neuroses in World War I. Better known in the British science community for his endeavors in anthropology, W. H. R. Rivers was the only British psychiatrist during the Great War to develop a complete and working psychoanalytical theory that enabled him to effectively diagnose and treat victims of “shell shock.”

Far ahead of his time, Rivers produced ideas that foreshadowed the diagnostic labels used today by psychiatrists dealing with combat related neuroses. Sigmund Freud would eventually adopt an approach similar to Rivers to help him understand war neuroses. Interestingly, very little has been written about Rivers and the great contributions he made to psychiatry. Only one biography and a handful of professional articles have ever been written about him, and they mostly celebrate his accomplishments in anthropology.

The main focus of this thesis is revisiting Rivers’s psychoanalytical approach to the diagnosis and treatment of “shell shock.” There was a minority of British psychologists who also attempted to adopt a psychoanalytical approach, but in comparison to Rivers their theories were incomplete and often strayed from Freudian principals. The majority of British medical professionals were adverse to psychoanalysis
and they presented theories that looked for causes in the genetics and personality traits of soldiers. Comparing their etiological beliefs and treatment methods to Rivers helps to illuminate the sympathetic nature and humanness of his psychoanalytical approach for the time period. The following chapter is devoted to reviewing what was already known about war related neuroses prior to World War I in an effort to shed light on the British mindset going into this conflict. Some attention will also be given to exploring Rivers’s life prior to the war to discover some of the experiences that latter helped him to form his ideas on “shell shock.” The conclusion will reiterate the findings of this thesis and briefly discuss why Rivers’s theory is still applicable to modern day cases of war neuroses.
CHAPTER II
BRITISH PSYCHOLOGY AT THE DAWN
OF THE GREAT WAR

At the time of Archduke Ferdinand’s assassination the field of psychology was still in its infancy, and there was almost a complete void of professional knowledge about the nature of war related neuroses. Previous experiences during the Boer War (1899-1902) presented to British military doctors the opportunity to study the psychological damage that prolonged exposure to modern weaponry could produce on the minds of soldiers in the battlefield. Unfortunately, medical officers obtained little knowledge of war neuroses during this conflict, choosing instead to ignore unexplained symptoms and simply diagnosing most cases as insane.\(^8\) Dr Thomas W. Salmon stated that regarding British army physicians in the Boer War, “[there was an overall] failure to recognize the real nature of the severe neuroses.”\(^9\) There are three main reasons why British medical officers, prior to World War I, failed to gain any real understanding of war related neuroses: negligence to utilize what was known about civilian cases of mental illness, an obsession to find a biological explanation for all neuroses, and a strong aversion toward the psychoanalytical ideas presented by Sigmund Freud.

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By the end of the 19th century there were already some established diagnoses in British medicine that pertained to the mental illnesses observed in society. Aside from general insanity, the most recognized psychological disturbances were hysteria, neurasthenia, and traumatic neuroses. First published in 1892 by Sir William Osler, *The Principles and Practice of Medicine* was the medical standard in England for several decades, and in World War I it represented the cognitive undergirding of psychiatry.\(^{10}\) Osler defined hysteria as a mental state in which thoughts control the body and produce unhealthy changes in its functions. He professed that the affection was common in women and effeminate men, and, aside from gender issues, the two most important predisposing factors were heredity and education. In other words, people were destined to acquire some form of psychological aliment if they had family members with a history of mental disorders, and/or if they did not have the intellect to properly control their reactions to sensitive experiences. Not surprising, in every case study that Osler used to relay information about hysteria the subject was a woman. Once exposed to strong emotional situations and/or sometimes after physical injuries, those predisposed to hysteria will begin to show commonly observed symptoms such as paralyses of a limb, contractures, anesthesia, loss of vision, irregular heartbeat, disturbed appetite, and loss of sleep.\(^{11}\)

Osler claimed that neurasthenia was a mental condition caused by overexertion, physical and/or mental; leaving the victim with an exhausted nervous

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system that then gave rise to a host of psychological and bodily inefficiency. The symptoms include: loss of appetite, muscle fatigue, sleeplessness, nightmares, tremors, feeling of hopelessness, and an overall physical and mental irritability. He argued that it only afflicted very sensitive, affluent, and intelligent men who struggled to deal with the pressures and strains of upper-class life in a modern society. Similar to hysteria, he professed that a family history of neuropathic tendencies represented another important predetermining factor as to whether or not an individual was susceptible to neurasthenia.12

The traumatic neuroses represented a morbid condition following shock that presented the symptoms of neurasthenia or hysteria or of both. Osler divided traumatic neuroses into three groups: simple traumatic neurasthenia, cases with marked hysterical features, and cases in which the symptoms suggest organic disease of the brain and cord. In contrast to cases with marked hysterical features (e.g., partial blindness, stuttered speech, violent tremors), the final group represented patients exhibiting extreme hysterical symptoms (e.g., complete blindness, mutism, limb paralysis) which Osler insisted must be connected to physical injury. Osler argued that traumatic neuroses usually followed an accident, often involving a railway train (hence the common name “railway spine” or “railway brain”), that inflicts physical injury and/or a concussion to the victim. However, Osler noted that severe mental strain combined with bodily exposure to extreme conditions was enough to cause it, as in a case of simple traumatic neurasthenia that involved a naval officer who was shipwrecked and exposed to the

12 Ibid., 1086-7.
elements for over a day before being rescued. Similar to hysteria and neurasthenia, a patient’s heredity, education, and gender predisposed him/her to traumatic neuroses.\textsuperscript{13} Expanding on Osler’s predisposing factors, RAMC officers of World War I added the importance of psychological constitution (i.e., personal history of mental disorders) and personality characteristics (e.g., overly sensitive to outside stimuli).

Though the symptoms of the neuroses described by Osler were strikingly similar to those found in psychologically wounded soldiers, British military doctors, before the Great War, ignored the connection because they continued to believe that the victims of these ailments were always women or effeminate men. Unwilling to believe that trained soldiers could develop symptoms associated with these illnesses, British medical officers (many of whom had no formal education in psychology) usually opted for a diagnosis of insanity because it was considered a more masculine type of neurosis to acquire.\textsuperscript{14} Not until the medical clearing stations of World War I filled with a disturbing number of “shell shocked” soldiers did British doctors finally begin to employ what was already known about hysteria, neurasthenia, and traumatic neuroses to help them in understanding the nature of war neuroses.

The ignorance of British psychiatry was further exacerbated by the fact that Freudian concepts of a dynamic relationship between the conscious and unconscious were strongly opposed in early twentieth century Britain. Paul Roazen suggests psychoanalysis was not well received in Britain because most members of the medical

\textsuperscript{13} Ibid., 1096-8.

community were trapped within a physical paradigm that kept them in search of biological causes for all neuroses. Furthermore, the majority of British psychiatrists had never used the psychoanalytical method to diagnosis and treat mental disorders because they were uncomfortable with Freud’s focus on conflicts of the sexual instinct to explain neuroses. However, an objective approach would have shown that in some cases (e.g., “shell shock”) psychoanalysis only works when the sexual instinct is replaced by other instinctual drives (e.g., self-preservation). One consequence of this rejection of psychoanalysis was that members of the Royal Army Medical Corp (RAMC), before WWI, had no alternative viewpoint to help them interpret psychological symptoms exhibited by soldiers. Caught in a biological paradigm RAMC doctors up through the Boer War often misinterpreted the symptoms of their patients as signs of insanity that had lain dormant in their genes until awakening under the pressures of war. Therefore, British medical officers gained no real knowledge of war related neuroses that could have helped them to understand and treat the epidemic of psychological casualties that appeared in the trenches of the Great War. In the introduction of his most popular book on the etiology of “shell shock,” W. H. R. Rivers stressed that

The medical administration of our own and other armies was wholly unprepared for the vast extent and varied forms in which modern warfare is able to upset the higher functions of the nervous system and mental activity of those called upon to take part in it.”


16 Salmon, 14.

In early fall of 1914, the first British cases of “shell shock” began to filter through military hospitals behind the developing trenches in France. Still ignorant of the psychological nature officers in the RAMC first looked for biological connections to “shell shock.” W. H. R. Rivers observed that due to the general materialistic paradigm of British medicine, medical professionals attempted to connect “shell shock” to the physical injuries that soldiers sustained in battle.\textsuperscript{18} Frederick Mott, a distinguished psychiatrist in the RAMC, described case studies in which he believed the symptoms were caused by microscopic brain hemorrhages produced by the shock waves of exploding shells, hence “shell shock.” He also hypothesized that “shell shock” might be connected to carbon monoxide poisoning due to the gases released by detonating shells.\textsuperscript{19}

Ironically the misleading term “shell shock” was first used by Charles S. Myers, a close colleague of W. H. R. Rivers and an advocate of psychoanalysis, in an article published in the \textit{Lancet} in February of 1915.\textsuperscript{20} Later, Myers admits:

I did not suppose, as Lieut.-Col. Frederick Mott was then attempting to show, that [war neuroses] arose from the effects of minute cerebral hemorrhages or other microscopically visible lesions. I attributed them, as they are now generally attributed, to mental [processes], but I was inclined to lay some emphasis on the physical shock produced by the bursting of a shell as a prime cause of [neuroses]. Later familiarity with the disorder, however, showed that emotional disturbance alone was a sufficient cause.\textsuperscript{21}

Overall, Mott’s initial search for a purely physical cause lacked evidence and there were too many cases of “shell shock” in which the soldier was not in close

\textsuperscript{18} Ibid.
\textsuperscript{21} Ibid., 13.
proximity to exploding shells. Hence, Mott and most other psychiatrists in the RAMC came to believe that the symptoms represented by “shell shock” resulted from a soldier’s psychological inability to deal with the stressful conditions of war.22

Eventually, RAMC psychiatrists noticed the similarity between Osler’s descriptions of symptoms shown by civilians suffering from hysteria, neurasthenia, and traumatic neuroses and those elicited by soldier’s suffering from “shell shock.” Unfortunately, most British doctors, including Mott, continued to be blinded by the physical paradigm, and they attempted to find a biological connection that could explain why “shell shocked” troops were psychologically unable to control their fears in the battlefield. In The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder, Allan Young explains that most British medical practitioners became satisfied with the simplistic idea that, aside from actual physical neural damage due to injury, the root of war neuroses could be traced to hereditary and/or constitutional factors belonging to the individual soldier, and deeper investigative “questions about the causes of the neuroses interested only a minority of physicians.”23 Among those was W. H. R. Rivers, who synthesized his experiences in neurology, anthropology, and psychology to pioneer a unique psychoanalytic theory that explained the etiology and epidemiology of war neuroses in the Great War.

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CHAPTER III

W. H. R. RIVERS BEFORE THE WAR

Richard Slobodin, Rivers’s only biographer, writes that in his formative years Rivers dreamed of becoming a medical officer in the Royal Army. His grandfather, William Rivers, a military professional credited with shooting the French marksman who fatally wounded Admiral Lord Nelson at Trafalgar, and his father, Henry Frederick Rivers, an ordained reverend and speech therapist (who helped W. H. R. Rivers with his own childhood speech impediment), represent the most likely role models for Rivers’s early career aspirations. Rivers also informs us that during his childhood he lost much of his ability to use imagery to recreate sensory experiences. In other words, he struggled to imagine the way a particular food had tasted or to mentally picture the floor plan of his childhood home. Although his father helped him to speak better, Rivers was never fully cured of his speech impediment, and he lived with his imagery deficiency throughout his life span. Slobodin suggests that Rivers became interested in psychology because he was hoping to find an explanation for these mental developments that had affected him since childhood.

25 Ibid., 3-8. Note: Rivers developed a speech stammer at an early age, and though his father helped him some, Rivers never fully lost his stammer.
Rivers was an excellent student planning to attend Cambridge University. Both, his father and grandfather were alumni, but unfortunately Rivers contracted a serious ailment in his last year of public schooling that kept him from completing the entrance exams to Cambridge. Instead, Rivers matriculated at the University of London and then attended St. Bartholomew’s Hospital, also known as Barts, to study medicine. Graduating in 1886, at the age of 22, he was, at the time, the youngest medical graduate in the long history of Barts graduates.27

After graduating, Rivers hoped to join the Army Medical Department, but many of his close colleagues advised that this option represented a dead end to his career. Heeding their warning, he stayed at Barts and began to develop a strong interest in neurology and psychology. Rivers’s mentors in neurology included the famous British neurologists Hughlings Jackson and Henry Head. Under the tutelage of Jackson and Head, Rivers investigated human instincts, and learned to look for biological causes in unexplained neuroses. However, Rivers felt that biology did not always offer satisfactory answers to certain questions pertaining to the etiology of mental neuroses. From 1892-1893, Rivers traveled several times to Germany to study the newly emerging theory of psychoanalysis. During this time he attended the lectures of the well known German psychiatrists Otto Binswanger and Emil Krapelin, who were direct disciples of Sigmund Freud. In Germany Binswanger and Krapelin trained Rivers in psychoanalysis, and encouraged him to look toward the unconscious for answers regarding undefined mental and physical ailments. Influenced by both perspectives, Rivers was able to see that other

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27 Ibid., 8-9.
instinctual drives besides the sexual instinct worked within the theory of psychoanalysis, and this would eventually lead to his theory on the etiology of “shell shock.”

Rivers understood that most British medical professionals were hostile towards psychoanalysis and that they preferred bio-medical explanations for any psychological disorders. Combining his knowledge of neurology and psychoanalysis helped Rivers to present a psychoanalytical theory that tried to fit into the materialistic paradigm of Western science. As a glaring example of this, Rivers attempted to get British colleagues to seriously entertain his theories on war neuroses by presenting them in a book titled, *Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses.*

In the spring of 1888, Rivers earned his M.D. in medicine and was elected a Fellow of the Royal College of Physicians. During his graduate years at St. Bartholomew’s Hospital, Rivers wrote papers on several psychological topics including hysteria and neurasthenia. These experiences would later help him to understand the nature of “shell shock.” In 1893, he fulfilled his Cambridge dreams when he was invited to St. John’s College to conduct lectures in experimental psychology, mostly centered on human perception. During his tenure at Cambridge Rivers was invited to join the Cambridge Anthropological Expedition to Torres Straits. Rivers never foresaw himself participating in the field of anthropology, but he had always expPresssed an interest in comparing the psychology of primitive cultures with those of advanced societies.

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28 Ibid., 1-6.
Seeing a golden opportunity to accomplish one of his goals, Rivers accepted the offer in 1898 and spent the next sixteen years focusing much of his energy on anthropological pursuits.

As an anthropologist, Rivers introduced an efficient and accurate system of genealogical data collection. Rivers’s methodological approach included a painstakingly detailed account of every member in every family being studied within the community of interest. This method strengthened the validity of anthropological conclusions, and helped the field gain wider acceptance within the scientific communities of Western society.30 Rivers formally introduced this method in his most famous anthropological work titled The Todas. Published in 1906, this book showcased three years of research in a small indigenous society located in the Nilgiri Hills of Southern India. Rivers provides an extensive appendix that uses chart diagrams to illustrate the descendents of the families included in the study. With this detailed information Rivers proposed that researchers could draw valid conclusions about many social aspects of a culture such as birth rates, deaths rates, and marital customs. Later, as a psychiatrist, Rivers’s methods in anthropology helped him in his efforts to diagnosis and treat psychological disorders as he developed exhaustive accounts of his patient’s past and present experiences.

As an anthropologist, Rivers compared the cultural and social aspects of various peoples. He was particularly interested in studying the similarities and differences of human psychology in modern and primitive societies. He discovered that in both primitive and modern societies the psychological concept known as suggestion played an

important role in the maintenance of human behavior. The commonly accepted definition was that it represented a psychological state during which a person’s physical and mental status could be altered through the unquestioning acceptance of a recommendation or idea. Rivers argued that this described an artificial form of suggestion that was more related to the conscious act of hypnotic persuasion. Combining his knowledge of instincts and human psychology, he worked on a definition of suggestion that better fit his anthropological observations. Rivers classified suggestion as a purely unconscious process of the gregarious instinct that “makes it possible for all the members of a group to act in unison so that they seem to be actuated by a common purpose.”

Based on his experiences with the indigenous people of the Solomon Islands in 1908, Rivers demonstrated the connection between suggestion and the gregarious instinct. He described that when members of the expedition needed to go ashore, five of the crew (native men) would almost instantly separate from their peers and take positions in a rowboat (steer-oar and rowing thwarts) without making direct communication with each other as to who would sit where. Rivers stated that there was no prior arrangement between the indigenous crew members, therefore “the harmony seems to have been due to such delicacy of social adjustments that the intention of five of the members of the crew to man the boat and of one to take the steer-oar was at once intuited by the rest.”

There was also evidence to illustrate this phenomenon happening in modern societies

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such as “the harmony of the passage of people on the pavements [in London] in which
the rarity of jostling is to be explained by an immediate intuition of the movements of
others which takes place unwittingly with all the signs characteristic of instinctive
behavior.” Rivers argued that “harmony” was the goal of the gregarious instinct, and
“intuition” represented the unconscious process of suggestion that helps to fulfill that
goal.

Rivers cited these observations as evidence to support his belief that the
process of suggestion belonged essentially to the instinctive side of the mind, and it was
linked directly to the maintenance of the gregarious instinct. Reflecting after the war,
Rivers claimed these anthropological discoveries helped him to “understand better the
place taken by suggestion both in the production and treatment of [mental] disease.” In
the case of “shell shock,” he believed that the enhanced state of suggestibility necessary
to produce symptoms of hysteria was caused by military training that excited the
gregarious instinct in soldiers when they were drilled to act in harmony with fellow
comrades and to obey orders without question.

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34 Ibid., 96.
35 Rivers, Medicine, Magic, and Religion, 50-1, 136-7.
36 Rivers, Instinct and Unconscious: A Contribution to a Biological Theory of the Psycho-
Neuroses, 206, 210-216.
CHAPTER IV

W. H. R. RIVERS AND THE ETIOLOGY
OF “SHELL SHOCK”

In July of 1915, Rivers joined the staff at Maghull Military Hospital as a Temporary Captain in the RAMC to treat the growing number of psychological casualties returning from the trenches in France. A year later he transferred to Craiglockhart Hospital in Edinburgh, where he would treat the majority of his “shell shock” cases, including the famous soldier poet Siegfried Sassoon. In the final year of the war, Rivers was appointed to the Central Hospital at Hampstead where he finished out his career in the RAMC treating British pilots suffering from war neuroses. Rivers formulated and refined his ideas about war neuroses and published them in 1920 in his book, *Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses*. Rivers included all of his previous writings on war neuroses as appendixes in this book. Although the title implied that he was coming from a biological perspective, it quickly becomes apparent that Rivers’s theories were primarily constructed within the realm of psychoanalysis.

In the introduction, Rivers argued that Sigmund Freud’s theory of psychoanalysis faced exceptional hostility from the medical community, and this was

hindering a fuller understanding of the etiology and epidemiology of “shell shock.” This aversion towards Freud’s ideas could be traced to his belief that a disturbance of the sexual instinct was the essential cause of nearly every psychoneurosis. Rivers agreed with Freud that most neuroses observed during times of peace related to the sexual instinct, but he did not believe that “shell shock” had any strong connection to desires and impulses associated to sex. Instead of dismissing Freud, Rivers objectively examined how other instincts might work within a psychoanalytical framework to explain war neuroses. He suggested that “the first result of a dispassionate study of the psychoneuroses of warfare, in relation to Freud’s scheme, was to show that in the vast majority of cases there is no reason to suppose that factors derived from the sexual life played any essential part in causation, but that these disorders became explicable as the result of disturbance of another instinct…the instinct of self-preservation.” 39 Essentially, Rivers had improved Freud’s psychoanalytical approach so that it could explain a wider array of mental disorders. In his own work, Rivers continued to rely on Freud’s concept of a dynamic relationship between the conscious and unconscious to assist in understanding how the mental processes of suppression and repression led to neuroses that attempted to solve the conflict between self-preservation and duty.

The main working premise of Freudian psychoanalysis posits that a natural function of the unconscious is to hide painful experiences that threaten a person’s conscious desire for pleasure. The unconscious is literally a prison for unwanted memories and socially unacceptable impulses that Freud related to the sexual instincts.

39 Ibid., 4-5.
The psychological defense mechanisms that assist in this process are known as *suppression* and *repression*. The former mechanism was recognized by Freud as a conscious effort to avoid unwanted memories and impulses, and to send them to the unconscious. The latter apparatus represented a purely unconscious force that attempted to keep painful memories and impulses from reaching conscious. Regardless of any initially successful attempts at suppression and repression, Freud argued that extremely unpleasant experiences and deviant desires would eventually reenter the conscious state in a disguised form represented by the physical and psychological symptoms of psychoneuroses.40

Rivers adopted most of Freud’s concepts, but he took the liberty of reversing Freud’s definitions for suppression and repression because within British psychiatry there still existed debate over the exact meaning of these concepts. Besides attempting to create a clearer definition for these terms, it is probable that Rivers switched them around in a further attempt to defuse the anti-Freudian mind-frame in Britain. He proposed that “suppression” was the “unwitting” (unconscious) process of making unpleasant experiences and/or socially unacceptable impulses inaccessible to consciousness, and “repression” was the “witting” (conscious) effort that assists the unconscious act of “suppression.”41 Unless otherwise stated, Rivers’s version of Freud’s psychoanalytical concepts will be denoted as “suppression” and “repression” throughout the remainder of this thesis.

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Using his modified Freudian approach, Rivers proposed that one form of neurosis associated with “shell shock” developed because some soldiers, particularly new recruits, lacking the skills of “repPression,” quickly failed to “suppPress” their instinctive reactions to self-preservation. While other soldiers, predominantly officers and professional troops, were often stricken by a different kind of neurosis due to a perpetual state of “repPression” that eventually failed to subdue their painful experiences and instinctive tendencies. Within the RAMC, the former neurosis was commonly diagnosed as a traumatic form of hysteria, while the latter neurosis was usually viewed as a traumatic form of neurasthenia. Rivers, having previously written about trauma induced hysteria and neurasthenia, acknowledged the glaring similarities between the symptoms of the neuroses in domestic cases and those found in war. However, for reasons that will now be explored, he proposed that the terms “substitution-neurosis” (traumatic hysteria) and “anxiety-neurosis” (traumatic neurasthenia) should be adopted because they more accurately represented the special characteristics of these war-related neuroses.

Rivers argued that “substitution-neurosis” was more prominent in volunteers and drafted conscripts because they had neither the experience nor proper training to properly “repPress” their fears of injury and death. The extreme shocks and strains of trench warfare excited the instinct of self-preservation that presented a soldier with three

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42 Ibid., 122-3.
possible actions: fight, flight, or immobility. Up until WWI, professional soldiers would typically satisfy their instinctive urges by fighting because they believed they were still in control of their own destiny, and with good training and execution they would make it out alive. Soldiers in the trenches during the Great War were not given many opportunities to fight, and most of the time they found themselves stewing in their own fears as they avoided the iron sights of enemy snipers and took shelter from artillery barrages. Furthermore, the absolute destruction caused by advanced weaponry on the Western Front created a situation where, given the chance to fight, even the most decorated veteran felt he had little chance to survive any major battle. Eric J. Leeds correctly points out in his book, *No Man’s Land: Combat & Identity in World War I*, that in war, “Rivers [believed] a man’s most rational response to anxiety is some kind of manipulative activity [i.e. fighting],” but, “. . . technological warfare created the conditions in which men were deprived of [this response].”45 This produced a feeling of helplessness that further strained a soldier’s unconscious ability to “suppPress” the other modes of action associated with self-preservation.

Attempting to flee the situation directly interfered with a soldier’s duties, and would be construed by military authorities, comrades, and the soldier himself as cowardice and mutiny. Perhaps more importantly, flight mode contradicted the goals of self-preservation because it increased the possibility of injury or death by leaving what little protection was offered by surrounding comrades (living and dead), craters, and trenches. The last viable option was that of immobility, but the soldier’s unconscious was

not able to perfectly fulfill this instinctive act because it also directly conflicted with his ideas of duty and cowardice. Lacking the conscious ability to effectively “repPress” his instinctual tendencies the new recruit’s unconscious mind is left alone to “suppPress” all three responses to self-preservation. After repeated and lengthy exposure to the extremely harsh conditions of trench warfare he inevitably confronted an episode or series of episodes that caused him to unwittingly lose control of his “suppPressed” impulse to immobility. Representing the only acceptable escape from emotional and physical stPress, the instinctual/unconscious responses of immobility reached the soldier’s conscious in a substituted form (e.g. paralysis in an arm, blindness, mutism/inability to speak) that were less congruent with his ideas of cowardice and duty, hence, “substitution- neurosis.”

This diagnostic label is similar to conversion disorder which is the current name used for hysteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Both of these chosen terms try to convey that the symptoms of this condition develop when an emotional conflict is converted into or substituted with a physical ailment. Echoing Rivers’s ideas on “substitution-neurosis,” the current understanding of conversion disorder professes that the symptoms are produced unconsciously. Today, psychologists use conversion disorder as a possible diagnosis for psychologically

46 Ibid., 52-60, 135.
wounded soldiers because they agree with Rivers that the traumatic experiences of war can cause this condition.\textsuperscript{48}

Rivers only chance to examine cases of “substitution-neurosis” came while he was stationed at Maghull Hospital because patients displaying hysterical symptoms were rarely sent to the mental wards at Craiglockhart or Hampstead.\textsuperscript{49} He observed in “substitution-neurosis” that some of the most obvious symptoms, including partial paralysis, inability to speak, and blindness, provided clear indication that the “suppressed” tendencies of immobility were finding their way to consciousness in a modified form. These psychosomatic conditions, produced in the unconscious, made it possible for a soldier to hold on to his conceptions of courage and duty while removing him from a life threatening environment that had originally awakened the instinct of self-preservation.\textsuperscript{50} Rivers concluded that,

\begin{quote}
  The most characteristic manifestations of hysteria (‘substitution-neurosis’), may be regarded as localized manifestations of the ‘suppression’ of the instinct of immobility . . . According to this view the symptoms of hysteria are due to the substitution, in an imperfect form, of an ancient instinctive reaction in place of other forms of reaction to danger.\textsuperscript{51}
\end{quote}

It is at this point that Rivers incorporated his theory of suggestion to explain how the “unsuppressed” tendencies of immobility are modified to produce the common symptoms of “substitution-neurosis.”

\textsuperscript{51} Ibid., 135.
For Rivers, “suppPression” and suggestion were both unwitting processes involved in carrying out the duties of human instincts. “SuppPression” was intimately connected to the instinct of self-preservation, and observations during his anthropological endeavors had led Rivers to conclude that suggestion helped to fulfill the goals of the gregarious instinct. As mentioned in the previous chapter, the job of the gregarious instinct is to lead all the members of a group to act together towards a common purpose of furthering the welfare of the group, and the power of suggestion allows this to happen intuitively between individuals. Although the group oriented gregarious instinct seems to conflict with the individualistic instinct of self-preservation, Rivers argued that these two natural forces act in unison because warfare is essentially a collective form of activity. Hence, he “regarded the state [of ‘substitution-neurosis’] as primarily one of ‘suppPression,’ as a means of promoting safety, which has been greatly modified through the process of suggestion coming into action through the gregarious needs.”

Rivers pointed out that mutism was a symptom that clearly exemplified how the power of suggestion, coming from the gregarious instinct, influenced the “suppPressed” instinct of immobility. When a group is faced with danger he argued that in order for all the members to be successful in their instinctual reactions to self-preservation it is essential that everyone acts in unison. Rivers stated,

If a group of animals is to adopt successfully the instinct of immobility, it is not only essential that all tendencies to…movements… shall be suppPressed; it is just as essential that every one of its members shall silence the warning cry which serves so useful a purpose on…occasions …[relating to the instinct of flight].

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52 Ibid., 90, 132, and 134.
53 Ibid., 133.
Therefore, mutism, suggested through the gregarious instinct, enables the instinct of immobility to be fulfilled thus removing the soldier from a life-threatening situation and satisfying the instinct of self-preservation. Rivers proposed that once a “shell-shocked” soldier was safe from immediate danger mutism often continues “because it provides a means of protection from further participation in danger, and is therefore utilized, not consciously, but in that unwitting manner which is characteristic of instinctive forms of behavior.” 54 Rivers concluded that the prevalent symptoms of “substitution-neurosis” represented a blending of the unconscious impulses emanating from the self-preservation and gregarious instincts.

Explained in the previous chapter, Rivers believed common soldiers went to the front lines in a highly suggestive state because their training had excited the gregarious instinct. It is this highly suggestive state that makes it possible for a combatant’s unconscious mind to accept the modified reactions to immobility (e.g. mutism). In his 1918 report, War-Neurosis and Military Training, Rivers explained to the Medical Research Committee in London that in boot camp combatants of the common ranks were instructed to follow orders without question, and they learned how to fight, physically and intuitively, as a single cohesive unit. This suggestive state was further enhanced because volunteer/citizen soldiers came from a low socio-economic background and an educational system that did not teach the repression of fear and its expression as a moral standard. Therefore, the minds of these combatants were vulnerable to the power of suggestion before they even stepped foot into the trenches.

54 Ibid., 133.
Conversely, the British officers typically came from quality public and private schools in the middle and upper echelons of society where they were strongly socialized to hide their reactions to fear that could be construed as cowardice. An officer’s ability to avoid suggestibility is strengthened because his duties in the trenches require him to give orders rather than to blindly obey them. Rivers proposed that the epidemiology of both types of war neuroses could be explained by investigating differences in the educational history and the military training/duties of officers and non-officers.55 This is best illustrated by investigating Rivers’s etiological understanding of the mental processes involved in the onset of symptoms related to “anxiety-neurosis.”

As with “substitution-neurosis,” Rivers believed that “anxiety-neurosis” also originated due to a conflict between the instinct of self-preservation and a soldier’s duties in the trenches. The main difference between the development of one or the other was how a soldier attempts to solve this conflict. In the case of “substitution-neurosis,” a soldier’s inability to “repPress” his fear resulted in a failure to “suppPress” instinctive actions of immobility that become greatly modified by the process of suggestion, working through the gregarious instinct. On the other hand, “anxiety-neurosis” will develop in a soldier who is trained to lead and has the intellectual and social skills needed to “repPress” the thoughts and emotions that threaten to overwhelm his unconscious ability to “suppPress” the instinct of immobility. This soldier is caught in a constant state

of anxiety that eventually leads to a mental disorder that Rivers appropriately labeled “anxiety-neurosis.”

Rivers first presented his theory of “anxiety-neurosis” in a lecture to the Royal Society of Medicine in December of 1917. Titled, *The Repression of the War Experience*, this work argued that “repression” is an...

...active or voluntary process by which it is attempted to remove some part of the mental content out of the field of attention with the aim of making it inaccessible to memory and producing a state of ‘suppression’...[and]...it is not the ‘repression’ in itself which is harmful, but ‘repression’ under conditions in which it fails to adapt the individual to his environment.

Unlike “substitution-neurosis,” which...

...incapacitates the patient from further participation in warfare and thus [successfullly] removes all immediate necessity for conflict between instinct and duty,” ‘anxiety-neurosis’...is a state or process in which the conflict has not been solved but is unduly active...so that the motives arising out of the instinct of self-preservation have gained in power, while in many cases the social factors have produced new conflicts and causes of anxiety which may be as potent as the primary conflict with the instinct of self-preservation.

Rivers also assumed that the nature of an officer’s duties and his stronger background in education made it so he was “less likely to be content with the crude solution of the conflict between instinct and duty which is provided by such disabilities as [mutism] or the helplessness of a limb.” Instead of developing psychosomatic/functional disorders, the officer suffering from “anxiety-neurosis” had symptoms that were less visible such as...
irritability, insomnia, nightmares, depression, general state of mental and physical
fatigue, loss of appetite, nervousness, slight tremors, and minor disorders of speech.

Rivers theorized that under prolonged strain a conscious attempt to “subdue
instinctive tendencies and banish painful experience…is as a rule wholly unsuccessful.” 60

At first, a soldier may be able to “repPress” his fears and emotions, but in long duration
“repPression” only served to intensify them. Rivers states that although in “anxiety-
neurosis,”

The original conflict is [due to] the re-awakened danger-instinct…this is often
wholly displaced by the affect of horror associated with some peculiarly painful
incident of war, or by the affect of shame following some situation which the
sufferer fears that he has failed to meet in a proper manner. 61

Hence, instead of developing symptoms that represented the “suppPressed” instinct of
immobility (e.g. paralysis, blindness, and mutism), Rivers argued that the symptoms of
“anxiety-neurosis” (e.g. depression, nervousness, and nightmares) reflected a soldier’s
futile attempt to indefinitely “repPress” a particularly horrific or shameful event(s), and
the longer this stasis continued without treatment the worst the symptoms would get. 62

Rivers describes,

A young officer who was sent home from France on account of a wound received
just as he was extricating himself from a mass of earth in which he had been buried
. . . and, upon examination in England, he appeared to be . . . nervous and suffered
from disturbed sleep and loss of appetite. 63

After healing from his wound, the patient began to eat again and claimed that he was
feeling better despite self reports of mild nervousness and occasional nightmares about

60 Ibid., 122-3.
61 Ibid., 123.
62 Ibid., 123, 234.
63 Ibid., 188.
his experiences in battle. The patient refused psychiatric treatment until he lost his appetite again and claimed his other symptoms had intensified to an unbearable level. Rivers postulated that these worsening symptoms represented the officer’s failing attempts to continually attempt to “repPress” his fears and doubts.

Foreshadowing current classifications for psychological conditions, there is evidence showing that “anxiety-neurosis” closely resembles posttraumatic stPress disorder (PTSD) which is found in a section of the DSM-IV-TR titled Anxiety Disorders.64 As with “anxiety-neurosis,” the symptoms of PTSD are caused by a person’s inability to psychologically cope with the stPress/anxiety that results from exposure to a traumatic event(s). Rivers’s list of symptoms associated with “anxiety-neurosis” are also very similar to those of PTSD, including nightmares, irritability, and nervousness. Lastly, in both PTSD and “anxiety-neurosis” it is argued that symptoms will only get worse the longer a patient remains unable or unwilling to deal with the traumatic event(s).65

Regardless of the type of “shell shock,” W. H. R. Rivers argued that all “the neuroses of war depend upon a conflict between the instinct of self-preservation and certain social standards of thought and conduct, according to which fear and its expPression are regarded as reprehensible.”66 The main difference between the various neuroses was the soldier’s ability or non-ability to “repPress” their instinctual reactions to

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situations that are life threatening. This approach showed sympathy towards “shell shock” victims because Rivers did not place blame on the soldier’s heredity or personal constitution as many of his British colleagues did. Instead, he argued that the cause of war neuroses could be found by looking at the lack of training time and the harsh battle environment that troops experienced in the Great War. This perspective did not garner him much support from the military and political leaders of the war who refused to take any responsibility for the epidemic numbers of psychological casualties. They would not believe that the lack of training time and the high fatality rate produced by the advanced weapons used in trench warfare had anything to do with the epidemiology of “shell shock.” Unfortunately, most of Rivers’s colleagues followed suit, and they gave his theories very little attention and/or support. For them it was a safer career move to put forth ideas that supported the politicians and commanding generals, rather than siding with a theory that chastised them. Finally, despite attempts to present his theory from a biological perspective, Rivers’s theory resonated too loudly with Freudian principles for most of his colleagues to seriously entertain.
CHAPTER V

BRITISH OPPONENTS AND ADVOCATES TO RIVERS’S APPROACH

Throughout the war, the majority of British psychiatrists displayed loyalty to the biological perspective, and remained skeptical toward Freud and his system of psychoanalysis. Although Rivers attempted to display his ideas in a biological light, it quickly became obvious to his colleagues that his approach was predominately a psychoanalytical one, and therefore, they did not seriously entertain his theories. The etiological consensus among those in the materialist camp was that a small percentage of “shell shock” victims actually suffered from a physical injury to their nervous system, whereas the majority of patients were predisposed because of heredity and/or personal constitution. Furthermore, they refused to believe that the unprecedented fighting conditions of modern warfare were responsible, and reasoned that the stresses and strains presented in the trenches of the Great War were any greater than those presented in past wars. Unsympathetically, they argued that the epidemiology surrounding the outbreak of psychoneuroses could be boiled down to one important fact that distinguished it from prior wars; the draft had let too many weak minded civilians become soldiers. This point of view was so strong that many British officers in the RAMC avoided any deeper investigations into the nature of “shell shock” and instead concentrated their efforts on
detailing the varying forms of the acute and subtle symptoms they observed while attempting to treat their subjects.

The famous British neurologist Dr. Lewis R. Yealland scoffed at the usefulness of psychoanalysis because he believed the true etiology of “shell shock” had already been discovered and agreed upon. He supplied only a brief explanation for the cause of “shell shock” in the preface of his widely read book, *Hysterical Disorders of Warfare*. Aside from patients who sustained physical injuries in the cerebrospinal nervous system, he simply stated that all neuroses of war could be attributed to a genetic and/or constitutional predisposition to entering a highly suggestive state of mind (the prerequisite to hysteria). 67 The remainder of Yealland’s book examined a plethora of case studies in an attempt to create a definitive work on the symptomatology and treatment of hysteria.

For instance, he presented six cases representing what he thought were various forms of hysterical disorders of speech. In one example, Yealland described a private who participated in several fierce battles before suddenly falling down unconscious three months later while attending to some horses. The patient remained unconscious for five hours, and when he regained consciousness he could no longer speak. The only clue Yealland gives to the psychological processes involved in the onset of hysteria is that the patient had somehow lost his ability to remain mentally strong, as he had already done successfully in previous battles. 68 In other words, it was the soldier’s fault for finally

68 Ibid., 7-15.
entering a highly suggestive state and succumbing to the thoughts and desires associated with fear. Besides illustrating Yealland’s unsympathetic approach to the etiology of “shell shock” this case also shows that, like Rivers, he was willing to believe that war related neuroses did not only develop after some shocking event (i.e., watching a friend get blown to bits) but could emerge due to prolonged exposure to the stresses found in modern warfare.

Dr. Hamilton Marr, another leading psychiatrist in Britain, saw no practical use for psychoanalysis in understanding and treating war neuroses. Supporting the biological approach, he firmly believed that aside from serious injury to the nervous system, all “shell shock” patients were genetically and/or constitutionally predisposed. He argued that acute mental diseases were not heritable, but instead people could inherit an unstable nervous system or mental weakness. In his book, *Psychoses of the War: Including Neurasthenia and Shell Shock*, Marr supplies the reader with a painstaking account of all the physical evidence that illustrated how a flawed nervous system could lead to the development of mental psychosis. He differed from Yealland by suggesting that all cases of “shell shock” were essentially examples of neurasthenia, and hysteria was simply a common subset or added complication of neurasthenia.69 Ironically, Marr’s chosen title for the book initially leads the reader to believe that neurasthenia and “shell shock” are two different afflictions.

From his observations, Marr deduced that a strict case of neurasthenia was rare and more often than not it was paired with hysterical symptoms that he claimed

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could not independently exist. He concluded that “hysteria is in reality a symptom complex of neurasthenia, one aspect and an important one of this affection, which is a functional affection of the cortical, bulbo-spinal and sympathetic neurons.” Exempting cases that could be directly attributed to organic causation (e.g. concussion from shell explosion), Marr’s approach included two general “shell shock” classifications: simple neurasthenia and hysterical neurasthenia. These diagnostic labels did not receive much support from other British psychiatrists because there was confusion in placing observed symptoms within either classification. For instance, he believed that depression, commonly thought of as a symptom of neurasthenia, could be a hysterical complication of neurasthenia, and fugues (temporary state of psychological amnesia), traditionally an affliction of hysteria, could be found in cases of simple neurasthenia. Most psychoanalysts, including Rivers, conceded that a victim of “shell shock” could temporarily exhibit both hysterical and neurasthenic symptoms, particularly at the point of breakdown, but they preferred firm symptom sets that allowed for more effective and consistent diagnosis.

Marr recognized that on the battlefield, “no one is free from anxiety, and in everyone, fearful emotions exist,” but, like most materialists, he did not believe that World War I combatants faced unprecedented levels of anxiety and fear. Instead, he argued that the “shell shock” epidemic could be attributed to the large percentage of British troops, conscripted from the civilian population, who, due to their hereditary and

70 Ibid., 47.
71 Ibid., 46-7, 54-5, 66-7.
72 Ibid., 47.
constitutional predisposition, lacked the mental stability necessary to control their stress levels and emotional responses to experiences in the trenches. The stress and emotions reached a state of toxic intensity which then initiated the dysfunctional neural activities responsible for the onset of war related neuroses. Marr claimed that men predisposed to “shell shock” could never be trained to succeed as professional soldiers, and under normal circumstances they would naturally avoid any participation in war.\textsuperscript{73}

Marr’s ideas contrasted greatly with those of Rivers’s which stated that the horrific combat conditions in the Great War and the lack of proper military training represented, in that order, the two most important epidemiological factors for the widespread occurrence of “shell shock” within the British Army. Additionally, Marr’s approach offers no explanation for how it was possible for even experienced professional soldiers of the BEF (British Expeditionary Forces) to become susceptible to war neuroses. Rivers’s theory effectively addressed this problem, but interestingly enough, all of the physical minded neurologists in the RAMC, including Marr, skirted over this issue. It would not be a leap of faith to assume that the materialists conveniently overlooked professional soldiers with “shell shock” because they represented a threat to the integrity of their theories in regard to the etiology and epidemiology of war neuroses.

Dr. Frederick Mott was another reputable neurologist in the RAMC who put forth a bio-medical theory to explain the causation and frequency of war related mental disorders. In \textit{War Neuroses and Shell Shock}, Mott argued that “shell shock” was a useful term if limited to cases where there was definite evidence of a shell or bomb bursting

\textsuperscript{73}Ibid., 47-8.
near enough to knock a man down, or blow him up in the air and possibly cause a temporary loss of consciousness.\textsuperscript{74} He proposed that under these conditions the concussions created by shell explosions could upset the natural stasis of the nervous system and produce afflictions similar to those observed in neurasthenia and hysteria. However, Mott believed that most psychological cases appearing from the trenches involved a combination of commotional (physical) shock (e.g., close vicinity to shell explosion) and emotive (psychic) shock (e.g., witnessing a comrade being blown to bits) and should be called war neuroses. He also admitted that based on his observations it was possible for a highly predisposed soldier to acquire a war neurosis strictly due to emotive shock.

Mott agreed with his fellow materialists that the high rate of war neuroses was completely unrelated to military training methods and/or fighting conditions in the trenches. Instead, he argued that it was the large number of civilian conscripts, lacking the constitution and/or genetics for military combat that explained the epidemiology of “shell shock” in the Great War. Similar to his fellow advocates, Mott offered no substantial theories to explain why a small number of hardened professional troops had also fallen victim to “shell shock.” He simply professed that sound minded and bodied troops might possibly fall victim to “shell shock” due to commotional shock, but were immune to the emotive shock needed to develop war neuroses.\textsuperscript{75}

\textsuperscript{74} Frederick W. Mott, \textit{War Neuroses and Shell Shock}. (London: Henry Frowde, Oxford University Press, 1919), 2.

\textsuperscript{75} Ibid., 201.
Like Rivers, Mott observed that volunteer/non-commissioned officers were more likely to acquire a neurasthenic form of war neurosis than drafted members of the common ranks whom he agreed were more susceptible to a hysteric form of war neurosis. Mott explained that men of the upper ranks had a greater “sense of responsibility which, in the officer worn out by prolonged stPress of war and want of sleep, causes anxiety lest he should fail in his duties. He fears that his memory may fail at a critical moment, and anxiety weighs heavily upon him; mental preoccupation leads to a continued struggle to overcome such doubts and fears.”76 This continued emotivity causes extreme mental exhaustion, and following any type of commotional shock or none at all, can lead to the dysfunctional neural processes responsible for neurasthenic symptoms. Seemingly influenced by Rivers, Mott agreed that neurasthenia should be renamed “anxiety-neurosis” because he too believed that it was a condition caused primarily by an exhaustive state of anxiety. However, contrasting with Rivers’s psychoanalytical approach, Mott argued that prolonged anxiety, in and of itself, could not cause neurosis, and hereditary predisposition and/or weak constitution was also required.

As for victims of hysteria, Mott claimed these were predominately unranked conscripts who lacked the temperament and/or healthy neural connections to deal with the stPress of war at any level. He professed that for these soldiers all it took was one or two intense emotional experiences to create a state of emotive shock.77 These hyper-emotional events would overwhelm a soldier’s genetic and/or constitutional shortcomings, making him highly suggestible to his natural reactions to fear. Examining

76 Ibid., 31.
77 Ibid., 112-3.
the symptomology of hysteria, Mott agreed with Rivers that immobility was the only course of action available to hysterical soldiers, but dissenting from Rivers, he argued that these soldiers did not have the proper nerve structure required to secrete the level of adrenaline needed to perform the actions of flight or fight. Ultimately, he believed it was the severity of a soldier’s genetic and/or constitutional predisposition that determined whether he would contract hysteria or neurasthenia once faced with extreme emotive experiences.

The etiological approach adopted by Mott to explain the spawning of neurasthenic and hysteric symptoms was defiantly biological, but it does contain an element of Freudian psychoanalysis seemingly inspired by the work of W. H. R. Rivers. In describing the onset of war neuroses, Mott acknowledged that there was a definite connection between the subject matter of a patient’s dreams/nightmares and his mental condition. Agreeing with Rivers, Mott wrote that repPressed emotive and/or commotional experiences eventually find their way back to consciousness in the form of the symptoms associated with war neuroses. However, Mott argued that in soldiers without a predisposition to war neuroses these repPressed experiences did not return as the symptoms associated with war neuroses, but they did return in this fashion for personality types that are genetically and/or constitutionally unfit for military service.

Despite the materialists’ animosity towards Freudian concepts, they still concurred with Rivers that symptoms exhibited by soldiers suffering from “shell shock” resembled those observed in civilian cases of hysteria and neurasthenia. They also agreed

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78 Ibid., 121-2.
79 Ibid., 117-21.
with him that war neuroses were primarily the product of psychological trauma and only
a small percentage of cases were directly due to physical injuries. However, members of
the bio-medical camp refused to agree with Rivers that the stresses and strains of the
Great War were unprecedented and represented the main epidemiological reason for the
high rate of "shell shock." Instead, they continued throughout the war to believe that
soldiers were predisposed to war neuroses because they possessed weak genes and/or
psychological constitutions, and the type of "shell shock" they acquired was completely
dependent on their level of predisposition. Despite the overall consensus against
psychoanalysis there were a few other British psychiatrists who advocated an approach
similar to Rivers, and, therefore, offered a more sympathetic approach to the etiology and
epidemiology of war neuroses.

Charles S. Myers was a close associate of Rivers and he too had studied
Freudian psychoanalysis prior to the dawning of World War I. Earlier in his academic
career, Myers happened to be a student of Rivers’s in anthropology at Cambridge
University, but he later specialized in psychology. Unlike Rivers who remained in
Britain, Myers served most of his term in the RAMC stationed in France, only miles from
the trenches of the Western Front. Thousands of cases of "shell-shock," many less than
48 hours removed from the trenches, were personally examined and recorded by Myers.
In *Shell Shock in France 1914-18*, he consolidated his experiences in an effort to explain
the psycho-pathology of war neuroses.80

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As mentioned earlier, Myers was initially confused between the symptoms of war neuroses and actual concussion, but he soon concluded that “shell shock” could “occur when the soldier is remote from the exploding missile, provided that he is subject to an emotional disturbance or mental strain sufficiently severe.” He agreed with Rivers that most symptoms associated with “shell shock” strongly resembled those belonging to hysteria and neurasthenia, yet he did not adopt Rivers’s suggested diagnostic categories, “substitution-neurosis” and “anxiety-neurosis.” Myers preferred to regard “shell shock” as an autonomous mental disease, and neurasthenia and hysteria as related sequelae or symptom sets.

Myers contended that Freud’s emphasis on the sexual instinct was unrelated to the etiology of “shell shock,” but at the same time he argued, in opposition to Rivers, that the conflict between self-preservation and duty “is not an invariable cause of these phenomena [and] a severe emotional “trauma” may suffice.” Self-preservation was simply a contributory cause and not essential, as it was for Rivers, in order for a soldier to develop “shell shock.” Instead, Myers proposed that “shell shock” was “a purely mental disturbance, where the tolerable or uncontrollable limits of horror, fear, anxiety, etc., are overstepped.”

Like Rivers, Myers believed that the neurasthenic worried consciously over his troubles, and the hysterical commonly relegated his troubles to the unconscious. In other words, “the breakdown in the neurasthenic is due to persistent wear and tear; in the

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81 Ibid., 25.
82 Ibid., 27-8, 65-6.
83 Ibid., 59, 73.
84 Ibid., 26.
hysterics this is avoided by a sudden snap or fission, whereby certain nervous or mental processes are “functionally dissociated,” or “unconsciously repPressed” by inhibition from the rest.” Myers was referring to Freudian repPression (Rivers’s “suppPression”) when he talked of inhibition in this quote, but unlike Rivers, he never gave the reader a complete understanding of how this concept related to both hysteria and neurasthenia. He was content with the psychoanalytical belief that unconscious repPression (Rivers’s “suppPression”) of severe traumatic experiences was the antecedent of hysterical symptoms, while the onset of neurasthenic symptoms could be traced to a constant and exhaustive state of brooding over emotionally painful thoughts and experiences.

Myers argued that poorly disciplined/trained units were more susceptible to “shell shock” because they had less self-control, therefore, when faced with danger they “will herd together in insecure places, the shells falling on which may cause grave bodily injuries to some, and “shell shock” to others from the effects upon them of these sights.” This differed greatly from Rivers, who focused on the lack of training in “repPression” as a contributing cause to the onset of “substitution neurosis” (hysteria), and the type of training as a reason for the high level of suggestibility that defines the character of the symptoms related to this form of neurosis. However, Myers did agree with Rivers, that men of the lower ranks typically contracted hysterical symptoms, while officers usually suffered from neurasthenic afflictions.

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85 Ibid., 28.
86 Ibid., 27-9.
87 Ibid., 38-40; quote on age 40.
Myers also concurred with Rivers that “the forces of education, tradition, and example make for greater self-control [or ‘repPression’ skills] in the case of the Officer,” inclining him toward the development of neurasthenia, while the hysteric’s condition was directly associated to his inefficiency in controlling “his instinctive acts to escape danger, the emotions which impel him to them, and the resulting conflicts.”  

Psychopathic predisposition was another contributory factor recognized by Myers who postulated that many cases of “shell shock” occurred in “subjects who have previously suffered from mental conflicts and maladjustments…in childhood [or more recently].” Yet, he also recognized that “even those who start with the strongest nerves are not immune from “shell shock,” if exposed to [prolonged] strain, or if subjected to severe enough shock.”

The final two statements closely parallel what Rivers advocated in *Instinct and the Unconscious*, where he supplied evidence illustrating how claustrophobia, acquired in childhood, could predispose a soldier to develop neurasthenic symptoms, and how an officer of the toughest caliber, mentally and physically, could still fall victim to war neurosis if the shock and strain being “repPressed” was excessive in character and duration.

The majority of British psychiatrists dealing with “shell shock,” both materialists and psychoanalysts, were concerned that soldiers might feign their symptoms to be relieved of their duties in the trenches. It is also true that all psychiatrists were under

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88 Ibid., 38-40, quotes on 38 & 40.
89 Ibid., 38.
90 Ibid.
Pressure to quickly return patients back to the trenches where the generals desperately needed to keep the ranks filled. Therefore, it is predicted that many soldiers with “shell shock” were misdiagnosed as malingering and then returned to the front where they continued to suffer from their condition. In some extreme cases these victims of malpractice were eventually accused of cowardice and executed. While in charge of a mental clearing station near the Western Front, Myers observed a few cases that he felt were examples of malingering. He concluded that it was relatively rare to find a man of good health purposely counterfeiting the symptoms of war neuroses. However, he did believe that some patients with mild cases of neurosis might try to consciously “exaggerate their symptoms or artificially prolong their symptoms, in order to retard their return to duty at the Front.” Rivers insisted that the symptoms of war neuroses originated in the unconscious, and therefore, could not be consciously fabricated for any real length of time. He also believed that a well trained psychiatrist would be able to expose attempted malingering once he began to analyze the patient for diagnosis and treatment.

At Maghull Hospital, G. Elliot Smith and T. H. Pear studied and employed psychoanalytic techniques in an effort to diagnose and treat “shell shock.” Echoing Rivers, they believed that one of the positive side effects of the war was that it finally encouraged psychologists in Britain to take a more scientific approach to understanding the nature of mental neuroses. Smith and Pear suggested that “the war has forced upon

93 Myers, 40-1.
[Britain] a rational and humane method of caring for and treating mental disorder among its soldiers,” and no longer could the British medical community confront the problem of mental disorders (in soldiers or civilians) with a “shifting and unstable blend of apathy, superstition, helpless ignorance and fear.”94 They argued that more sympathetic, insightful, and common sense approaches had already emerged in the other first world countries (e.g. America, France, and Germany), and it was now time for Britain to join those ranks.

In 1917, Smith and Pear published their observations and thoughts in a book titled, _Shell Shock and Its Lessons_. This work more closely resembled Myers’ stance than Rivers’s, presenting “shell shock” as an autonomous mental ailment that was primarily due to an emotional disturbance. However, opposing Myers, Smith and Pear did not see neurasthenia and hysteria as symptom sets within “shell shock.” Instead, they argued that there were three stages involved in the development of “shell shock,” and symptoms similar to neurasthenia and hysteria could be observed in the various stages.95

First, a soldier’s senses were overwhelmed by the severe shocks and strains of trench warfare, and he entered a state in which he tried to suppress (Rivers’s repress) his emotional responses to this environment. At this point the soldier might not show any obvious outward signs of his developing neurosis, but, similar to neurasthenia, the soldier’s constant mental battle could lead to bouts of depression and anxiety. The unprecedented conditions of warfare in this conflict forced a soldier to hold a state of

95 Ibid., 2-8, 15.
suppression for an unusually long duration because he was unable to vent his fears through the action of fighting eye to eye with his enemy. Eventually, this stressful stasis wore down a soldier’s ability to keep his instinctual and emotional reactions in check, and once a bomb exploded near enough for him to be rendered unconscious or dazed he entered the second stage of “shell shock.”

After recovering full consciousness, the soldier exhibited a combination of hysterical and neurasthenic symptoms such as mutism, blindness, partial paralysis, slight tremors, nightmares, severe depression, irritability, and loss of self-confidence. Smith and Pear proposed that the movement and sensory disorders related to hysteria “often vanish after a short space of time, as suddenly and dramatically as they appeared.” Neurasthenic symptoms always lingered, however, and the human mind attempted to interpret these strange experiences, as well as those related to past hysterical episodes, through a process of rationalization that initiated the third stage of “shell shock.”

Without timely intervention, a soldier believed that the witnessed phenomena of his behavior could only mean that he was going insane, which then had the affect of assimilating the current symptoms into his personality. Now the soldier erroneously believed that his character was faulty in some way, and this was the reason for his “shell shock.” The symptoms typical in this final stage are identical to the neurasthenic symptoms found in the earlier stages of “shell shock,” but now these afflictions had become entrenched into the patient’s personality, making them more powerful in affect and harder to remove once treatment finally begins.97

96 Ibid., 8-11, quote on 11.
97 Ibid., 15-9.
Smith and Pear suggested that “not all the motives of a patient’s present beliefs, attitudes and actions are conscious; the entry into consciousness of some of the unacceptable motives and memories is obstructed by various mental process.” However, they never directly refer to Freud’s concept of repPression (Rivers’s suppPression) as the main “obstructive” mental process involved in “shell shock,” and, unlike Rivers, they failed to connect the importance of the conflict between self-preservation and duty. They do briefly referred to the flight instinct as one of the “unacceptable motives” emerging from the unconscious, but overall, their proposed etiology focuses on the witting act of suppPression (Rivers’s repPression) as it related to subduing memories of an exaggerated emotional tone for a prolonged period of time.

Smith and Pear agreed with Rivers that war neuroses were not solely the product of some genetic deficiency that turned soldiers into cowards once they hit the battlefield. They believed that “in the causation of psychoneuroses, heredity undoubtedly counts, but social and material environment count infinitely more.” They stPressed that even the fittest and most experienced soldier was subject to mental neuroses if exposed to extreme fighting conditions for prolonged periods. Smith and Pear also agreed with Rivers that it was important to gain a detailed history of the patient to uncover any possible experiences in their past (e.g. traumatic events prior to the war), that may have predisposed them to developing “shell shock.” However, differing from Rivers, they firmly believed that most patients were predisposed, and they made no references to the

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98 Ibid., 72.
99 Ibid., 9, 91-3.
100 Ibid., 88.
101 Ibid., 6.
amount or type of training as contributory factors in the etiology/epidemiology of “shell shock.”

In *Outline of Abnormal Psychology*, the British psychiatrist William McDougall adopted a psychoanalytical approach, closely comparable to that of Rivers, to describe the nature of the neuroses found in World War I. In fact, McDougall implicitly stated that he firmly advocates the approach developed by Rivers. He believed that “shell shock” was an umbrella term for all war related neuroses that he also primarily grouped into cases of hysteria and neurasthenia. McDougall supported Rivers’s argument that “shell shock,” like all mental neuroses, was caused by a conflict between instincts and social standards. He too, felt that Freud’s reliance on the sexual instinct was unwarranted in the case of war related neuroses, instead, proposing that instinctive reactions associated with self-preservation were more relevant.

The particularly stressful conditions of the World War I combat environment overly excited the instinct of self-preservation. However, training and socialization had taught these combatants that avoiding their duties in the trenches was mountable to treason, or, at the very least, cowardice. The conflict emerging from this situation caused unbearable mental anguish that a soldier attempted to resolve, consciously and subconsciously, through repression. McDougall postulated the following:

Danger of [“shell shock”] comes when the contending motives work obscurely, unrecognized, or disguised by rationalizations, reasons which we invent to explain and excuse our yielding to the promptings we do not acknowledge; and especially is there danger of [“shell shock”] when one of the unrecognized motives

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103 Ibid., 19-20, 61-3, 136.
is of a nature such that we will not, dare not, recognize it, but rather repPress it. Thus it is not conflict, but rather the repPression to which conflict of motives may lead, that is the great source of neurotic troubles.\textsuperscript{104}

Interestingly, McDougall steered away from the term unconscious, instead, preferring the term subconscious, and he never differentiated between suppPression and repPression as Freud and Rivers did. He simply viewed repPression as both a subconscious (unwitting) and conscious (witting) process, but, like Rivers, he did suggest that repPression was more likely to produce neurotic symptoms when it took place subconsciously.\textsuperscript{105} Also like Rivers, McDougall stPressed that regardless of one’s ability to consciously “repPress” the conflict “if the ‘repPressed’ tendency is strong, and circumstances are such as to keep it alive, to stimulate it anew, the conflict continues subconsciously [where it continues to be] distPressing and exhausting to the patient,” and eventually caused the common symptoms associated with neurasthenia such as depPression and general fatigue.\textsuperscript{106}

As for hysteria, McDougall’s etiological belief was similar to what Rivers had proposed. He agreed that hysterical symptoms emerged from the repPressed conflict if the soldier was also highly suggestible due to a poor intellect, lack of self-assertiveness, and low military ranking (fewer responsibilities). Troops fitting this description quickly failed in their conscious attempts at “repPression” that left their unconscious minds unassisted and unchecked in the effort to “suppPress” suggested instinctual and emotional tendencies. With exposure to the shocks and strains of war, these soldiers

\textsuperscript{104} Ibid., 217.
\textsuperscript{105} Ibid., 217, 222-3.
\textsuperscript{106} Ibid., 219-20.
would lose their abilities to both “repPress” and “suppPress” their instinctual and emotional reactions to the danger. At this point, McDougall differed from Rivers because he proposed that a state of dissociation entered to protect the soldier from further mental anguish and physical harm through a subconscious splitting of his personality. The normal personality was abolished from consciousness by a highly suggestible personality that allowed instinctual and emotional tendencies to play out, hence, ending the conflict.107 Rivers opposed dissociation as a necessary step in the formation of hysterical symptoms. He argued there was an “absence of evidence of alternate consciousness,” therefore, hysteria was a state created solely by “the two [unconscious] processes of suppPression and suggestion.”108

McDougall was the only psychoanalyst who supported Rivers’s argument that suggestion was an unwitting process intimately connected to the gregarious instinct. However, he preferred a more simplified viewpoint and proposed that the act of accepting a suggestion was a process of imitation, rather than intuition as Rivers did.109 McDougall argued that the hysterical symptoms observed in a soldier originated when his dissociated personality imitated the instinctual and emotional suggestions found in the combat environment.110 For example, a hysterical patient with functional paralysis of his arm might have contracted this condition during the heat of battle when, after seeing one of his comrades lose an arm, his dissociated personality imitated this injury because this

107 Ibid., 124-6, 236-7.
could effectively remove the normal personality from further contact with danger and fear. McDougall, unlike Rivers, never attempted to explain the possibility that suggestions emanating from the gregarious instincts and “suppressed” tendencies of the danger instincts might be working together unconsciously to produce the symptoms associated with hysteria.\footnote{William McDougall, \textit{An Introduction to Social Psychology}, 104-10.}

Although there existed various differences between the psychoanalytical methods employed by Rivers and his fellow advocates, there was a consensus of opinion within this small group that all war related neuroses were the product of “reppressed” and/or “suppressed” conflicts. However, Rivers’s approach was highly unique because he presented a more thorough and accurate integration of Freudian concepts, while simultaneously advancing psychoanalysis by incorporating the instinct of self-preservation so that this method could effectively describe the etiology of war neuroses. Freud did not write much on war neuroses, but he agreed with Rivers that the sexual instinct could not logically explain the etiology of “shell shock.”\footnote{Ulman and Brothers, \textit{The Shattered Self: A Psychoanalytical Study of Trauma}. (New Jersey: The Analytic Press, 1988), 164-9.} Regardless of any inaccuracies or inconsistencies found in the psychoanalytical theories put forward by Rivers’s peers, they all believed that the etiology of “shell shock” involved a dynamic relationship between the conscious and unconscious minds. In contrast to the biological theorists, Rivers and his fellow advocates also agreed on a more sympathetic approach that emphasized the connection between the unprecedented stressors that World War I soldiers had to endure and the instinct of self-preservation.
CHAPTER VI

RIVERS’S APPROACH TO TREATMENT

W. H. R. Rivers was the only British psychiatrist during the war to advocate a strictly psychoanalytic approach to the treatment of war related neuroses. He believed that effective treatment methods should follow the same etiological approach used by the practitioner to diagnosis their patients. However, effective treatment depended first on obtaining a sound understanding of the etiology involved in acquiring “shell shock.” Rivers felt that most treatment methods used by his British colleagues were unsuccessful in the long term because they did not have an accurate interpretation of the mental processes involved in the nature of war neuroses and/or there was inconsistency between their etiological beliefs and treatment methods.\(^{113}\)

Consistent with the psychoanalytical approach he used to theorize on the etiology of “shell shock” and to diagnose his patients, Rivers utilized psychoanalysis and re-education (a.k.a. sublimation) as his primary methods of treatment. Originally called the “talking cure” by Freud’s famous associate Josef Breuer, this treatment method involved first exploring the suppressed and repressed thoughts, emotions, and memories responsible for a patient’s condition (psychoanalysis), and then helping him/her to assimilate these discoveries in a more healthy manner to alleviate their condition.

Rivers argued that psychoanalysis was the only treatment method that could ensure long term success with war related neuroses, and he strongly opposed the use of methods associated with suggestion (e.g. hypnotism and faradism) that were popular with both materialists and other psychoanalysts.

Rivers feared that suggestive treatment could actually prolong “shell shock” because these methods focused on symptoms instead of causation. Additionally, he believed that a suggestive approach increased the patient’s propensity to enter and remain in a suggestive state, an important stage in the etiology of “shell shock.” Though a patient may be immediately relieved of particular symptoms through suggestive techniques, the experiences and thought processes associated with the onset of his illness were not addPressed. Instead, the patient was usually advised to avoid any thoughts pertaining to the war, and to try in isolate themselves from all sources (e.g. people and newspapers) that may cause them to reflect on the war. Rivers proposed that in time the symptoms would reappear with an elevated severity since the nature of the neurosis had been left to simmer and intensify.  

Rivers supplied an example of a young British officer with “anxiety-neurosis” that had first been treated by a therapist trained in hypnotism. While in a hypnotic state the patient was urged to forget and/or avoid recalling the war experiences that had led to his current mental state. After isolating himself from the war, the patient’s symptoms ceased for a period of time, but eventually came back in an amplified form that left him


even more miserable than before. Placed under Rivers’s care, he partook in psychoanalysis to give up his practice of “repPression,” and to gradually remember his thoughts and emotions of the war. Rivers was then able to re-educate the patient so that he began to view his experiences in a manner that was more congruent with the socially accepted notions of participation in war. The young officer immediately experienced a relief in the intensity of his symptoms, some of which completely disappeared.116

Rivers did hint that suggestive treatment might prove some value in extreme cases involving experiences so painful that the subjects consciously and/or unconsciously withhold pertinent information relating to the onset of their illness. In one case study, Rivers admitted that he was contemplating hypnosis as a last resort to extract the “repPressed” experiences responsible for his patient’s condition. The subject was completely unwilling to divulge information that could assist Rivers in treatment, and meanwhile, the subject’s depPressive symptoms were worsening to a point of becoming life threatening. However, Rivers finally got the facts he needed from a close friend of the patient that had fought alongside him in the war. Pretending not to have this information, Rivers then carefully conducted psychoanalysis in order to help his patient to voluntarily recall his fears and guilt of not being capable of performing his duties in the battlefield. Rivers then used re-education to assure him that he was not alone in these thoughts and feelings, and reminded him that he had carried out his duties exceptionally well prior to his breakdown. Strengthened by this insight, the patient ceased to have

116 Ibid., 193-4.
episodes of depression and expressed his desire to return to his unit on the Western Front.\textsuperscript{117}

It was also possible that the “repPressed” and/or “suppPressed” experiences related to the onset of “shell shock” might not have any kind of redeeming value that could justify psychoanalysis and re-education. For example, one of Rivers’s patients had been flung head first into the rotting remains of a German soldier, some of which entered into his mouth. The victim went unconscious and upon recovering consciousness he began to vomit uncontrollably for an extended period of time. Several months following the incident, the soldier developed acute symptoms of “anxiety-neurosis” that included recurring nightmares, severe bouts of stomach discomfort, and a complete loss of appetite. The patient’s only relief from his condition came when he had gone far into the British countryside, away from everything that might remind him of the war. During attempts at psychoanalysis the subject found it nearly impossible to discontinue his state of “repPression” due to the extremely repulsive nature of his experiences. Rivers stated that the patient did show some slight improvements in his symptoms, but eventually it was decided that the best course of action involved leaving the army and returning to the countryside.\textsuperscript{118}

As with Freud, dream interpretation played an important role in Rivers’s approach to diagnosing and treating victims of psycho-neuroses. He agreed with Freud that the latent content of dreams could represent the fulfillment of socially unacceptable

\textsuperscript{117} Ibid., 195-7.
\textsuperscript{118} Ibid., 192-3.
wishes which were normally “repPressed” and/or “suppPressed” in the waking life. However, differing from Freud, Rivers argued that in many dreams the wish is not fulfilled but frustrated, and he suggested that in such cases the fate of the desire/wish influences the affective aspect of the dream. In the case of “shell shock,” Rivers believed the subject matter of his patients’ nightmares represented their frustrated attempts at fulfilling their desires to remove the conflict between self-preservation and duty. Due to the ill-fated nature of their wishes (e.g. cowardice for fleeing the battle) the dream content of “shell shocked” troops did not represent fulfillment but instead focused on material that was the source of conflict. Therefore, Rivers proposed that dream content could supply a therapist with the thoughts, emotions, and experiences responsible for the onset of war related neuroses. It was the psychiatrist’s duty to use psychoanalysis to extrapolate this dream content, and to then re-educate the patient so that he can stop “repPressing” and/or “suppPressing” this same content. The final result of this process was helping the patient to solve the conflict between self-preservation and duty.

Rivers’s most famous client was Siegfried Sassoon; a non-commissioned officer (NCO) in the British Army, and a world renowned war-poet. Sassoon had volunteered for duty and after a prolonged tour on the Western Front, his bravery and efficient battalion leadership earned him the Military Cross. Upon recuperating from a bullet wound, he began to suffer from recurring nightmares, irritability, and a growing

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121 Ibid., 73-5, 153-8; Rivers, *Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses*, 178-84, 244-7.
indifference towards prolonging the war. After writing a series of anti-war poems and letters which placed him in danger of being court-martialed, Sassoon’s superiors transferred him out of the trenches to the care of Dr. Rivers at Craiglockhart. Sassoon described the details of two recurring nightmares revolving around his experiences on the Western Front. In one, he and his battalion were caught in a grave situation in which he knows they are “…all doomed to perish in the worst possible of all hopeless [offensives].” The plot of the second nightmare is associated with Sassoon’s dread that he had “forgotten how to be an officer,” and his fear that he can’t face the strains of war again.122 Rivers certainly would have considered the content of these disturbing dreams as evidence that Sassoon was losing his ability to successfully “repPress” the conflict between self-preservation and duty. There is much conflicting evidence in regards to Sassoon’s mental condition, but because he exhibited some of the symptoms, Rivers’s probably believed that Sassoon was in the early stages of “anxiety-neurosis.” However, he never diagnosed Sassoon with “anxiety-neurosis,” and aside from prescribing rest and relaxation, Rivers continued a course of psychoanalysis and re-education to change Sassoon’s negative image of the war.123

Another important purpose of psychoanalysis in the treatment of “shell shock” was it gave a therapist the opportunity to investigate whether or not a patient had experiences prior to the war that might have predisposed him to acquiring a neurotic condition. Representing a more sympathetic viewpoint than that supported by

122 Sassoon, Sherston’s Progress, 68-9.
123 Ibid., 3-5, 9-12, 32-4, 44-6, 57, 67; Wilson, Jean. Siegfried Sassoon: The Making of a War Poet. (New York: Routledge, 1999), 394-5.
materialists, Rivers did not believe that a neurotic predisposition came from heredity or personality traits (i.e. psychological constitution). Instead, he argued that it was possible for a soldier to have suffered from prior psychological conditions in their civil life that may or may not lead to the development of war related neuroses. Rivers cites the example of a patient suffering from “shell shock” that was directly related to a claustrophobic disorder that had affected him since childhood. This soldier witnessed fellow comrades being buried alive in dugouts that had been hit by artillery rounds, and he became so fearful of the same thing happening to him that he developed a severe case of “anxiety-neurosis.” Through psychoanalysis and dream interpretation, Rivers discovered that the patient had been “suppressing” a childhood memory that involved being trapped in a very narrow passageway. Upon remembering this incident, together with sublimation, the patient began to show signs of recovering from the symptoms associated to his claustrophobia and “anxiety-neurosis.”

It cannot be known exactly how effective and successful Rivers’s treatment method was, but he professed that in only a few cases he was not able to obtain substantive and enduring results. There are also the testimonies from some of Rivers’s patients and colleagues that attest to the quality and character of his treatment approach. Siegfried Sassoon wrote that Rivers was truly empathetic to the suffering that his patients endured, and his treatment techniques humanely produced positive results. Sassoon personally thanked Rivers for helping him, and stated that everyone should be made

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aware of the great contributions Rivers had made to the field of psychoanalysis.126 Robert Graves, another famous war-poet who developed “anxiety-neurosis” but was never hospitalized, visited Craiglockhart several times when he chaperoned his friend Sassoon to his appointments with Rivers. On several of these occasions Graves had conversations with Rivers that helped him to understand his own condition. He also stated that Rivers had cured his friend of “anxiety-neurosis,” that then qualified him fit for duty again.127

Fellow psychiatrists from both the psychoanalytical and biological paradigms acknowledged Rivers’s unprecedented accomplishments regarding the treatment of “shell shock.” McDougall admired Rivers’s approach because with his corrections to classic Freudian principles (e.g. adopting the instinct of self-preservation) he had made psychoanalytical methods more effective and widely accepted.128 Although he remained opposed to psychoanalysis, Mott credited Rivers for his original ideas regarding the interpretations of dreams agreeing that they proved helpful in the treatment of war neuroses.129 Myers wrote that Rivers had earned the gratitude and affection of all his “shell shocked” patients for his unsurpassed ability to compassionately and kindly alleviate them of their neuroses.130

Regardless of Rivers’s gentle approach to treatment and the forgiveness that his etiological beliefs granted to victims of “shell shock” he should not be mistaken as a pacifist. He understood that the main objective for RAMC psychiatrists was to cure “shell shock.”

126 Sassoon, 10-11, 32, 34, 67.
128 McDougall, Outline of Abnormal Psychology, 23-4, 182.
129 Mott, War Neuroses and Shell Shock, 117-9.
shocked” soldiers as quickly as possible and return them to the field of battle.\textsuperscript{131}

Although Rivers believed that the unprecedented shocks and strains of the combat environment had caused the outbreak of war neuroses, he suggested measures that could be taken to prevent soldiers from developing war neuroses. For instance, he argued that soldiers should not be exposed to life threatening situations for long periods of time, and they should be given longer leaves from the front lines. Rivers also stressed that military training should include drills that focus on teaching troops how to “repPress” their instinctual fears.\textsuperscript{132}


\textsuperscript{132} Ibid., 224-6.
CHAPTER VII

BRITISH ADVOCATES AND OPPONENTS TO RIVERS’S TREATMENT METHOD

There existed a small group of British psychiatrists in the RAMC who also advocated a psychoanalytical approach to the treatment of “shell shock.” However, differing from Rivers, none of them were adamant about avoiding all other methods of treatment and they often used more than one technique. Frequently, symptoms were first addPressed individually, and then the actual causation of the patient’s neurosis was studied and treated. This was in opposition to Rivers’s belief that all symptoms could be effectively cured by solely concentrating on the “repPressed” and/or “suppPressed” material from which the neurosis had originated. Furthermore, in comparison to Rivers some of the treatment methods employed by other psychoanalysts were inhumane.

Dissenting from Rivers’s argument that all war neuroses should be treated strictly through psychoanalysis, Charles S. Myers proposed that every case of “shell shock” needed to be treated on its own merits. For some patients, particularly those suspected of malingering or exaggerating symptoms, successful treatment may require a stern reprimanding, while in others a more sympathetic approach of psychoanalysis and re-education was needed to achieve the desired goals. Contrasting from Rivers, Myers also saw no harm in first addPressing specific symptoms before attempting to cure the
subject of their neurosis. He believed that certain extreme psychosomatic conditions (e.g., paralysis and blindness) commanded so much of a patient’s attention that it was nearly impossible to focus on the cause of the neurotic state. Therefore, Myers encouraged medical officers to utilize suggestive measures (e.g., hypnotism, faradism, and hydrotherapy) to temporarily remove these symptoms, thereby regaining the subject’s attention and making it possible to cure the neurosis through psychoanalysis and re-education.\textsuperscript{133} In addition to his belief in the inhumaness of faradism and hydrotherapy, Rivers viewed Myers’ approach as possibly harmful because “shell shock” patients were already in a highly suggestive state that could become further reinforced through suggestive methods, hence, confounding the effectiveness of psychoanalysis and re-education.\textsuperscript{134}

Psychoanalysts, Smith and Pear, proposed that in a few cases of “shell shock” successful results can be best attained through a combination of strict isolation and psychotherapy. In these cases the sufferer is so negatively affected by any recollections related to the war that every effort should be made by the therapist to seclude him in a room or ward completely devoid of any persons and objects that may, without the therapist’s guidance, remind him of the painful thoughts, emotions, and experiences related to his neurosis.\textsuperscript{135} This approach was in opposition to Rivers, who argued that efforts to remove all stimuli that may cause the patient to recall his war experiences only

\textsuperscript{133} Myers, \textit{Shell Shock in France 1914-18}, 49-61.
adds strength to the processes of “repPression” and “suppPression” which can then worsen the neurotic state and the symptoms associated to it. ¹³⁶

Smith and Pear also believed that hypnotism could help a neurotic patient to gain confidence in their therapist if it was judiciously employed to extract memories too well buried to be recovered in psychoanalysis. Having now remembered something directly related to their condition that was once unobtainable, the subject may develop a new level of trust and belief in their therapist’s abilities to cure them. ¹³⁷ Rivers resisted the use of hypnotism to recall even the most recessed memories because it placed the subject in a heightened suggestive state which might complicate their neurotic condition. Furthermore, Rivers feared that under hypnosis a patient can recall false memories that a therapist may subconsciously wish upon his patient to illuminate the cause of “shell shock.” ¹³⁸

William McDougall closely followed Rivers’s method of treatment, but he had different beliefs on the effectiveness of psychoanalysis, as a stand-alone approach, to cure victims of war neuroses. In contrast to Rivers’s theory, McDougall argued that psychoanalysis and suggestion were intimately related, and any successful treatment through psychoanalytical measures was contingent on the powers of suggestion. According to McDougall, transference, an essential step in Freudian psychotherapy whereby repPressed and/or suppPressed material was passed from patient to therapist, required an unconditional trust in the therapist that left the patient in a highly suggestive

¹³⁶ Rivers, 185-8, 203.
¹³⁷ Smith and Pear, 36-8.
¹³⁸ Rivers, 11, 104, 212.
state. It was this state of high suggestibility that allowed a therapist to present ideas related to re-education that were then faithfully accepted by the patient.\textsuperscript{139} Rivers never addPressed the validity of this connection, but it is likely that he would have argued McDougall was confusing a patient’s confidence in their therapist with a state of suggestibility more akin to hypnotism. Rivers also made it clear that effective treatment through psychoanalytical measures was ultimately dependent on a patient’s self-knowledge and self-reliance, neither of which can be obtained through suggestive methods.\textsuperscript{140}

Similar to Rivers, McDougall also felt that re-education (he preferred the term readjustment) was an important step in the psychoanalytic approach to curing soldiers with war neuroses. However, McDougall argued that only patients of good intelligence could be taught the nature of their disorder. Men of lesser mental abilities could not objectively and dispassionately perform critical evaluations of all the factors responsible for their condition. Therefore, it was the therapist’s duty to persuade these men to adopt a more positive view of the experiences, thoughts, and emotions related to their neuroses. While McDougall preferred this process to be carried out with the cooperation of the patient in a fully waking state, he admitted that in some cases this goal was best achieved with the patient in a hypnotic state.\textsuperscript{141} These ideas contrasted with Rivers’s belief that all patients of war neuroses, regardless of intellect, could and should be taught the nature of

\textsuperscript{139} McDougall, \textit{Outline of Abnormal Psychology}, 427-8, 471-2.
\textsuperscript{140} Rivers, 257.
\textsuperscript{141} McDougall, 470-1.
their disorder. In fact, Rivers proposed that treatment would not have lasting results if the patient was not aware of the etiology of his neurosis.142

While the treatment methods of other British psychoanalysts were not always as consistent with psychoanalysis as Rivers, they were definitely preferable to techniques used by materialists. Members of the RAMC prescribing to the biological approach firmly believed that aside from hereditary and constitutional predispositions the process of suggestion was to blame for the onset of symptoms associated to “shell shock.” With no effective way to cure patients of their predispositions to neuroses, the materialists focused on methods of suggestion to counteract the symptoms of “shell shock,” hence, the term counter-suggestion was commonly used. Following the teachings of Charcot, most British psychiatrists relying solely on suggestive methods of treatment believed that success largely depended on defeating the patient’s neurotic will to remain sick by buttPressing their normal will to be healthy. In order to accomplish this goal the therapist must first impose their own will onto the patient, thereby defusing the neurotic will and allowing the therapist to make suggestions that would be accepted by the patient’s normal will.143 This approach ultimately led to aggPressive suggestive methods designed to remove symptoms with little regard to any ill-effects that the patient may experience. Furthermore, suggestive treatment approaches never addPressed the nature of “shell shock,” and it was common for symptoms in remission to reappear once the patient returned to the trenches or at some point upon returning home.

142 Rivers, 204, 227, 247.
Lewis R. Yealland worked almost exclusively with soldiers suffering from symptoms of hysteria, and as a materialist he firmly believed that there was no real practical use for a psychoanalytical approach to the treatment of war neuroses. He argued there was not substantial evidence showing that any type of treatment, including psychoanalysis, could alter the temperamental instability of these patients, but the removal of symptoms did produce positive changes in their mental attitudes. With a well adjusted attitude and freedom from debilitating symptoms it was possible to return these men to the trenches where their commanders desperately needed the manpower. Yealland proposed that the quicker a patient could be fully cured the less chance his symptoms had of resurfacing. He advocated the use of intensive suggestive methods, deployed in a stern and disciplinarian manner that could end the patient’s symptoms in a single session.\textsuperscript{144} The following treatment of hand paralysis illustrates the unsympathetic and inhumane nature inherent in Yealland’s approach: Speaking to his patient Yealland states,

\begin{itemize}
  \item If you do not accept the treatment I shall be in a position to accuse you plainly of [malingering], a grave military offence.”…[Accepting treatment, the patient] was taken to the exercise room and mild faradism was applied up and down the arm by means of a roller electrode, during which time he was ordered to open and close his hand. When he did not make satisfactory progPress I increased the strength of the current, refusing to listen to anything he had to say; all attempts at speaking being met with, “I do not wish to hear what you have to say – move your hand”…after persisting ten minutes with faradism the use of the hand was completely restored.\textsuperscript{145}
\end{itemize}

After removing the symptom(s) associated with the patient’s neurotic condition, Yealland considered him cured and fit to return to duty. Rivers strongly disapproved of these harsh

\textsuperscript{144} Yealland, \textit{Hysterical Disorders of Warfare}, v-vii, 17.
\textsuperscript{145} Ibid., 91-2.
tactics, and argued that symptoms would soon reappear since the nature of the neuroses had not been dealt with.

A materialist, Marr believed that the symptoms of war neuroses could be alleviated by correcting chemical imbalances in the brain and spinal column. He proposed a pharmaceutical approach to treatment that included a complex mixture of tonics, sedatives, and hypnotics (i.e., sleep aids). Digestive disturbance, a common symptom in neurasthenia was characterized by one or more of the following: irritable bowels, diarrhea, acid-reflux, constipation, loss of appetite, and vomiting. Marr believed that digestive disturbance should “be remedied by means of purgatives, aperients, tonics, and special diet, and in this connection, a diet of milk and farinaceous food, and as small a quantity of nitrogenous food as possible, is to be preferred.” ¹⁴⁶ To help strengthen the nervous system and reduce the high level of anxiety found in neurasthenia, Marr prescribed the “administration of such tonics as Easton’s syrup or strychnine…[in combination with]…the use of sinusoidal electrical baths, [a] high frequency apparatus in the form of the effleuve taken from a Wimshurst machine.”¹⁴⁷ Marr proposed that a neurasthenic’s lack of restful sleep due to recurring nightmares and/or the inability to fall and stay asleep could be cured with sedatives and hypnotics, but in some cases sinusoidal electrical baths were all that was needed.¹⁴⁸

Though not mentioned in relation to the treatment of neurasthenia, Marr believed that psychoanalysis was an effective approach to helping patients with hysteria.

¹⁴⁶ Marr, Psychoses of the War, 120.
¹⁴⁷ Ibid.
¹⁴⁸ Ibid., 120-1.
He argued that “in capable and conscientious hands, [psychotherapy] yields good though
temporary results, particularly with respect to hysteria, which, as has already been
noticed, is not only caused but may be [permanently] relieved by suggestion.” 149
However, Marr’s idea of psychoanalysis took on a materialistic character because he felt
that the therapist must gain a position of authority and demand the confidence of his
patient in order to persuade the him to health.150 Rivers argued that when used properly
psychoanalysis produced more positive and enduring results than suggestive methods, but
without the patient’s self-confidence and self-efficacy psychoanalysis was an ineffective
approach to treatment.

Similar to Yealland, Mott thought that electro-therapy (faradism) was an
excellent suggestive approach to the treatment of war neuroses. He also approved the use
of hypnotism in the removal of functional symptoms such as blindness, mutism, and
paralysis. Different from the techniques employed by the other materialists, Mott
advocated the use of regimented exercise as a method of suggestion suited for recovering
normal movement to the limbs of a patient suffering from contractures. In this approach
the therapist would instruct the patient to complete a progPression of various exercises
that slowly made improvements to the patient’s condition until finally restoring normal
function of the affected limb.151 Regardless of the chosen suggestive method, Mott
stPressed that a therapist must be sure to take a disciplinary approach to ensure success:

All patients should be made to salute officers and stand to attention when they enter
the wards. Laxity in discipline and excuses for bad conduct should not be

149 Ibid., 122-3.
150 Ibid., 123-4.
151 Mott, War Neuroses and Shell Shock, 107, 276-80.
tolerated…No case should be discharged from the army with a curable functional nervous disability. He should be told that he will remain in the hospital until he is either fit to return to his command depot, placed in a category, or discharged.  

Focused only on removing the symptoms, Mott never searched for what had caused them in the first place.

Mott had little faith in the ability of psychotherapy to produce positive therapeutic results, and he writes only a few short paragraphs on the subject. Ignorant of Rivers’s theories, he argued that the followers of Freud focused too much on the sexual aspect of psychoanalysis even though the war had shown that this position was no longer tenable. Mott did suggest that psychoanalysis could help a therapist to discover and defuse the thoughts and emotions responsible for a patient’s high level of anxiety. However, he never mentioned how this treatment approach could also alleviate other symptoms by addressing and curing the cause of the neurosis. Rivers opposed Mott’s view because he believed that psychoanalysis could effectively cure all symptoms associated with war neuroses by repairing the unhealthy psychological processes that had caused them in the first place.

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152 Ibid., 277.
153 Ibid., 287-8.
CHAPTER VIII

CONCLUSION

After the Treaty of Versailles Rivers continued to focus on deconstructing the biological paradigm that still dominated thinking in the British educational system. His main goal was to end ignorance and hostility toward the field of psychology which was primarily aimed at psychoanalysis, and make it an accepted science. He published a couple books that illustrated the importance of psychology within the realms of anthropology and political science. In another book, *Conflict and Dream*, Rivers further attempted to defuse hostilities towards psychoanalysis by showing the biological function of dreams and psychological conflicts. Immediately after the conclusion of World War I Rivers wrote a journal article, *Psychiatry and the War*, in which he proposed that an important effect of the war was to bring psychology into closer relations with neurology, a process still going on today. He believed that the instinctive, emotional, and unconscious characteristics of “shell shock” had altered the attitudes of British psychiatrists towards the usefulness of a psychoanalytical approach to neuroses. Rivers expressed his hopes that psychoanalysis would help create a more sympathetic and humane approach to the care and treatment of mental disorders in Britain.

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Personally, Rivers had synthesized his expertise in anthropology, neurology, and psychology to form an original psychoanalytical theory on the etiology and treatment of “shell shock.” In comparison to other British psychiatrists, especially those belonging to the materialist paradigm, Rivers offered a kinder and more objective approach to war neuroses. In his book, *Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses*, Rivers attempted to portray his approach as primarily a biological one by illustrating the connection between human instincts and the development of war neuroses. However, his beliefs were actually more closely associated with Freudian concepts of a dynamic relationship between the conscious and unconscious mind. Rivers took the liberty of manipulating Freud’s terminology to fit his own ideas and observations, and he denounced the idea that sexual instincts had anything to do with the causation of “shell shock.” Regardless of these facts, Rivers’s theories did not find a warm reception among the members of the bio-medical camp who continued throughout the war to remain skeptical of the psychoanalytical approach.

In a brief cross-cultural examination with Germany it becomes apparent that British psychiatrists were not the only ones opposed to psychoanalysis. Throughout the war German psychoanalysts were viewed with scorn by the majority of German psychiatrists who, like in Britain, were distrustful of Freud’s belief that all neuroses started with a conflict of the sexual instinct. Rivers’s counterpart in Germany was the psychoanalyst Ernest Simmel who also suggested that psychoanalysis could explain the nature of “shell shock” by avoiding any sexual connections and viewing it as a disturbance related to the instinct of self-preservation. Similar to Rivers, Simmel’s
theories fell on deaf ears as most German psychiatrists shared the British view that some soldier’s were simply predisposed to acquire “shell shock.”

Throughout the duration of World War I many British military authorities, including officers in the RAMC, argued that “shell shock” was simply another word for cowardice. Military authorities were concerned that the term was demoralizing troops, and perhaps even encouraging them to become malingerers in order to escape their duties in the trenches. In response, the British Army ordered RAMC personnel to initially diagnose their potentially “shell shock” patients with Not Yet Diagnosed Nervous (NYDN) disorder, and an official classification of war neurosis could be made only after the soldier’s commanding officer provided a written testimony that the mental breakdown occurred after exceptional exposure to the stPresse of war. Despite growing evidence, including Rivers’s lectures to the Royal Society of Medicine, Medical Research Committee, and Air Medical Investigation Committee, the military establishment continued throughout the war to believe that healthy British troops were “[mentally] immune to such weakness.” Tragically, this meant that many actual “shell shocked” troops were never properly diagnosed or even recognized as being mentally injured, and were instead accused of cowardice and either dishonorably discharged or executed.

159 Corns and Hughes-Wilson, Blindfold and Alone: British Military Executions in the Great War, 82; Rivers, Instinct and the Unconscious, 185-204, 205-27, 241-7.
Today there are relatives of these executed soldiers who are still fighting a legal battle to have them posthumously exonerated for their supposed crimes against their country.\textsuperscript{160}

Rivers offered an explanation that was considerably more sympathetic to those suffering from “shell shock” because it proposed that protracted exposure to the extremely stressful conditions of modern warfare could create a conflict between duty and self-preservation in any soldier, regardless of training, experience, heredity, or constitution. Also his treatment methods were sound and humanely produced positive results that earned him the respect and admiration of his patients. Rivers’s ideas were welcomed by the few RAMC psychiatrists that studied psychoanalysis at Magull and Craiglockhart. However, none of Rivers’s fellow advocates presented theories that honestly followed a psychoanalytical approach from beginning to end. His supporters remained somewhat distrustful of Freudian ideas whereas Rivers objectively augmented Freud’s approach so that it would more accurately depict the etiology of “shell shock.” Agreeing with Rivers, Freud admitted after the war that there were definitely other driving instincts besides the sexual instinct that unconsciously guided people’s actions.\textsuperscript{161}

Today, military psychiatrists still acknowledge that the conflict between self-preservation and duty is one of the primary causes of war-related neuroses, but other combat stressors have been added, some of which Rivers addpressed and some that he did not. A commonly accepted list of combat stress factors that precede the formation of war neuroses are shown here:


- Biological Factors - fatigue, thirst and hunger, sleep and sensory deprivation, adverse environments (heat, cold), and disruptive circadian rhythms.
- Intrapsychic Factors (individual psychology) – fear of death or maiming, fear of showing cowardice, belief or non-belief in the cause, belief war is being won or lost, breakdown of narcissistic defenses (invulnerability, social security, faith in a religion).
- Interpersonal Factors (group psychology) – unit (group) cohesion, quality of leadership, “buddy” system.
- Combination of Factors – military situation (attacking or retreating), indirect fire (artillery, bombs).\(^{162}\)

Rivers’s theory addresses nearly every factor mentioned above. The first two examples of intrapsychic factors are directly related to Rivers’s belief that “shell shock” was primarily caused by the conflict between the instinct of self-preservation and a soldier’s required duties. The only factors not cited by Rivers are those pertaining to religion and the “buddy system,” although he did firmly believe that group cohesion and/or lack of it played an important part.\(^{163}\)

Rivers’s psychoanalytical theory pertaining to the nature of the neuroses associated with “shell shock” in World War I represented a true landmark in the history of understanding the psychological effects of war. Unfortunately, many of his ideas were lost after the Great War because most psychologists in Britain continued to distrust any Freudian approaches to the etiology and treatment of mental disorders. Through time


hostile attitudes toward psychoanalysis have eased, and Rivers’s ideas can be observed in much of what we now know about PTSD and war-related cases of conversion disorder. Psychologists today should celebrate and credit Rivers for his pioneering efforts to create one of the earliest psychoanalytical approaches to the etiology and treatment of war neuroses.
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