Progress Derailed: How the Great War Altered the Course of French Psychiatry

The First World War marked an abrupt halt in the development of French psychology, particularly in the study of trauma. The 1880s and 1890s saw remarkable advancements in neurology, which included Jean-Martin Charcot's new research on hysteria. His studies redefined its origin and inspired many of the neurologists who would become integral in handling the devastating effects of "war neuroses" after the outbreak of the First World War in 1914. These wartime neurologists were faced with an onslaught of soldiers suffering from what were called "functional disorders", which consisted of physical symptoms without a corresponding injury. Symptoms of functional injuries ranged from "paralysis and anaesthesia to mutism and deafness".[1] Between the incredible number of cases doctors were presented with and the socio-political environment the War created in France, neurology underwent a shift in ideology away from Charcot's revelatory discoveries regarding hysteria. The priority of neurologists was now to cure the soldiers of their functional problems and return them to a desperate and demanding front line.

Though he died over a decade before the outbreak of the war, Jean-Martin Charcot's studies on trauma greatly influenced wartime psychology. In a striking contrast to historical studies on hysteria, Charcot studied the effects of trauma in working class men. For years, 'hysteria' had been associated solely with the "fragile emotions" of women from the upper and middle classes of society. Charcot's groundbreaking case studies introduced a new diagnosis for

[1] Gregory M. Thomas, *Treating the Trauma of the Great War: Soldiers, Civilians, and Psychiatry in France, 1914-1940*, Baton Rouge: Louisiana State University Press, 2009, 20.

men called 'traumatic neurosis' that would alter both public and medical perception.[2] Charcot and his students argued that hysteria (literally meaning "wandering womb") was not an affliction of wayward female anatomy. Charcot believed hysteria was instead a disorder of the nervous system that could affect both women *and* men.[3] This nervous affliction, as theorized by Charcot, required both a hereditary predisposition and an environmental stimulus in order to generate symptoms of traumatic neuroses. Charcot believed the "traumatic stimuli acted on this prior constitutional susceptibility, and the fact that some individuals developed elaborate neurotic symptoms… [was] explained by the presence or absence of this background".[4]

Many of Charcot's hysteric patients suffered an injury from a railway or workplace accident. Though the bodily harm done was minor, patients presented with symptoms that could not be attributed to any physical injury. Charcot found that the most common symptoms were "motoric and sensory disturbances of the extremities- anaesthesias, hyperesthesias, paralyses, and contractures of all kinds". Railway and workplace accidents had been studied before, and generally led neurologists to the conclusion that industrialization caused a perceived loss of control and was responsible for these unique symptoms.[5] In a small number of Charcot's cases, however, patients suffered from a physical accident outside the workplace. In the case of "Mar", the young man developed neurological symptoms two weeks after he was assaulted and stabbed, while "Greff" almost drowned on a fishing trip and developed an eye twitch and motor

[2] Mark S. Micale, *Jean-Martin Charcot and les névroses traumatiques: From Medicine to Culture in French Trauma Theory of the Late Nineteenth Century.* Collected in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age 1870-1930*, Edited by Mark S. Micale and Paul Lerner, Cambridge University Press, New York, 2001. 115-117.
[3] Thomas, 21.
[4] Micale, 118-119.
[5] Ralph Harrington, "The Railway Accident: Trains, Trauma, and Technological Crises in Nineteenth-Century Britain", in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age 1870-1930*. Ed. Mark S. Micale and Paul Lerner. (New York: Cambridge University Press, 2001). 36.

dysfunction. The presence of these cases, unrelated to new technology, eliminated industrialization as a possible cause, and Charcot found that the most potent environmental stimulus was fear.[6]

Furthering this theory, Charcot looked at four cases of soldiers who had seen active fighting. He wrote of "D-ray", a young soldier who was injured during the conflict at the Paris Commune. Fifteen years later, "D-ray" developed a number of symptoms after being caught in a thunderstorm. Charcot noted that rather than damage from a physical accident that occurred so long ago, the mental experience "carries the pathogenic charge". Charcot wrote that "the emotion [is] almost unavoidably inseparable from an often life-threatening accident". Though seemingly unremarkable at the time, historian Mark S. Micale points out the time between the Paris Commune and Charcot's publication of this case study is the same as the gap between the Vietnam War and the emergence of post-traumatic stress disorder as a diagnostic category, perhaps accrediting one of the first recorded instances of post-traumatic stress disorder to Jean-Martin Charcot.[7]

Charcot's theory that traumatic neuroses was caused by emotion and mental experience confirmed to some doctors that victims were "faking" or simply had an "overly emotional personality". This was a common conception in many industrialized countries, perpetuated to deny victims of railway accidents financial compensation. Charcot, however, argued that traumatic neurosis was a legitimate medical issue. The most influential neurologist who continued Charcot's research on trauma was Sigmund Freud. Freud studied in Paris from 1885 to 1886, concurrent with at least six major publications by Charcot. Freud translated one of

[6] Micale, 116, 120-121
[7] Micale, 122-123

Charcot's volumes of case studies and, shortly after, drew his own conclusions and presented his theories on "male hysteria" as a solely psychological phenomenon. Though Freud had very little influence in France at the time, Charcot's theories were greatly advanced by the Austrian doctor and made a major impact on psychology after the War. In France, Charcot had a number of students who served as influential doctors during the War while continuing his studies on traumatic neuroses. The most notable of these students was Joseph Babinski, whose "reworked" theories of hysteria dictated wartime opinion and treatment of soldiers.[8]

After Charcot's death, Babinski worked to replace his mentor's definition of hysteria with his own. Babinski proposed that almost all symptoms that Charcot attributed to hysteria could be caused by another neurological problem. The few that could not were caused by "suggestion", or the belief that they were present. Babinski decisively wrote "there exists no criterion which allows one to distinguish between suggested phenomena and simulated phenomena. Only moral considerations can support a doctor's decision to set aside the hypothesis of simulation".[9] Babinski labelled his theory "pithiatism", meaning "curable by persuasion". Persuasion, he believed, was the opposite of "suggestion" and was the cure to functional disorders, so long as it was done by an authoritative and strict doctor. The doctor's job was simply to convince the patient that his symptoms were no longer present, and he would find his patient cured.[10] Neurologists quickly adopted Babinski's pithiatism over Charcot's traumatic neuroses due to the social climate in France. The idea that affected soldiers did not have any

[8] Micale, Pg. 123-124, 128-130
[9] Marc Roudebush, A Battle of Nerves: Hysteria and Its Treatments in France During World War I, in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age 1870-1930,* Ed. Mark S. Micale and Paul Lerner, (New York: Cambridge University Press, 2001), 261.

[10] Roudebush, 260-261.

"real" symptoms allowed doctors to treat their patients quickly and send them back to the front without any long-term care. Military hospitals operated under a great deal of restrictions and the war effort relied on soldiers returning to the front as soon as their functional injuries were gone.

Babinski's model of hysteria also benefited from the social panic occurring in France. The late nineteenth and early twentieth century found France experiencing a "crisis in masculinity". This crisis was caused largely as a result of the declining birth rate and the perception of decreased male virility. The fears over lost masculinity dated back to France's military defeat during the Franco-Prussian War in 1870-1871 and the loss of Alsace-Lorraine. After this, men attempted to restore their honour by "adopting old male codes of honour and military virtues such as personal courage and heroism".[11] After the outbreak of the First World War, men saw the possibility of winning back the lost territory of Alsace-Lorraine. Along with showcasing their heroic natures, achieving this represented the "restoration of sexual honour and the regeneration of large and morally pure families".[12] In this social climate, the choice of some neurologists to label their patients as 'hysteric' was to challenge his masculinity. Though Charcot has proven that hysteria was not rooted in female anatomy, the public perception that hysteria was a female disease did not change. These doctors hoped that the humiliation of their shattered masculinity would give the soldiers "no incentives to remain hysterical".[13]

The moral panic of a "decadent and degenerate" France would come to dominate the sphere of psychology not only for the duration of the war, but for decades after. The fear of degeneration manifested itself easily in the dichotomous categorization of wounded soldiers. The physically wounded soldier was a courageous ideal of masculinity who would "persevere in the

[11] Thomas, 48-49.
[12] Roudebush, 264.
[13] Thomas, 48-49.

face of danger", while the *simulateur,* or hysteric, was the effeminate and weak-willed manipulator who ran from danger instead of facing it honourably, and became a scapegoat for vice and immorality.[14] Current medical theory was clear in its belief that if a disorder "is not grounded in physiology, it had to be grounded in morality- or immorality".[15]

These moral fears also dictated the locations where neurology centres were set up. While England had hospitals set up away from the front lines, neurologist Gustave Roussy expressed the fear that if soldiers were not treated before "being evacuated to comfortable hospitals in the interior", they could pass their hysteria on to other men. Additionally, Roussy expressed that patients "needed to realize that there was no hope of being sent home", a concept that would soon become hospital policy.[16] As British officer and poet Siegfried Sassoon writes in his memoirs, "if 'war neuroses' were indiscriminately encouraged, half the Expeditionary Force might go sick with a touch of neurasthenia".[17]

The high incidence of war neuroses in soldiers was perceived as an "epidemic and as a genuine threat to the strength and morale of the army". There was a fear that functional illnesses and injuries were contagious, and would spread, as Babinski suggested, through "suggestion". The first step in treatment, therefore, was isolation. As well as preventing the spread of functional illness, neurologists Maxime Laignel-Lavastine and Paul Courbon believed that good soldiers had to belong to a "collective mentality", and being removed from the front would encourage individuality. Laignel-Lavastine and Courbon argued that "as soon as he regained a sense of his individuality the seeds of anti-social behaviour were sown, and the injured soldier

[14] Roudebush, 265.
[15] Roudebush, 277-278
[16] Thomas, 36.
[17] Siegfried Sassoon, Sherston's Progress, Country Life Press. Garden City, New York, USA. 1936, 13

was liable to shirk his obligations".[18] During the soldier's isolation, the doctor would reintegrate him into military life through a reintroduction to orders and hierarchy. The doctor could then use methods proposed by Babinski to disorient his patient until "he finally abdicates at the hand of his therapist, accepting the doctor's will and agreeing to take the road to recovery, the road which returns toward the battlefield, and toward those perils against which his sickness had been a protection".[19] In other words, his masculinity would be returned and he could yet again attempt to prove his heroism in battle.

In December 1916, the Neurology Society of Paris met and voted that "pithiatic soldiers should not be permanently discharged". Authorities feared that discharging hysterics would lead to a mass desertion via "simulated hysteria". A diagnosis of pithiatism instead called for rapid treatment in a neurological centre and for the affected soldier to be immediately returned to duty.

During this meeting, neurologist André Léri asserted that "war neuroses are almost all hysterical manifestations" and that half of the patients in neurological centres were pithiatics. Treating these men, he asserted, required only "simple and energetic" psychotherapy.[20] Babinski spoke to both his critics and supporters when he stipulated that treatment of "genuine hysterics" and soldiers with "hysteric manifestations" could be treated in the same way. His proposed form of psychotherapy saw the patient as "an actor on the stage", to whom the doctor must issue a "moral shock, a fright, a simple surprise caused by an unforeseen accident" in order for him to "forget his role momentarily". The doctor would then convince the patient that his symptoms have

[18] Roudebush, 266.
[19] Roudebush, 265-267.
[20] Thomas, 106-107.

ceased and obtain "a complete cure on the spot".[21] In his explanation, Babinski speaks of barraging his patient suffering from "hysterical paralysis" with multiple questions, medical tests, and military-style commands. These distractions would, in theory, make the patient forget he is paralysed and he would move his paralysed limbs. The doctor would assert his role as the patient's superior and firmly command the patient to repeat the movements until the paralysis has disappeared.[22]

One common way of inflicting this "shock" was literal: the doctor would use a current of electricity to treat the affected areas, such as the limbs of the aforementioned solider, or the mouth and tongue of a soldier suffering from mutism. This technique was known as faradism. The most enthusiastic user of electrical currents was a student of Babinski, Clovis Vincent. He claimed rapid results from the use of high-intensity electrical currents that he would apply to the patient's body. The electric shock would "provoke a movement, startling the patient, and 'proving' that the paralysis was only 'illusory'". This treatment would only be applied to those who were not diagnosed with a "legitimate" injury because it would, as Vincent believed, "be dangerous… or at least cruel and unjust"[23]. Vincent's questionable methods were brought into public scrutiny during the trial of Baptiste Deschamps, a patient who, out of fear, punched Vincent when faced with his painful electrical therapy after being told by a friend that Vincent's methods had killed one of his previous patients. Whether or not this is true, the controversy surrounding the trial and the public sympathy given to patients such as Deschamps brought an end to Vincent's "unrelenting attack" with electricity and supplanted it with more moderate

[21] Roudebush, 262
[22] Roudebush, 261-262.
[23] Roudebush, 268.

methods.[24] Léri, Babinski, and Vincent were only three of the many doctors who treated their patients using "correctional" techniques and were more interested in "justice and discipline than in recovery or therapy". In this sense, they treated their patients based on the stereotypes and public image perpetuated by French morality.[25]

Not all neurologists rejected the idea of psychological injury. A minority of French doctors followed Charcot's model more closely and believed that an accusation of "unconscious simulation was unjust and illogical". Paul Sollier was another of Charcot's students and an outspoken critic of pithiatism and of the restrictions placed on neurologists by the War Office. He wrote to the Minister of War in 1915, complaining that "the state was taking sides in an unresolved theoretical debate… elevating to the status of dogma a most contested and questionable doctrine", and that pithiatism was "casting an insulting and undeserved suspicion on men who have spilled their blood for France".[26] By the end of the war, however, Sollier was among those neurologists who employed the use of isolation and "moral treatment", claiming that "the war had validated his approach".[27]

Unlike Sollier, the chief of neurology at the Salpêtrière medical clinic, Joseph Jules Dejerine, was among the minority of doctors who championed Charcot's methods and used in-depth psychotherapy in their treatment of soldiers suffering from functional disorders. In his method, the patient was first isolated, as per normal, and then "confessed his entire life" to the doctor, who was to identify the cause of the disorder through conversation. This method,

[24] Roudebush, 272-273.
[25] Roudebush, 260-261
[26] Roudebush, 272.
[27] Roudebush, 259-260.

however, relied on the gradual building of trust between doctor and patient. In the current climate of war, prolonged treatment did not suit the needs of the military. The War Office was uninterested in Dejerine's theory that psychotherapy was more likely to prevent relapses; they needed French doctors to do their part and send men back to the front.[28] Additionally, the Neurology Society of Paris had determined that under Babinski's model of pithiatism, extended treatment would result in a familiarity between the patient and his doctor that would upset the power dynamics and decrease the effectiveness of the doctor's superior moral counselling[29]. Therefore, because pithiatics were unable to be discharged from service, patients who were not cured quickly enough would be moved to another hospital and the treatment process would begin again until the patient was eventually cleared for service.

The outbreak of the war changed the progressive direction of French neurology. Charcot's advances in the theory of hysteria were pushed aside in favour of the morality-centred pithiatism which could, in theory, be treated much more quickly. Babinski's theory also supported the social climate of the home front and reinforced patriotism by contrasting the brave and masculine soldiers of the front lines to the hysterical "shirkers" being treated in hospitals. Diagnosing soldiers with pithiatism provided neurologists with the ability to keep up with the demands of the front lines and the War Office through rapid and correctional treatment. With the knowledge of modern psychology at our disposal, it is clear that Babinski and those who adopted

[28] Thomas, 20-21.
[29] Roudebush, 258-260.

his theories obtained their successes at the expense of their patients' mental health, and it was "thus that their self-sacrifice was mocked and maltreated".[30]

[30]Sassoon, 72.

Bibliography

Harrington, Ralph, "The Railway Accident: Trains, Trauma, and Technological Crises in Nineteenth-Century Britain", in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age 1870-1930*. Ed. Mark S. Micale and Paul Lerner. (New York: Cambridge University Press, 2001). 31-56.

Micale, Mark S., "Jean-Martin Charcot and les névroses traumatiques: From Medicine to Culture in French Trauma Theory of the Late Nineteenth Century", in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age 1870-1930*. Ed. Mark S. Micale and Paul Lerner. (New York: Cambridge University Press, 2001). 115-139.

Roudebush, Marc. A Battle of Nerves: Hysteria and Its Treatments in France During World War I, in *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age 1870-1930*. Ed. Mark S. Micale and Paul Lerner. (New York: Cambridge University Press, 2001). 253-279.

Sassoon, Siegfried. *Sherston's Progress*. Garden City: Country Life Press, 1936

Thomas, Gregory M.. *Treating the Trauma of the Great War: Soldiers, Civilians, and Psychiatry in France, 1914-1940.* Baton Rouge: Louisiana State University Press, 2009.