On and Off the Battlefield: Literary Depictions of War Trauma before PTSD

by

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Introduction

The conceit for this thesis began last summer, when I interned at the Office of the Clinical Director (OCD) at the National Institute of Mental Health in Bethesda, Maryland. The OCD is a psychiatry-liaison service, offering psychiatric consultations to the non-psychiatric patients who make up a good deal of the population at the NIH’s Clinical Center, the hospital located on campus. This hospital is unique in that there is no emergency room: every patient in its walls, and those in its outpatient programs, is part of a research protocol. Patients are referred by their outside doctors because they have a rare immune disorder, or cancer at such a late stage no one else will treat it. In other words, to receive care at the NIH Clinical Center, you must be seriously ill in an interesting way. During the few months I was there, I had the opportunity to accompany the OCD’s psychiatrists on consultations with these interesting people.

One patient from that summer was the impetus for this thesis. The patient was a middle-aged woman suffering from a rare clotting disorder, one that affected all of her siblings as well. She was unable to walk or stand for long periods of time because of the pain the blood clots caused her. Her doctor asked someone from the OCD to talk to her because she reported that lately she had been crying at the drop of a hat and had no idea why. In talking to her, it became apparent that her past was still haunting her. She had left an abusive husband 15 years prior.

Abusive how? she was asked. “Oh,” she replied, “emotionally abusive. You know, one time he held me down by my shoulders and refused to let me go, but he never hit me. Another time I took my daughter into my bedroom with me because he
was mad, and he shot the lamps on either side of the bed.” With a gun? we asked in horror. “Yes of course with a gun,” she replied. But he didn’t shoot at her – he was only emotionally abusive. Her matter-of-fact manner startled me, but the psychiatrist continued with her questions. Did her new husband, the one who treated her well and whom she loved remind her of her abuser? “Sometimes. On occasion. It’s just little things he does sometimes, the way he talks to me once in a while. But it’s fine, really.”

Before we left, the psychiatrist told the patient, “I think you might have some signs of posttraumatic stress disorder from your abusive marriage and that could be why you’ve been so tearful lately.” I was floored – how could a relationship that ended 15 years ago still be affecting this woman so much? That this disorder could persevere, despite the separation from her abuser, despite the entirely new life she created for herself, was both fascinating and horrifying. I wanted to learn more about this thing that could sear into a person’s psyche and reappear at seemingly random times.

As a student of the College of Letters, I sought to combine this psychiatric topic with literary analysis. I have been taught to approach history through literature, and vice versa, considering how one shapes the other. I chose to look at novels from the interwar period to attempt to discover PTSD in someone who didn’t know they had it; in a way, to recreate the consultation I had witnessed. I was drawn to war novels because the disorder was first discovered in veterans, who have a special place in society, especially as far as trauma is concerned. In combat, they both inflict pain and suffer from it. At home, they are caught between their image as powerful heroes,
and their pitiful status as PTSD victims. As Judith Herman says, “[t]he veteran is isolated not only by the images of the horror that he has witnessed and perpetrated but also by his special status as an initiate in the cult of war.”¹ This contrast was even greater in the years following World War I because PTSD was unknown, so the associated trauma was considered weakness of character that conflicted with the heroic image.

The major themes of this paper will be to examine how selected books from the interwar period predicted modern interpretations of trauma while revealing the hardships psychologically afflicted veterans suffered while trying to reintegrate into society. It will look at the healing role writing played in Remarque and Woolf’s life stories and how their characters benefitted by, or suffered when they were prevented from, communicating in a similar way. Finally, by comparing Barker’s novel to the ones from the 1920s and 1930s, this paper will explore how current fiction writing about trauma is restricted by the PTSD diagnosis.

I chose to analyze Erich Maria Remarque’s *All Quiet on the Western Front* (1928) and *The Road Back* (1931) along with Virginia Woolf’s *Mrs. Dalloway* (1925) because their stories of mentally wounded soldiers are products of their time and harbingers of the future *DSM* diagnosis. Identifying symptoms of modern-day PTSD in these fictional characters from the 1920s and 1930s shows the enduring nature of reaction to trauma and the changing nature of treatment and acceptance. The stories are portrayals of the social stigma mental health patients faced and careful portraits of mental anguish. In addition, both authors suffered their own personal trauma, and

identified writing as a therapeutic release for them, analogous to modern-day forms of treatment for PTSD.²

I also wanted to examine the impact of a codified PTSD diagnosis in recent novels set during the World War I era, but written after 1980. I chose to look at Pat Barker’s *Regeneration* (1991), a book of historical fiction set in 1917. Writing in the age of the PTSD diagnosis, Barker cherry picks what biographical information she wants to include about her historical characters and shows how modern methods of treatment can be applied to her fictional soldier-protagonist, a sign of the reductive effect a diagnosis has on the fictional approach to a disorder. Unlike World War I era novels, Barker believed she knew what her soldier-protagonists were suffering from and that it could be cured. Barker focuses on the same themes that interested Remarque and Woolf: what does it mean when a manly soldier breaks down, how can a soldier reconcile a military identity with a civilian one and the difficulty and necessity of communicating traumatic events in order to heal. By comparing these books the change brought about by the PTSD diagnosis becomes evident. Barker’s characters receive appropriate medical attention, and she makes it obvious that they will recover.

The first chapter will discuss the history of PTSD, from its genesis as a condition known as railway spine, up to the current *DSM-5* criteria. The second chapter will cover Remarque’s two novels that together paint a picture of a soldier whose posttraumatic symptoms, developed in the trenches, make it hard for him to

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reintegrate into a society that doesn’t understand him. The third chapter will examine Virginia Woolf’s character Septimus Warren Smith, a soldier four years out of the war whose posttraumatic symptoms are coming to a head and whose doctors cause him more harm than good. The fourth chapter will focus on *Regeneration* to examine how the PTSD diagnosis affected the way in which current depictions of mentally distressed World War I soldiers are written.

The *DSM* is a relatively new tool and its checklist method of diagnosing PTSD (as well as other psychological disorders) is still controversial. For that reason, when discussing these books I have chosen not to use the *DSM-5*’s specific criteria, but rather the overarching themes of PTSD: symptoms of intrusion, hyperarousal and constriction, borrowing from Judith Herman’s categories in *Trauma and Recovery*. I also use the *DSM-5* categories of avoidance, negative alterations in cognition and mood, and functional significance. (I discuss the meaning and application of these terms below in Chapter Two.)

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3 Herman, *Trauma and Recovery*. 35.
Chapter One

The History of Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) is a relatively new diagnosis, though it is an old phenomenon. The current fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*, 2013) lists PTSD under Trauma- and Stressor-Related Disorders. It was first introduced as a diagnosis in the *DSM-III*, released in 1980. Its symptoms are associated with many other established disorders, such as major depressive disorder, generalized anxiety disorder and various personality disorders. Doctors and laypeople were historically skeptical about PTSD because it shares symptoms with so many other diagnoses and because its sometimes-delayed onset made doctors suspicious of malingering patients.

The diagnosis of PTSD differs from all others in the *DSM* cannon in that its cause is specified in Criterion A: exposure to a traumatic stressor. Developing characteristic symptoms after exposure to a life-threatening event now identifies PTSD, whether the trauma happens to or is witnessed by the victim. The symptoms can present as fear-based reexperiencing in the form of nightmares and flashbacks, triggered by stimuli that may or may not be related to the original trauma. This reexperiencing can cause physiological reactivity, such as a racing heart, that recalls how the victim felt during the original trauma (Criterion B). Stimuli that remind the victim of the trauma are avoided, either consciously or unconsciously. These stimuli can include people, places, and troubling thoughts (Criterion C). The victim may

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5 Malingers are patients who exaggerate or feign illness in order to escape duty or work.
suffer from beliefs that the world is bad, feel depressed and guilty, lose the ability to experience positive emotions, and feel estranged from other people (Criterion D). After the trauma, the victim may be irritable, quick to anger, or engage in reckless behavior. The victim may also have an exaggerated startle response, and have difficulties concentrating (Criterion E). These symptoms must last for more than one month (Criterion F), and cause clinically significant distress or impairment in social or occupational functioning (Criterion G). For an exhaustive list of the symptoms, see the *DSM-5*.\(^5\)

The following is a condensed history of the PTSD diagnosis, beginning with the condition known as railway spine in the 1860s up to the *DSM-5* of today. This chronology highlights the stigma faced by PTSD sufferers, the skepticism that traumatic response had a physical cause and the gender and class connotations that labeled the victims.

**Physiologic Beginnings**

The earliest entry for the word “traumatic,” from the 1656 edition of the *Oxford English Dictionary*, gives the definition, “belonging to wounds or the cure of wounds.” This word, clearly referring to a physical event, would eventually take on a psychological meaning in the nineteenth century with the publication of *On Railway and Other Injuries of the Nervous System* (1866) by surgeon John Eric Erichsen.\(^7\)

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\(^5\) American Psychiatric Association and American Psychiatric, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5.* 271-75.

Erichsen, who treated many railway injuries, reported the strange way his patients behaved, exhibiting symptoms including faintness and trembling, fluttering pulse, incoherent speech and thought, amnesia at the time of the trauma and mental “disquietude.” Because accident victims exhibited the same symptoms as patients suffering from surgical (i.e. physical) shock, he argued that the cause must be similar. The similarity he identified was damage due to physical force – the body shaking during a train crash, which he believed would damage internal organs.

Erichsen identified two types of patients reporting symptoms that were outwardly the same. There were those in which the damage from the shakes and shocks would be visible in a postmortem examination and those who suffered a more glancing blow whose physical damage was invisible. Erichsen posited that in either case traumatic shock occurred exclusively through concussion of the spine. Though what he describes would now be identified as symptoms of PTSD, he only addresses in passing the patient’s mental state, believing that the symptoms were due to invisible spinal lesions. The typically “uninjured” patient – one without postmortem lesions – was described as initially calm and asymptomatic. However, when the patient arrived home, the effects of his injury began to surface, including feelings of revulsion, tearfulness, excitability and inability to sleep. As his (hypothesized) spinal lesions developed further, he becomes anxious and his thoughts are confused. On occasion these patients become paralyzed in their limbs. For all these symptoms to stem from the same undetectable event, the bodily structure must be one that connects

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all parts of the body and can be damaged without any postmortem evidence: the nervous system (16).

The surgeon also warned about a third type of patient, one who was malingering in order to gain compensation from the railroad company. Erichsen was not the only suspicious doctor. Herbert Page, another surgeon, cited a law passed in 1864 entitling victims of railway accidents to compensation and remarked on the speed at which many victims recovered once they had been compensated (17).

Unlike Erichsen, Page recognized non-physical causes of the disorder. He believed that intense fear, independent of physical jolting, could cause this traumatic syndrome. “Intense fear – characteristically, fear plus the element of surprise – is an assault equivalent…or analogous…to physical violence. The meaning of fear is in its pathogenic effects,” which were the same as a physical shock (21). However, it was thought that fear worked on the body in a physical way, meaning that the traumatic response was still due to invisible, physical, somatic harm. At the time of the traumatic event, the patient was thought to be overcome with fear and anger, his body physically primed to attack or flee but prevented by his mind from moving. It was hypothesized that this conflict caused his blood pressure to drop so low that deterioration occurred in the heart and nervous system, leading to the traumatic symptoms.⁹

Jean-Martin Charcot, a French neurologist, took this notion one step further by attributing the traumatic reaction to purely psychological reasons, a condition he called hysteria (19). Though hysteria had been considered a purely female malady,

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Charcot recognized its symptoms in those suffering from railway spine. He pointed out that the symptoms – paralyses, contractures, numbness of limbs, depression – are exactly the same in both men and women. However, “[m]ale hysteria... was unlike the female malady in that it presupposed no constitutional or acquired vulnerability” (20). Nevertheless, male sufferers were generally thought to have feminine qualities that made them particularly vulnerable to trauma reactions.

**Theories of Memory and Secrets**

The current DSM-5 PTSD diagnosis identifies disturbing memories and dreams as one of the main symptoms of the disorder. Erichsen and Page referenced memory only in passing (26-7). During the later years of the 19th century, nerve specialists became fascinated with the idea that unresolved memory might play a role in trauma and that there may be more than one layer of consciousness in the mind. Doctors including Théodule Ribot, Pierre Janet and Sigmund Freud began to look to the unconscious for the cause of a traumatic reaction instead assuming a physical lesion. This approach accompanied the beginning of psychotherapy as we know it.

Ribot developed the concept of multiple consciousnesses in his 1883 study *Diseases of Memory: An Essay in the Positive Psychology*, in which he discusses the importance of amnesia. Ribot discusses the self as “two interpenetrating states of being” (29). The first is the sum of all current states of awareness, the “me” in the present. The other is the “conscious personality,” the self that is the subject of its own history – the self in memory. The state of self-awareness especially thrives on memory, but both states are affected by *hypermnesia*, too much memory, and
amnesia, no memory. Though some amnesia is necessary, too much leads to what Ribot calls “periodic amnesia,” a concealment of memories from the self that results in pathological transformation (30).

There are two types of periodic amnesia: the “developed form” consists of alternating conscious personalities, each with its own store of memories. The “undeveloped form” is associated with people who are in a hypnotized or dissociated state. Doctors realized that they could implant memories and commands in patients who fell under the “undeveloped” category. These patients often did not remember what had happened to them during a dissociative spell until they were put under hypnosis again. This established that these implanted “concealed memories could endure over very long periods” of time and affect the patient when they were recalled. Recall could be triggered by a posthypnotic signal. For example, under hypnosis the patient is told that when the therapist snaps his fingers, she will jump. In her unhypnotized state, she jumps hearing the snap but doesn’t know why. This kind of posthypnotic suggestion provided the prototype for the harmful, repressed memory that affects a victim who does not understand the cause of her suffering (32).

As noted previously, it was accepted that patients with railway spine often suffered amnesia of the moment of trauma. This memory loss was key for the theory that purely mental trauma could cause the shock reaction. If the cause of the trauma is not physical, then the idea or memory of the shocking event might be enough to trigger hysteria, even in patients who do not consciously remember the event. Nerve doctors believed that this effect could be studied and treated by hypnosis – like the
“undeveloped” patients – through restoring the troubling memories to their proper, conscious place in order to get rid of the hysterical symptoms.10

Further delving into the idea of memory as a cause of trauma, Pierre Janet did many posthypnotic experiments on his own patients, in whom he discovered multiple personalities. His findings led him to the belief that instead of alternating consciousnesses, there existed simultaneous consciousnesses (32-33). By 1898, Janet concluded that pathogenic secrets – memories that cause the hysteric bodily harm – might include memories that are concealed from the conscious personality, as part of amnesia (34). These memories caused behaviors called “psychological automatisms” which divide into two categories. Total automatisms involve the entire body being outside of the control of consciousness, as in a hypnotized state. Partial automatisms often originate in traumatic experiences. They affect only parts of the body, and account for common hysterical symptoms such as paralysis and numbness. In other words, “somatic symptoms have attached themselves to a painful and intrusive memory” (34).

The pathogenic secrets were what Janet called “subconscious fixed ideas” – they endured over long periods of time and produced automatisms over which the conscious personality had no control (34). These fixed ideas are dangerous because they are not integrated into the patient’s “self.” To integrate the memory, it must become part of the victim’s self story. “The teller must not only know how to [articulate the memory], but must also know how to associate the happening with the

other events in his life, how to put it in its place in that life history.”¹¹ Unless the individual is able to find a place and a meaning for the fixed idea, it will endure as a split-off part of his personality, resulting in intermittent hysterical attacks (35). Janet believed that the role of therapy was to help the patient bring these fixed ideas into consciousness, then to help him recite them until they lost their emotional attachments. Only then could the patient integrate these ideas into his life story and be freed from his hysterical symptoms.

Like Janet, Freud believed that “[h]ysterics suffer mainly from reminiscences,”¹² and rejected Erichsen’s explanation that emotional reactions to trauma were caused by physical forces. Freud believed that traumatic experiences were always charged with high emotion and reactions at the time (tears, anger) discharge the attached emotional effect, leading to the formation of normal memories. However, if the trauma is too painful, a reaction discharge is not possible. The nervous system must therefore manage the sudden surge of excitation, while keeping the body in a constant state. These unabreacted (undischarged) memories enter into a second consciousness, because the conscious personality wishes to banish them from awareness. These are the kinds of memories that lead to hysterical symptoms. The symptoms are an attempt to adequately discharge the emotion, but because the memory is repressed, the cause of the reaction appears to be unknown (36-37). Once again, it is through hypnotic revival and integration of the memory that the patient can be cured.

World War I

World War I produced a new group of hysteria patients, in much larger numbers than the victims of railroad accidents. Under the unremitting strain of trench warfare, men broke down and acted like the hysterical women studied by Charcot and Janet. Soldiers screamed and wept uncontrollably, they became mute or stuttered, their legs and arms became numb and they were unable to do their duties. Military doctors had never seen such widespread reactions to trauma, concluding that conscripted armies were not made up of “real” men. Perhaps to underscore their conclusion, they adopted Charcot and Janet’s terms, dubbing the men “hysterical” and “neurasthenic.” From the very beginning, men who broke down were identified as effeminate. These disorders supposedly were most likely due to heritable traits of timidity, predisposing the soldier to be susceptible to shock. Both hysteria and neurasthenia were originally women’s disorders, applied to soldiers who showed the same symptoms during the war.

Though both hysterical and neurasthenic women were usually from the upper class, when applied to men these terms took on class and gender connotations: enlisted men were hysterics, officers were neurasthenic. Lower-class enlisted soldiers were thought to be weak and effeminate and thus predisposed to hysterical outbursts. By contrast, officers, of hardier stock and better breeding, were gradually worn down by caring for their men. Psychological symptoms were thought to have “grafted” themselves onto these mental or physical wounds, accounting for the emotional
response. Military authorities attempted to suppress reports of psychiatric casualties because of their demoralizing effect on the public, increasing the stigma.

The Royal Army Medical Corps (RAMC) divided war neuroses into four disorders: shell shock, hysteria, neurasthenia and disordered action of the heart. (I focus on the first three disorders because they are most pertinent to the novels that will be discussed.) All these disorders were considered “functional” rather than “organic,” meaning that they “might have biological origins” (53). In other words, despite the work of Janet and Freud, these disorders were presumed to result from invisible neurological lesions and abnormalities, like railway spine.

Because so many were stricken with these functional disorders, the typical etiological event was thought to be exposure to forces generated by high explosives, leading to the name “shell shock.” Proximity to an explosion was thought to be sufficient to decompress the spinal fluid enough to disturb the brain and the central nervous system, generally evidenced by a concussion. This physical explanation for hysterical symptoms was touted by Frederick Mott, an English neuro-pathologist. His prolific writing on the subject played a large part in convincing other doctors that hysteria had a physical cause. By 1916, Army doctors were arguing that the event actually had two parts: the physical shock and an accompanying emotional shock that led to disturbing memories of the explosion (59). As it was often hard to tell the two apart, the link between the diagnosis and concussion was broken, and shell shock became nothing more than a synonym for “war neuroses” (60). The more specific

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14 In this case, hysterical means there is no evident physical damage that could cause these symptoms.  
diagnoses, hysteria and neurasthenia, therefore fell under the umbrella title of “shell shock.”

The military diagnosis of hysteria was based on partial or complete loss of control over sensory, perceptual or motor functions, not on the etiology. The most common symptoms included paralysis, gait disorders, tremors, spasms, amnesia and mental confusion. Overall, hysteria was defined by what it was not: “hysteria is not the combination of neurological problems that it resembles” (56). It was, however, the diagnosis that was most suspect for malingering. Doctors were warned that malingerers might claim to suffer from symptoms of hysteria. “[P]atients with hysteria deceive themselves and malingerers seek to deceive others” so hysterics should love examinations, and malingerers hate them (58). It nevertheless took an expert eye to distinguish malingerers from a truly hysterical soldier. Clinicians believed that men who suffered from hysteria were prone to suggestion and developed symptoms because they had a weakness of character and will (62-63).

Though the symptoms of neurasthenia presented the same way as hysteria, neurasthenia was diagnosed more frequently in officers. Neurasthenia was more acceptable because it did not reflect the weakness of the patient. Instead, “[t]he disorder could originate in a weakness imposed from the outside, a weakness that was the result of a mechanical process, in which a man’s physical defenses were gradually worn down” through exposure (62). This nerve exhaustion was thought to be due to long periods of intense mental and physical strain. The onset could be sudden or gradual, the result of a slow wearing down of the victim’s nerves until they were utterly exhausted (52). Hysteria was not thought to occur in these upper-class men
“because of what could be assumed about the patient’s breeding and education and the process of selection and monitoring [in the army] that produced frontline officers” (63).

As the frequency of cases of war neuroses increased, the RAMC changed its approach to diagnosis and treatment. Advanced neurological centers were established a short distance from the front to analyze the severity of the cases. Patients were then sorted into wards based on their symptoms, though hysteria and neurasthenia had separate wards. Patients who required extended or specialized treatment were evacuated to neurological centers in hospitals in Britain (61). The general aim of treatment was to get the soldiers back to the trenches as soon as possible. Because these were “functional disorders” whose symptoms were somatic, the cure involved treating the body and the mind.

The RAMC established two types of therapeutic guidelines for doctors assigned to nerve cases. The first was analytic, based on the assumption that the neurotic’s unconscious mind was working against the conscious mind and the body. The doctor’s role was to promote the successful processing of mental conflicts. The other protocol was disciplinary, based on animal training techniques. The patient was put on a special diet, given electric shocks and had commands shouted at him. After a few days, he was told that the only way to free himself from this situation was to give up his symptoms, implying that the patient’s malady represented willful action (68). The patient’s recovery would confirm that there hadn’t been anything wrong in the first place, further stigmatizing those diagnosed with war neuroses (56). Both of these methods of treatment will be discussed in more detail in Chapter Three.
The *DSM*

Missing during World War I and up to the 1980s, was a standardized psychiatric nosology (classification of disease) for war neuroses. Interest in the subject dropped off quickly after World War I ended. It was picked up again during World War II, but dropped off again soon after 1945 (89). It was only in the aftermath of the Vietnam War that posttraumatic symptoms were given full attention. “[T]he national experience of defeat in a discredited war had made it possible to recognize psychological trauma as a lasting and inevitable legacy of war,” leading to PTSD’s inclusion in the *DSM-III* in 1980.16

The *DSM-III* marked a huge change from the *DSM* editions that had come before. The *DSM-I* (1952) was shaped by its editor, Adolph Meyer, who saw mental health as a gradient: “healthy” at one end and severe “mental illness” at the other. Each diagnostic group represented quantitatively different personality reactions to psychological, social, and biological stimuli. The *DSM-II* (1968) was flawed by its failure to provide formal criteria to delineate disorders. Both manuals were tied to a Freudian, psychodynamic approach, making it difficult to extend the definitions to other schools of psychiatry, or to use them as a base for scientific research (98-99).

The process for the *DSM-III* began in 1974. It cleaved more closely to Emil Kraepelin (1856-1926) than Freud, espousing his view that the classification of mental disorders demands careful observations of the symptoms in order to group disorders together. In other words, psychiatry must identify different kinds of diseases

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16 Herman, *Trauma and Recovery*. 27.
in order to map out the progress of the disorder and learn what treatments are effective (98). Therefore, the *DSM-III*’s lists of criterial features are not based on theory, but rather on statistical analysis and agreement among diagnosticians.

The *DSM-III* PTSD diagnosis is linked to analysis of disorders experienced by Vietnam veterans. Throughout the early 1970s, there seemed to be an epidemic of suicides, antisocial acts and bizarre behavior committed by these veterans. In VA hospitals, the veterans were admitting to horrible atrocities in Vietnam the media hadn’t reported. Instead of believing their patients, doctors immediately gave them the diagnosis of paranoid schizophrenic, assuming that their horrible stories were part of their psychosis. It was the nurses and social workers at these hospitals who noticed that, if veterans’ stories were taken at face value, the basis for a diagnosis of schizophrenia disappeared. In addition, many of these men were treated with electroshock therapy, which we now know does nothing to help treat the underlying trauma (108-9).

Though a few people recognized the disorder, it was difficult to get the psychological community at large to acknowledge the legitimacy of veterans’ symptoms. A committee of six people, including Sarah Haley, a VA social worker, and Jack Smith, a Vietnam War veteran were put in charge of defining this post-war disorder for the *DSM-III*. They named it “catastrophic stress disorder” but the proposal was initially rejected because “[m]inus the etiological process, the disorder’s symptomatology coincided entirely with the symptoms of already established diagnoses – depression, generalized anxiety disorder, panic disorder and paranoid schizophrenia – and would thus be superfluous” (110). However, when they were
able to show that serious burn victims experienced the same post-traumatic psychological reactions, the diagnosis was accepted. PTSD was included in the *DSM-III* in the section on anxiety disorders.

In the *DSM-5*, PTSD now has its own section, Trauma- and Stressor-Related Disorders. This underscores the fact that PTSD has many depressive symptoms, and is no longer considered to be exclusively an anxiety disorder. In each edition of the *DSM*, the PTSD diagnosis has become more descriptive, and more inclusive. Criterion A, the list of events that can trigger PTSD, now includes many different types of stressors, including witnessing a traumatic event, and is not delineated as an event “that would evoke significant symptoms in almost anyone” as it is in the *DSM-III*. This change shows that the diagnosis has gained legitimacy and expanded from its purely military roots to encompass many other sources of trauma.

The novels that this thesis will explore, Erich Maria Remarque’s *All Quiet on the Western Front* (1928) and *The Road Back* (1931); Virginia Woolf’s *Mrs. Dalloway* (1925); and Pat Barker’s *Regeneration* (1991) echo the historical development of the diagnosis. Though the fictional doctors’ perspectives on trauma are heavily influenced by the period in which the authors were writing, the soldier-protagonists display strikingly similar symptoms regardless of the publication date. The novels also illustrate the way in which the symptoms and sufferers of war neuroses were treated during World War I and how the attitudes towards trauma changed after PTSD was added to the *DSM*.

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17 For a table showing the changes to the PTSD diagnosis between the *DSM-III* (1980) and the *DSM-II-R* (1987) please see Young, *The Harmony of Illusion*. 117.
Chapter Two
Remarque’s Anti-Hero’s Journey

This chapter will examine two books by Erich Maria Remarque, *All Quiet on the Western Front* (1928) and *The Road Back* (1931). Though each book has a different protagonist, taken together they form a single portrait of a soldier who served on the Western Front and then attempted to reintegrate into civilian life once the war ended. This chapter will examine the impact of trauma on soldiers, especially when they try to return to civilian life and argue that the act of writing *All Quiet on the Western Front* and *The Road Back* aided Remarque’s personal recovery from his own war trauma. Therapeutic for the author, these novels revealed truths about a soldier’s mental trauma that intrigued the public and angered the Nazis.

Though classed as fiction, the works are semi-autobiographical. This connection is made clear in *All Quiet* – the protagonist’s name is Paul Bäumer, and Remarque’s real name is Erich Paul Remark, changed to Erich Maria Remarque to disassociate himself from earlier works he had published. Paul dies at the end of the novel, but Remarque completes his story of a mentally wounded soldier through the character of Ernst Birkholz, the protagonist of *The Road Back*. Ernst was a member of Paul’s company, though the two were not close – Ernst is never mentioned in *All Quiet* and Paul makes a single appearance as a name on the list of the company’s dead in *The Road Back*. They are linked by their experiences on the battlefield and at home.

Remarque’s life story is controversial, starting with the fact that he never fought on the Western Front itself, though he was stationed in a trench nearby. In November of 1916, at the age of 18, the author was conscripted into the German army
along with others in his school class. He was assigned to the Second Company of the Field Recruiting Depot of the Guards Reserve Division, located in trenches near the front. His mother was gravely ill throughout this time, and Remarque was often given compassionate leave to go home and see her. During the battle of Flanders, in July 1917, Remarque sustained injuries from grenade shrapnel in his neck, left knee and right wrist, and was evacuated to an army hospital in Germany. He rejoined the 78th Infantry in October, and was declared fit for duty four days before the Armistice, November 11, 1918.

In 1928, ten years after the Armistice, Remarque wrote *Im Westen nichts Neues* (*In the West Nothing New*) which was published in novel form in English as *All Quiet on the Western Front* in 1929. Writing about his war experiences proved to be cathartic for Remarque. He says that he could not understand the cause of his “serious bouts of depression” and therefore consciously wrote about them, producing the book in a mere six weeks. In an interview with Axel Eggrebretch in 1929, Remarque stated that “[i]t was through these deliberate acts of self-analysis that I found my way back to my war experiences…. The shadow of war hung over us, especially when we tried to shut our minds to it.” Though *All Quiet* does not provide specific dates in its narrative, Remarque gives much of his biography, discussed above, to Paul. However, Remarque’s mother died around the time he was hospitalized and Paul dies at the time Remarque rejoined his company. The book was an overnight success and sold 1.2 million copies, a record.

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19 Ibid. 9.
20 Ibid. 33.
21 Ibid. 9.
In Germany, the reaction to *All Quiet* was extreme and opinions polarized. On one hand it was a best seller. But on the other it was criticized for not identifying time and place in order to fact check – though the lack of structure underscores that it is about a traumatic experience. Regardless, the public clamored for more, to the point that Remarque had to flee Berlin for Osnabrück where he could write the sequel, *Der Weg zurück (The Road Back)* in relative peace.\(^22\) It was serialized between December 1930 and January 1931 in the same journal as *All Quiet*, before being compiled and published in April 1931. This book took Remarque longer to write, and the reception was mixed. The premise of the sequel is that war was the defining experience for this lost generation and that their reintegration was hindered because all of the young men’s skills came from war and all of their accomplishments were bound up in it. Many critics rejected that premise.\(^23\)

The main opposition to Remarque’s writing, especially *All Quiet*, came from the National Socialists. *All Quiet* was dangerous because it effectively demythologized warfare and the concept of the “hero,” two cornerstones of the Third Reich’s plan for war.\(^24\) The campaign against the author was spearheaded by Goebbels himself, and attacks were personal and political in nature.\(^25\) Remarque’s books described war and its effects in a cold light, without patriotism or glorification of valor. In addition, in *All Quiet*, Remarque began to describe a nameless illness, and in *The Road Back* he showed that it follows a soldier home. Pointing out that men who seemed fine were in fact suffering made Remarque an enemy of the state. These

\(^22\) Ibid. 69.  
\(^23\) Ibid. 70-71.  
\(^24\) Ibid. 39.  
\(^25\) Ibid. 18.
men were not the “Iron Youth” German propaganda made them out to be. The Nazis felt Remarque portrayed the men in the front lines as emotionally unbalanced.

Remarque’s books investigate what kind of people war creates. His characters are not heroes, only soldiers, only human, and they suffer from an unnamed disorder. His soldiers themselves are antiheroes and their tales, though full of valor, do not give them the rewards a hero would deserve. In *All Quiet*, Paul attempts to rescue his best friend though he himself is injured. Though they make it to the medical tent, the doctors immediately realize that Paul’s friend has died minutes beforehand, without Paul noticing. This kind of senseless death devoid of cause and effect was in opposition to Nazi propaganda. Where a hero, with good on his side, would triumph, Remarque’s soldiers are only trying to live through their anguish. Remarque’s books draw attention to the kinds of heroes that war creates: though Ernst, in *The Road Back*, was also a brave soldier, he is unable to talk to his mother and feels undeserving of the accolades with which society showers him. Remarque does away with the mythological feel of the battlefield: in the trenches, there is no good or bad, only looming death.

The response to this message eventually forced Remarque to leave Germany. All Quiet and *The Road Back* were placed on the index of prohibited literature by the Nazis, and were burned as part of the book burning ceremony in Berlin in 1933. The message of confused soldiers that these novels portrayed must have hit close to home for many of the members of the lost generation and the Nazis could not allow the anti-war hero to flourish as they geared up for another great war. Remarque fled to

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26 Ibid.
Switzerland and lived there until his German citizenship was revoked in 1938. The following year he went to America.²⁷

Shell Shock

Remarque’s soldier-protagonists, though disenchanted with war, do not wish to be seen as psychologically damaged. At the time in which Remarque was writing, psychological trauma was seen by many as a ploy for insurance compensation. In 1925, the Reich Insurance Office asked medical officers what they thought of shell shock. The resulting report concludes that “without the existence of liability laws of any kind” shell shock would not exist.²⁸ This policy of assumed malingering was adopted by the Nazi party in 1939. Because shell shock was seen as a sign of weakness, the label of a money-hungry malingerer, it makes sense that Remarque’s men wouldn’t wish to be identified with the mentally wounded.

Remarque delineates the precursors of shell shock in new recruits, stuck with Paul and his friends in a trench while waiting for a bombardment to let up. Though Remarque describes soldiers suffering from war neuroses, his protagonists distance themselves from them because of the stigma attached to the label. “[One] sobs; twice he has been flung over the parapet by the blast of the explosions without getting any more than shell-shock. The others are eyeing him. We must watch them, these things

²⁷ Ibid. 19-20.
are catching, already some lips begin to quiver.” Remarque describes “front-line madness” a kind of dangerous recklessness that overcomes some men to the point that they must be wrestled to the ground. “It affects [some] so that they begin to rave, to run away – there was one man who even tried to dig himself into the ground with hands, feet, and teeth. It is true, such things are often simulated, but the pretence itself is a symptom” (AQ 279). In these descriptions, it is clear that Paul is in no way identifying himself with these sufferers.

After the war, Ernst passes a demonstration composed of war cripples while out walking one day. There are the amputees, the blind, the men missing eyes and chunks of their faces.

Then come the shakers, the shell-shocked. Their hands, their heads, their clothes, their bodies quake as though they still shuddered with horror. They no longer have control of themselves; the will has been extinguished, the muscles and nerves have revolted against the brain, the eyes become void and impotent (RB 247).

Ernst feels totally separate from the nervous sufferers he observes, as, it can be surmised, does Remarque. Like Paul on the battlefield, Ernst has maintained control of himself. The soldiers about whom Remarque writes do not have shell shock – yes, the memories sink deep down inside them and resurface years later, but the physical

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29 Erich Maria Remarque, All Quiet on the Western Front, trans. A. W. Wheen, 3rd ed.(Toronto: Ballantine Books, 1982). 109. Future references will be cited parenthetically in the body of the text as AQ followed by the page number.
symptoms, for the soldiers, never manifest – they are not broken. It is clear from this passage that Ernst does not identify with the wounded – he watches their procession with interest, but is aware that he is not as badly off as they are. Though he knows he is not as able to do and enjoy things as he once was, he can still take pride in the fact that he got out of the war relatively unscathed. He, like others in his society, can look down on the outwardly shell-shocked. This, however, leads to cognitive dissonance – though Ernst is closer to civilians than the shaking soldiers, he isn’t mentally whole. Ernst never considers talking to anyone about the emptiness and confusion he feels inside, but can freely think of it in relation to other, poorer souls.

**War Trauma and its Symptoms**

Though it is possible to diagnose Ernst with PTSD using the criteria in the *DSM-5*, Paul’s story takes place almost entirely on the battlefield, making it more difficult to identify what would now be regarded as symptoms of this disorder. For that reason, I use Judith Herman’s three overarching categories of post-traumatic stress disorder symptoms to assess both characters. These categories are “constriction,” “intrusion” and “hyperarousal.” Constriction refers to alterations of consciousness, such as dissociation and depersonalization – feeling as if you were in a dream, or outside of your body. It describes the emotional detachment so evident in Paul and Ernst when they try to interact with their families – they seem utterly unable to do so, and in fact Remarque describes very little non-trauma-related emotion. Intrusion includes symptoms like flashbacks – memories so vivid the sufferer

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31 Herman, *Trauma and Recovery*. 35.
believes he or she is there. This cluster is evident in the memories of the battlefield described by the two soldiers; their vivid description is in sharp contrast to the almost complete absence of detail about the world in which they live. Herman states that it is almost impossible to control these types of memories – it is theorized that they are encoded differently from normal memories, and thus act differently later on.\textsuperscript{32} Finally, hyperarousal refers to an exaggerated startle response, constant vigilance, nightmares and trouble sleeping, all of which the soldier-protagonists display.

In addition, Herman states that the highest risk of post-traumatic stress disorder occurs when “the survivor has been not merely a passive witness but also an active participant in violent death or atrocity. The trauma of combat takes on added force when violent death can no longer be rationalized in terms of some higher value or meaning.”\textsuperscript{33} Both of Remarque’s protagonists realize that the enemy is not so different from themselves, making the war harder to rationalize. They are also haunted by visions of enemy soldiers they killed with their own hands. Remarque’s books combine this moral conflict with Herman’s symptoms, creating a nuanced portrait of traumatized men.

Trauma shapes the structure and the language of both books. This is especially apparent in the lack of descriptive language, save during a flashback or traumatic memory, indicative of the constricted affect of those suffering from PTSD. The factual nature of the writing reflects the constricted nature the soldiers must adopt on the battlefield. This way of being is something that cannot be explained to civilians, and other soldiers just know – there is no need for discussion. In fact, Remarque

\textsuperscript{32} Ibid. 39.  
\textsuperscript{33} Ibid. 54.
provides very little description of the battlefield or of Paul’s fellow soldiers. The reader is given a name and, at most, a line of description about their personalities, i.e., “Tjaden, a skinny locksmith of our own age [19], the biggest eater of the company.” This perfunctory depiction enforces the walls these soldiers must put up when they are at the front. Only one, Kat, the leader of their group of friends and the one to whom Paul is closest, is assigned an eye color – blue (AQ 3). It is silly to grow too close to their comrades, even those known before conflict broke out.

This constriction carries over to the men’s reactions to death. Death is a part of life on the front and it is impractical to mourn the dead. Fourteen days prior to the start of the narrative, the company set out 150 strong, and they returned, on the day this narrative begins, numbering only 80. Remarque gives no commentary on this drastic decrease, but rather begins the next paragraph, “Last night we moved back and settled down to get a good sleep for once” (AQ 2). Paul, whose death is reported by an anonymous third party on the last page of the book (AQ 295) is otherwise the last man standing of his friends. He barely mourns any death, except Kat’s, whose body he dragged through gunfire, refusing to believe he had died. Upon learning that his friend had expired, Paul experiences a period of intense dissociation (AQ 291).

Details lead to attachment and soldiers cannot let themselves get attached, the realization of the loss is too traumatizing.

Through close encounters with enemies Remarque explores what happens when a soldier lets his constriction slip and begins to truly examine his environment. When Paul stops to reflect on the fact that instead of sharing cigarettes with Russian POWs, he would be shooting at them if they were free, “[he is] frightened: [he]
dare[s] think this way no more. This way lies the abyss. It is not now the time but [he] will not lose these thoughts, [he] will keep them, shut away until the war is ended” (AQ 194). The soldiers occasionally acknowledge the unnamable horror that presides over the front. “Two years of shells and bombs,” one of Paul’s friends says to him, “a man won’t peel that off as easy as a sock” (AQ 87). And Paul agrees, without letting himself reflect too much on what surrounds him at the time. Instead of delving into this nameless horror, the soldiers fold it away to keep surviving. Though Paul never makes it to the end of the war, these thoughts do rise again in Ernst.

The hallmark of a traumatic event is the lack of processing that happens at the time, indicated by Paul’s reaction to his negative thoughts. Remarque does not try to express what is plaguing Paul, but rather lets the reader come to the moral conclusions that the soldier must back away from in order to survive. Just as Remarque does not explain to his reader what these deep feelings truly entail, neither are Paul or Ernst able to disclose them to their families or comrades. With other soldiers there is the feeling of shared experience, a unity that does not require explanation, but regardless negative thoughts are never spoken about.

In one of longest and most vivid sections of All Quiet, Remarque explores what happens when that constriction is breached. Paul is caught in a foxhole in no-man’s land during a bombardment. A man falls over him and, “I do not think at all, I make no decision – I strike madly at home, and feel only how the body suddenly convulses, then becomes limp, then collapses. When I recover myself, my hand is sticky and wet” (AQ 216). Paul here suffers from peritraumatic dissociation, which is to say that when he was acting during the traumatic event, it was as if he was in a
dream. When he later “regain[s] control of [him]self” (AQ 216) he realizes that the man happens to be French, and is still alive. Though the original act is over in a paragraph, Paul spends over ten pages alone with the dying French soldier. “This is the first time I have killed with my hands,” he thinks, a person “whom I can see close at hand, whose death is my doing.” Time seems to slow for Paul, and the day drags on until the man is finally dead around three in the afternoon (AQ 221).

Once the man is dead, Paul “can no longer control [his] thoughts,” a sign that he is absorbing the horror of his situation. This space for reflection makes Paul realize that the enemy is no different from him. “We always see it too late. Why do they never tell us that you are poor devils like us, that your mothers are just as anxious as ours?” (AQ 223). He is still stuck with the corpse in no-man’s land, giving him ample time to process what he did, leading to feelings of guilt. He goes through stages of dealing with this grief, from “[s]o long as I do not know his name perhaps I may still forget him” (AQ 224) to seeing the pictures in his wallet and learning that he is Gérard Duval, compositor. “I swear blindly that I mean to live only for his sake and his family,” to send them money, and to become a printer like his victim (AQ 225).

Meaning making is an important part of the end stage of recovery from trauma. It helps the victim to integrate the traumatic experience into his life story – pain has not been for nothing, it occurred so the victim can help others in the future. Paul comes close to taking this step, but he is ultimately not ready to do so, as Remarque himself was not until ten years after World War I ended. “By afternoon [Paul is] calmer. [His] fear was groundless. The name troubles [him] no more” (AQ
226). Paul is not ready to think over what he did any more than he was already forced to. To do so would destroy the veneer of manliness he needs to be a good soldier.

Paul is found by his friends and doesn’t mention his ordeal until the next morning, when he can hold it in no longer. “You don’t need to lose any sleep over your affair,” Albert tells him. Paul agrees. “And now I hardly understand it myself any more” (AQ 229). This experience has briefly broken through his constriction, but to keep himself functioning, Paul returns to his closed-off state. “The terror of the front sinks deep down when we turn our back upon it…. And this I know: all these things that now, while we are still in the war, sink down in us like a stone, after the war shall waken again, and then shall begin the disentanglement of life and death” (AQ 140).

Intrusive symptoms are flashbacks and recurrent, disturbing dreams about or somehow related to the trauma. They can also take the form of troubling memories, even if the content would seem to be benign. In Remarque’s novels, these memories are marked by being out of place for the environment, their incongruity causing distress. They are full of visual detail, seeming more real than the soldier’s surroundings, which emphasizes how out of context they are. In All Quiet, Remarque shows how a PTSD-like intrusive memory of home can cause as much harm as a flashback to the battlefield. He does this through the “mad story of Detering,” a soldier in Paul’s battalion (AQ 275). Detering sees a cherry tree in a garden and it instantly reminds him of his home. This memory is out of place on the battlefield and the juxtaposition leads Detering to do something rash – he deserts that night. “A week after we heard that he had been caught by the field gendarmes,” and presumably shot
(AQ 277). This story passes without further comment. Just as the realities of the battlefield must be filtered out of consciousness to make life bearable, so must memories of a past life be discouraged. The memories of home serve to remind the soldiers of a past too painful for them to access.

These memories threaten to overturn the carefully constructed armor the soldiers have against the horrors of the battlefield. “[I]t has reinforced us with dullness, so that we do not go to pieces before the horror, which would overwhelm us with clear, conscious thought” (AQ 274). For that reason, they must construct a new identity on the battlefield that civilians cannot understand, but other soldiers can. It is an identity with shields built in to protect the soldier from the horrors he faces in the trenches. When Paul is at home on leave, he is overcome by a memory, not of the peaceful past, but of the front, a place where he feels at ease.

I look out of the window; –beyond the picture of the sunlit street appears a range of hills, distant and light; it changes to a clear day in autumn, and I sit by the fire with Kat and Albert and eat potatoes baked in their skins.

But I do not want to think of that, I sweep it away…. I want to feel that I belong here [at home] (AQ 171-72).

This memory, which comes about in the same way and with the same detail as a traumatic flashback, makes Paul uncomfortable. Why can’t he feel at home when he is at home? The Front has changed him to the point where he only feels comfortable with fellow soldiers, not with his family. A memory like this cannot be integrated into his identity – how can he interpret the Front if it is both where he wants to be, and where he is most afraid?

In addition to memories that bring up questions of identity, Paul suffers from intrusive memories about the battlefield that become most apparent when he is at
home, talking to his parents. It is evident from the second he arrives home on leave that he is distressed and aware of his alienation from his parents, increasing his constrictive tendencies. Paul reflects,

But I cannot get on with people. My mother is the only one who asks no questions. Not so my father. He wants me to tell him about the front; he is curious in a way that I find stupid and distressing; I no longer have any real contact with him…. I realize he does not know that a man cannot talk of such things; I would do it willingly, but it is too dangerous for me to put these things into words. I am afraid they might then become gigantic and I be no longer able to master them. What would become of us if everything out there were quite clear to us? (AQ 165).

Paul realizes that he cannot discuss what is happening at the front – he is not ready to process the horrific events he has lived through.

Unlike Paul, Remarque’s reflections upon some of his war memories helped him begin to integrate them. In The Road Back, the author gave these memories more context and a narrative, for example, revealing details about an English captain who haunts Ernst. The progression of the appearances of the English captain, from factual retelling, to dream, to hallucination from which Ernst literally runs in terror shows the worsening symptoms the soldier suffered. It also provides his trauma with a story arc. Written after All Quiet, The Road Back indicates that Remarque had a better understanding of his own symptoms, allowing him to pinpoint where they began and show them coming to a crescendo.

The English captain first appears as an intrusive memory that Ernst recalls when talking with his mother. “I once threw a bomb at twenty yards that tore the legs off an English captain. He screamed terribly. He threw back his head, mouth wide open, and, propping himself on his rigid arms, his trunk reared like a seal; then rapidly he bled to death” (RB 133). The visual detail indicates how vivid the memory
is for Ernst. And yet this memory passes by without comment, it is merely there to indicate that he has changed from what his mother believes him to be. The captain reappears in a dream Ernst has months later, in which he relives the entire action of killing, from sighting his enemy to throwing the grenade. This time, however, the man does not die, but begins to chase Ernst, whose legs are now also failing (RB 228-29). This dream is described in the present tense, showing that Ernst feels that this is happening to him now – he is back on the battlefield, reliving one of his most traumatic moments. He wakes up attacking his landlord, thinking he is the English captain. Ernst cannot believe it was a dream, and is unable to get back to sleep (RB 230-31).

The final appearance of the English captain is at the end of a long line of dead comrades Ernst hallucinates. Ernst’s friend Ludwig has just killed himself and Ernst is having trouble processing this fact. One after the other, his dead friends from his battalion appear in front of him.

But suddenly the horror, the astonishment breaks in me; for slowly a stronger, a darker shadow has arisen. Propped on its arms, it creeps in through the door; it takes on life, bones grow within it, a body drags itself in, teeth gleam chalky-white out of the black face, eyes now flash in the deep sockets. Rearing like a seal, he crawls in, toward me – the English captain! And trailing behind him, rustling, the puttees. With a slight lurch he flings himself upwards, reaches toward me with clutching hands (RB 276).

The detail of each encounter with the English captain shows how the memory was seared in Ernst’s mind. The specifications, from his posture to the color of his teeth and the noise of his legs dragging behind him make these visions seem more real than life. Presumably, like Paul, Ernst witnessed his enemy’s suffering but was unable to let himself deal with it at the time. He is now recalling the event at times of distress.
Symptoms of hyperarousal include an exaggerated startle response and hypervigilance. The relative calm of Osnabrück, which both of the soldiers and Remarque himself call home, is the perfect setting to display just how frayed the nerves of the soldiers are. After the constant alertness they needed at the front to preserve themselves, (AQ 54) they do not know how to act in a peaceful place. Ernst describes it as, “[u]p at the Front there our nerves were always strained to the utmost; any minute it might be a matter of life and death. So [at home], of course, they flap about like sails when the wind has dropped” (RB 192). This hyperarousal is also present in Paul, who is “startled a couple of times in the street by the screaming of the tramcars, which resembles the shriek of a shell coming straight for one” (AQ 165).

Inability to concentrate is another symptom of hyperarousal. Both soldiers, who had been avid readers before the war, seem unable to become absorbed in books that formerly gave them pleasure (AQ 171). Ernst cannot concentrate, and in fact gives his books away to a friend. “I tried to read a bit only yesterday. But it’s queer, you know – I don’t seem to be able to concentrate properly any more. By the time I’ve read two or three pages I find I’m thinking of something else altogether. –As if one were looking at a blank wall” (RB 101). Paul suffers similarly, “[Civilians] have worries, aims, desires, that I cannot comprehend…[I] try to explain to [them] that this is really the only thing: just to sit quietly” (AQ 168). Both soldiers cannot comprehend civilians who have plans for the future because they feel as if they have none. These restricted relationships with others combined with this lack of concentration would now be indicative of PTSD.
Despite the intensity of these symptoms, neither soldier divulges his suffering to friends or family. They were supposed to be Iron Youth, and to have such problems would relay them into the realm of women. Only women had such hysterical fits and spurts of fear. They, on the other hand, had lived in war, surely they are too tough to be haunted by memories. And yet both soldiers realize that they are not the same people they were before serving, nor are they the “human animals” they became at the front (AQ 56).

**Civilians and Family**

Going home serves as a reminder of the change that has taken place in these soldiers and leads them to have crises of identity. Civilians have already separated themselves from the war, have already decided that their young men are heroes, but these soldiers do not see themselves that way; therefore they cannot mentally connect and are left searching for an identity. The soldiers know that they are physically home and yet they are not comfortable because they can no longer access the person they were before the war. Because they refuse the title of hero their society wishes to give them, the soldiers become antiheroes. They cannot explain what the battlefield was really like, and therefore can’t tell anyone why they aren’t proud of their service. Though Paul tries to be comfortable during his leave, he is unable to. “[A] sense of strangeness will not leave me,” he thinks, “I cannot feel at home amongst these things. There is my mother, there is my sister…there the mahogany piano –but I am not myself [here]. There is a distance, a veil between us” (AQ 160). The dash in this quotation communicates the abruptness with which Paul realizes his isolation.
Despite all of the things that are familiar to him, try as he might, he does not feel at home.

Living through a traumatic event destroys a person’s sense of self, which can only be rebuilt as it was originally built – through connections with others.\textsuperscript{34} When Paul and Ernst are at home, however, they are closed off. When they are with other soldiers, they do not speak of the war, because they are aware of the shared sense of understanding fostered in the trenches. As Herman says,

\begin{quote}
In fighting men, the sense of safety is invested in the small combat group. Clinging together under prolonged conditions of danger, the combat group develops a shared fantasy that their mutual loyalty and devotion can protect them from harm. They come to fear separation from each other more than they fear death.\textsuperscript{35}
\end{quote}

Remarque illustrates this through the stilted way in which his soldiers interact with their families and the comfort they find while around fellow veterans. In fact, these soldiers feel they cannot talk to civilians at all; war is all they know. “[T]he generation that grew up before us, though it has passed these years with us already had a home and a calling; now it will return to its old occupations, and the war will be forgotten – and the generation that has grown up after us will be strange to us and push us aside” (AQ 294).

The namelessness of the trauma on the battlefield makes it impossible to communicate to someone who hasn’t witnessed it. For this reason, Paul prefers to be alone, or with his fellow soldiers, so that he doesn’t have to explain himself. When Paul is home on leave, he has an encounter that illustrates the disconnect between soldier and civilian. “A head-master shakes hands with me and says: “So you come

\begin{footnotes}
\item[34] Herman, \textit{Trauma and Recovery}. 61.
\item[35] Ibid. 62.
\end{footnotes}
from the front? What is the spirit like out there? Excellent, eh? Excellent?” I explain that no one would be sorry to be back home” (AQ 166). The general perception is that the soldiers on the front lines cannot be suffering as much as the civilians who must deal with privations and rations (AQ 165-66). Though Paul attempts to explain that in fact the conditions are bad, and war is not as simple as the head-master seems to think, it has no impact on the civilian. Paul reflects on his personal experience of this lack of understanding,

I find I do not belong here any more, it is a foreign world. Some of these people ask questions, some ask no question, but one can see that the latter are proud of themselves for their silence; they often say with a wise air that these things cannot be talked about. They plume themselves on it (AQ 168).

The utter ignorance of the conditions at the front makes it impossible to explain.

This civilian disconnect continues after the war is over. The Road Back is set right after the armistice, when the Kaiser has fled Germany and a socialist uprising is underway in Berlin. Though this revolution seems to have left Ernst’s hometown relatively untouched, he sill does not feel at home there. He has the distinct feeling that he has changed too much to fit in anymore. “Life has moved on, is still moving on; it is leaving us [soldiers] behind almost as if we were superfluous already” (RB 37). This feeling carries over in his interactions with his parents. When he is around his mother, he “suddenly…feel[s] how alien and alone [he] really [is]” (RB 134). The feeling lessens when he is around his friends from the trenches, with whom he has a shared past. Then he doesn’t have to explain what it was like in the trenches, nor worry that someone will ask. With them, he is safe from the flashbacks that seem to haunt him when he with civilians or alone – the sense of understanding without
speaking comforts him. As Ernst puts it, “A man cannot talk about the things out there with civilians, and I know nothing else” (RB 64).

Most likely due to his inability to reconcile his new identity of soldier with his former identity of son, the longer Ernst stays in his house, the worse his symptoms become. “Everything around me seems to have come loose,” he thinks (RB 67). Ernst has trouble getting battle out of his head and adapting to his new environment.

“Consciousness hovers between waking and dream…. distant gunfire floats in, shells pipe over softly, and the tinny ringing of gongs sounds nearer, announcing a gas attack” (RB 130). When Ernst wakes up more, the noises consolidate into his mother setting the table for dinner. Home is not as comforting as he believed it would be while out at the front. The familiar setting feels strange, which makes Ernst feel alienated from the people in it. He knows he’s changed, but his parents expected him to stay the same. He realizes he must leave, and tells his parents that he has to “go and report [him]self” at the barracks, though this is a lie (RB 68). He cannot be with them any longer and yearns to be with his comrades, who do not expect him to be anything other than he is – a soldier, like them.

This alienation is augmented by soldiers’ inability to communicate with the people around them. The soldiers feel they live in a society that subtly rejects their lived experience in favor of the romanticized one, implying a nullification of their identity. War is a chaos that cannot be articulated. The idea of being forced to speak about their experiences is distressing to both Ernst and Paul, in part because they feel they do not possess the correct words to relay their experiences. Ernst reflects, “I haven’t experienced anything. It was just war all the time; how should a man have
experiences there?” before deciding that he “cannot talk” about such things (RB 66). There is a measure of socialization in this reflection – the question isn’t what could a man experience there, but what should he experience. The act of speaking with a person gives the speaker immediate feedback as to whether what was said is appropriate. The war was so disorganized Ernst can barely explain it to himself, let alone to others. What if his experiences were not the ones he should have had? He already knows that he was not the hero everyone believes soldiers to be.

In All Quiet, Paul has a similar conversation with his mother. When she asks if it was very bad out there, he thinks, “Mother, what should I answer to that! You would not understand, you could never realize it. And you shall never realize it. Was it bad, you ask. – You, Mother, – I shake my head and say: “No, Mother, not so very. There are always a lot of us together so it isn’t so bad”” (AQ 161). He realizes that there is something indescribable about the horror of the battlefield. Like Ernst, Paul does not ask himself what he can say, but rather what he should say – a soldier would instantly understand what it was like to be out there, but what does a civilian expect him to say? His answer is a literal break from the truth, illustrated by the dashes around the person he feels he must protect. Putting the horrors in plain language would make it too real to the both of them. It is best to keep the front as a “shadow…within [the soldiers themselves]” (RB 266-67).

Remarque’s soldiers experience particular distress around their mothers, a disturbance Remarque likely experienced himself. He was not able to speak with his mother who died in September 1917. His protagonists are 19, still boys who want comfort from their mothers. The war, however, has turned them into men and given
them the identity of soldiers. They therefore cannot explain their agonies to their mothers and feel increasingly isolated from the families that once brought them comfort. The mother’s presence now distresses them, reminding them that they are still young but irreconcilably changed – they do not wish to be soldiers around their mother, and yet they cannot be the boys the mothers think they still are.

This discomfort and alienation is evidenced by the use of descriptive language. Paul’s mother is very ill with cancer, which is perhaps why he wishes to protect her from knowing the details of his existence at the front. This plays into the dichotomy of physical and mental illness. Paul’s mother is visibly, physically suffering, and Paul is not. How can he burden her with his feelings of unease, his unnamed discomfort? Paul also does not wish to disillusion his mother, does not wish to make it clear that he is no longer the boy she raised. There is very little description of her, save that she is feeble and her “hands are white and sickly and frail” (AQ 159). In contrast, when she asks him if there is gas at the front, Paul thinks, “Should I tell her how we once found three enemy trenches with their garrison all stiff as though stricken with apoplexy? Against the parapet, in the dug-outs, just where they were, the men stood and lay about, with blue faces, dead” (AQ 161). The amount of detail put into the description of the aftermath of a gas attack makes the battlefield seem much more real than home. Home doesn’t have the same vibrancy the battlefield does, and that Paul feels as if he is in a dream there – the battlefield is his reality, and he identifies as a soldier, not a son.

Attempting to talk with his mother brings up troubling memories for Ernst as well, which puts a strain on their relationship. When she reproaches him for cursing,
he explains that all soldiers are like that. The look of pain on her face makes him realize that for her, he never was a soldier, never stopped being her child. Her assumption of his innocence makes him think of the atrocities he committed, almost as if his mind were trying to prove her wrong, and show him that she is no longer a source of solace.

My gaze drops from her hands to my own. In May ’17 I stabbed a Frenchman with these hands. The blood ran nauseatingly hot over my finger and in a panic of fear and of rage I stabbed again and again. And when the Frenchman, choking, clapped his hands to the wound, I could not stop myself, but stabbed through his hands too, till he sagged down like an emptying tube. And afterwards I vomited and the whole night through I wept. Only next day was Adolf Bethke able to comfort me (AQ 132).

This quotation makes it clear that only a soldier can comfort Ernst. Soldiers are the only ones who instantly know the context of such flashbacks, without requiring explanation of the conditions in the trenches. With them he can be part of a pack of soldiers, anonymous. They do not have to put their experiences into words, but they are also denied the chance to do so. His mother’s ignorance of the true content of war, and his inability to put her right, brings up more memories. He cannot believe that his mother is so caught up in the fact that he has become so coarse as to curse. He, who has killed men in cold blood.

Paul, at the end of his leave, set to return to the front, thinks to himself, “I ought never to have come [home]. Out there I was indifferent and often hopeless – I will never be able to be so again. I was a soldier, and now I am nothing but an agony for myself, for my mother, for everything that is so comfortless and without end” (AQ 185).
The bond between soldiers on the battlefield negates the need to explain their experiences to each other. In the trenches, leaving the horrible sights unarticulated allowed soldiers to survive. However, going home and trying to reconnect with family necessitated the explanation of battlefield experiences, something Remarque’s soldier-protagonists found themselves incapable of doing. To fully reintegrate into society, these antiheroes have to integrate their traumatic memories into their identities; make the unspoken spoken. This is part of the process of recovering from PTSD, the final step of which is meaning making. When this is accomplished, the sufferer is finally ready to find a purpose in his life stemming from his newly integrated identity and thus can move on from the trauma.

Meaning making is the process of finding a reason why the trauma is part of who you are – it is creating meaning for a new, post-trauma life. For example, a veteran may run a group for veterans, in order to help others conquer trauma as he has. As part of the final stage of recovery from PTSD, bonds with the community must be reestablished. For Remarque, this recovery came from writing his war novels. Ten years after the war was over, Remarque realized that his failure to communicate was taking a toll on his mental health and thus decided to write his story down. While he is writing both for the civilian and the veteran, he doesn’t explain himself or his feelings. He describes the battlefield, the home front; the way flashbacks come and go with no warning. By illustrating this illness he brings attention to the way soldiers were treated, and what society must grow to understand.

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36 Ibid. 209.
He is, in fact, teaching. Because there wasn’t a PTSD diagnosis at the time, Remarque uses his books to teach his readers about the silent battle former soldiers are fighting. He also points out, by showing the issues surrounding teaching, that the older generation cannot speak for this lost one – they do not understand and cannot prepare young men for the atrocities of war.

Writing creates a space between the storyteller and the recipient, bypassing the possibly negative civilian reaction to the soldier’s war experience. Writing allows Remarque to tell about the flashbacks he must have suffered without actually speaking about them. No value judgments are given when flashbacks occur; they are, in fact, unremarked upon by others (save when Ernst attacks the farmer) because he does not speak about them. The writer trusts the reader to integrate these symptoms into the full picture of the character. In writing, the full extent of the aftermath of trauma comes to light – these soldiers are not weak. It is apparent that they are trying to live as everyone else.

This type of writing has been found to be beneficial for coping with trauma, in that it helps to integrate the experience into a life narrative. Remarque calls this exercise of writing “self-analysis,” something that he did not do on the battlefield. Writing does seem to serve as an effective treatment for Remarque. By the end of The Road Back, Ernst still experiences memories of the battlefield, but they do not haunt him in the way they did before. Remarque learned to cope with his memories through the act of writing, and allows his character, Ernst, the same mental relief.

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37 Pennebaker and Chung, "Expressive Writing: Connections to Physical and Mental Health." 3.
In these novels, meaning making seems to be tied to teaching. Remarque himself was training to be a teacher before he was drafted into the army. He did not choose this career because of a deep passion for teaching, but rather because training to become a primary school teacher did not place any financial burden on Remarque’s parents, who were not well off. Meaning making can be realized through educating others: meaning can be found in fulfilling work.

Through the theme of teaching – the crux of which is explanation – Remarque shows how difficult it is for returning soldiers to make the unspoken spoken. Remarque’s characters are never allowed to speak in this way, in part because their role models were so flawed. These soldiers are not ready to explain themselves, and thus cannot pass on knowledge. Teaching is unbreakably linked to explanation, but how can these soldiers explain the wordless horror that was the trenches, especially if they cannot explain the unnamable illness that is plaguing them? If they are in a place that lacks words, how can they be expected to pass knowledge on to the next generation, especially when their teachers did so little for them.

Within the first 20 pages of All Quiet, the reader is introduced to Paul’s former life as a student, and how aggravating his teachers had been. Paul concludes from his school experience only that authority figures cannot be trusted and the bookish life has no bearing on the harsh realities of war. “During drill-time Kantoreck gave us long lectures until the whole of our class went…to the District Commandant and volunteered” (AQ 11). The teachers strong-armed their young students into signing up. Paul knows that his professors were only doing what they thought was best for him and his fellow students and that seeing them go to serve their country
filled the older generation with hope. “And that is why they let us down so badly” (AQ 12). The young men trusted their professors, who led them to their death, to the hell that is combat. “The first bombardment showed us our mistake, and under it the world as they had taught it to us broke in pieces” (AQ 13). The teachers represent a world that these men are forced to leave behind. It is a world in which they were allowed to be boys and to grow up slowly. “While they taught that duty to one’s country is the greatest thing, we knew that death-throes are stronger.” (AQ 13). This idyllic world is one the soldiers wish they could get back to, but as the story of Detering illustrated, to do so is dangerous. It leads to desertion or madness; overall it leads to shame and confusion.

A similar view of teachers is shown when Ernst, in *The Road Back*, goes back to school to complete his teaching degree. During his training, it is apparent that the professors’ romantic and naive view of war has not changed. Where they see heroes, the disillusioned soldiers see corpses, illustrating the distance between civilians and soldiers. For Remarque, teachers are just as out of touch as other civilians, but because they are teachers they have a greater responsibility to tell the truth. They instead give a positive reason for the struggle the soldiers reject. Confronted with a class that is much smaller than the one prior to 1918, the principal gives a speech, commemorating not only those men who fought, but also the souls who were left behind the lines. “Sometimes perhaps it has been harder for us than for our brave lads in field out grey yonder,” he says, claiming the war was hardest on civilians, a stance Remarque thinks is divorced from reality. The principal’s voice turns solemn as he implores his audience to remember the “heroes who have found rest…under foreign
soil and sleep the long sleep beneath the green grasses.” He is interrupted by laughter and corrected. “In the mud of shell holes they are lying, knocked rotten, ripped in pieces, gone down into the bog – Green grasses!” exclaims one of the students (RB 112-13). This naïveté is insulting, especially given that these are the men whose role it is to prepare children for the world.

Ernst’s inability to be the person he was before, and his puzzlement about what he can do to fix himself, change his outlook on the world. He feels guilty and dirty, “polluted,” (RB 232) in a way that would now be seen as a symptom of PTSD. At the same time, feelings of shame overwhelm him, and he realizes that he cannot do his job. “How then should I presume to teach you?” he wonders to himself, contemplating his students. “Behind me, still pursuing, are the bloody years – How then can I venture among you? Must I not first become a man again myself?” (RB 232) The memories that plague Ernst remind him of his identity as a soldier, and the violence that that entails. He feels that he lost something in him that made him human, and before he can go back to life as it was, he must somehow regain humanity. Moreover, he cannot teach these children – it is too much responsibility for someone so damaged, who has seen too much of the world. He dismisses the class, quits his job and goes home that day (RB 233).

This decision to leave teaching is part of Ernst’s recovery: he is able to gain some insight into himself. “One part of my life was given over to the service of destruction…. But life remained in me. And that in itself is enough, of itself almost a purpose.” He goes on to think that “it is enough that I work to dig out again what was buried during the years of shells and machine guns” (RB, 311). Remarque keeps what
these things are purposefully vague – Ernst can both dig out and deal with his memories, and the landscape of Germany. He does not need to be a pioneer, but rather to help others and himself where he can. With this realization, the past does not plague him anymore (RB 312). Similarly, Remarque himself does not need to be a pioneer or a literal teacher, but he, as an author, can teach through writing. Through describing and organizing his symptoms, he has helped both himself and others identify what might be wrong.

Remarque’s interconnected novels *All Quiet on the Western Front* and *The Road Back* create a striking portrait of a psychologically wounded soldier. His books demythologized the battlefield and destroyed the notion of the hero-soldier, making Remarque one of the first novelists to describe the psychological reality of the battlefield. Remarque’s fictional depictions of his own post-war symptoms capture the disorder now known as PTSD and the difficulties soldiers experience when trying to rejoin the civilian world. Writing helped the author to integrate his memories and these books end on an optimistic note, showing that with proper treatment, war neuroses can be overcome.
Chapter Three

The Impact of the Unspoken

This chapter will focus on Virginia Woolf’s novel *Mrs. Dalloway* (1925), in which she sketches a character, Septimus Warren Smith, who suffers from a form of trauma that I argue we would now recognize as PTSD. Septimus is indeed a casualty of WWI, like Remarque’s protagonists, but Woolf’s interest in Septimus may stem from her own domestic trauma that resulted from losing her mother at a young age, and psychological problems that we would now likely recognize as bipolar disorder. While the previous chapter examined soldiers who, like their author, were able to conquer their trauma through self-examination, Woolf’s character Septimus is unable to express himself and examine his trauma. In portraying Septimus, Woolf is reacting to – and rejecting – the prevailing wisdom and ideology that governed treatment of mental health patients in the interwar years. She also writes to legitimize a patient’s suffering as a reaction to loss that is shared by men and women, healthy and sick alike.

Woolf saw her personal struggles reflected in the mentally afflicted soldiers who were trying and failing to reenter society. At the time, her bipolar disorder would most likely have been labeled “neurasthenia,” one of the acceptable diagnoses for women. During the war, soldiers with similar symptoms would have been considered victims of shell shock. Woolf herself suffered many bouts of “nervous breakdowns,” the first of which occurred after her mother’s death, when she was 13.\(^{38}\) Writing about it almost forty-four years later, she describes herself in that time as feeling “nothing

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whatever.” ³⁹ This lack of emotion clearly affected Woolf deeply, and she described herself as “obsessed” with the presence of her mother – an obsession that only would subside when Woolf wrote about her in To the Lighthouse (1927). ⁴₀ Much like Remarque says when writing about his war experiences, Woolf says, “I suppose that I did for myself what psycho-analysts do for their patients. I expressed some very long felt and deeply felt emotion. And in expressing it I explained it and laid it to rest.” ⁴¹

Woolf developed an intense scorn for doctors and their practice and Mrs. Dalloway clearly contains a critique of psychiatric medicine. Woolf’s symptoms intensified to the point where she was put into the care of Sir George Savage, an eminent psychiatric doctor, and Violet Dickinson, who became a close friend. Woolf was often prescribed a rest cure, during which she was not allowed to write or read, the opposite of what she later realized she needed. To address the inadequacy of her care and the demeaning way those afflicted with mental problems were treated, Woolf wrote many of her own symptoms into Septimus Warren Smith. During her time with Dickinson, she hallucinated birds singing in Greek, a symptom Septimus also displays. Woolf’s reaction to her mother’s death is mirrored by Septimus’s reaction to his friend’s death and his symptoms flow from the fact that he didn’t feel anything when Evans died. During this time, Woolf also attempted suicide by jumping out a window, as Septimus does, but her window proved to be too low to be fatal. ⁴² By giving Septimus so many of her own qualities, Woolf makes it clear that

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⁴⁰ Ibid. 80.
⁴¹ Ibid. 81.
⁴² Whitworth, Virginia Woolf. 10.
for her, trauma is above all caused by loss, and the reaction to loss, both at home and on the battlefield.

*Mrs. Dalloway* takes place in London over the course of a single day in June. It focuses on Mrs. Clarissa Dalloway, an upper class woman preparing for a dinner party and her counterpoint, the middle-class veteran Septimus Warren Smith who suffers from war neuroses.\(^43\) Though their lives are totally separate, both characters are caught up in unresolved memories from the past. While Clarissa is able to integrate her remembrances into her present life, Septimus is tortured and driven to suicide by his. He is plagued by memories of his best friend, Evans, who died on the battlefield and suffers because he is unable to articulate why and how this man meant so much to him. To acknowledge the depth of feeling would be taboo in proper society and he thus represses his feelings.

Clarissa, along with the doctors who treat Septimus, is a representation of the interwar English society for whom Septimus is an unwelcome reminder of the carnage of war. Her dinner party is the epitome of the class system that began to fall apart in the trenches, but that she and the doctors maintain through social gatherings for the upper-class and diagnoses for the war-ravaged. Septimus’s wife, Rezia takes him to see Sir William Bradshaw, an eminent nerve specialist. Bradshaw immediately recommends Septimus be institutionalized. Back at their house later in the day, another doctor, Dr. Holmes, visits the Warren Smiths. Rather than see this doctor and face his judgment, Septimus commits suicide by jumping out a window. Sir William

nevertheless goes to Clarissa’s party, though he arrives late. His wife explains that they were delayed because one of his patients, a veteran (Septimus) has killed himself.

**Trauma and Taboo Relationships**

The previous chapter examined the problems soldiers face when they are seen as both hero and antihero; Woolf brings to light how soldiers who broke down were labeled as weak. Woolf was aware of the stigma that went along with mental illness, having been a patient herself. She rejected the notion that men who broke down were cowards and that cowardice is “effeminate.” Rather, she examines the force of trauma on both men (Septimus) and women (herself) and in doing so, shows that it is not feminine qualities that cause breakdowns, but rather stoic responses to death and feelings whose expressions are discouraged by society. Woolf makes it clear that many of Septimus’s symptoms stem from the fact that the intensity of his relationship with Evans would have been frowned upon by society. For that reason, he cannot allow himself to think about it, nor to integrate the memory of Evans’s death into his life story, mitigating his trauma.

Septimus displays many symptoms of what we would now call PTSD, but which would not have been accepted as symptoms of illness at all in Woolf’s time. Septimus’s stoic response to Evans’s death would now be referred to as peritraumatic dissociation, a feeling of unreality at the moment of trauma. For Septimus, this was experienced as a numbness that does not go away, though he is proud of his dearth of feeling at the time (86). Because society would not understand
his relationship with Evans, Septimus cannot talk about it, his constrictive symptoms
manifesting in his inability to speak at all. A paper from Hammer et al. (1999)
estimated that between 30-40% of patients with combat-associated PTSD develop
psychotic symptoms, such as visual hallucinations and delusions; all of these
symptoms occur in Septimus’s case. His intrusive symptoms are mostly visual
hallucinations of Evans appearing to him from the dead. Septimus is constantly on
alert, part of his hypervigilant symptoms. Finally, he attempts to avoid his thoughts of
going mad, as well as Dr. Holmes, who becomes the representative of human nature
for Septimus – his ultimate judge who cannot understand his plea (92). These
symptoms will be discussed through the lens of guilt: Septimus’s guilt at being unable
to mourn his friend and the guilt that society presses upon him with its rigid gender
and class delineations.

Woolf provides background on Septimus’s life before the war, showing a
passionate, hard-working idealist who finds his identity on the battlefield. As a young
man Septimus moved to London by himself. He found a job at “Sibleys and
Arrowsmiths, auctioneers, valuers, land and estate agents” (85). There he fell in love
with Miss Isabel Pole, though she ignored his advances. His boss predicted that in ten
or fifteen years Septimus would be running the company, but the war changed those
plans. “Septimus was one of the first to volunteer. He went to France to save an
England which consisted almost entirely of Shakespeare’s plays and Miss Isabel Pole
in a green dress walking in a square” (86). This is an England filled with love,
promise and great works of writing, things that seem beyond Septimus’s

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comprehension when he returns. From this rather bookish portrait of a youth, Septimus becomes a man in the trenches. “[H]e developed manliness; he was promoted; he drew the attention, indeed the affection of his officer, Evans” (86). They are inseparable and it is through this friendship, shaped by the military atmosphere, that Septimus finds his place in the world.

Woolf rejects the notion that Septimus developed symptoms because he was effeminate. She blames society’s rigid gender roles that dictate that one man cannot have deep feelings for another as the wellspring for his distress. To admit the intensity of the attraction between him and Evans would undercut the manliness Septimus acquired in the army. “They had to be together, share with each other, fight with each other, quarrel with each other.” The bond between soldiers on a battlefield goes deeper than friendship and for Septimus, deeper than his relationship with his wife. When Rezia met Evans, she thought of him as “‘a quiet man’… undemonstrative in the company of women” (86). Septimus knows that he couldn’t explain this relationship to a civilian, because in the civilian world there is no room for what meant so much in the trenches. He is therefore unable to put into words what, exactly, his closeness to Evans meant. To care for Evans would make him weak, something Septimus rejects.

Septimus’s symptoms thus are seen to spring from his stoic reaction to Evans’s death. His reaction is exactly what he expects of himself, because society has dictated that men do not display emotion.

But when Evans…when Evans was killed, just before the Armistice, in Italy, Septimus, far from showing any emotion or recognising that here was the end of a friendship, congratulated himself upon feeling very little and very reasonably (86).
Septimus is proud of his manliness – to mourn for Evans would have made him seem weak, the kind of feminine man who breaks down, not the brave man he has become. He does not let himself recognize the end of a friendship, or process this event and therefore is unable to let it go later on. At first he is happy. “The War had taught him. It was sublime. He had gone through the whole show, friendship, European War, death” without a scratch (86). But the identity acquired in the army, so bound up in Evans and being a man in general, makes it impossible for Septimus to go back to life as it was. To mourn, he must admit that his bond was more meaningful than he realized; he must admit that he is going mad because he cared for a man. In addition, to acknowledge the loss would be to examine the full scope of the horrors of war, something Septimus cannot allow himself to do. In fact, besides Evans’s death, Woolf provides no details of Septimus’s war experience as he has so thoroughly blocked it out.

However, the loss of his relationship with Evans remains unresolved and guilt-imbued visions of Evans haunt Septimus. Evans’s presence is the harbinger of disturbing memories and visions. “There was [Septimus’s] hand; there the dead. White things were assembling behind the railing opposite. But he dared not look. Evans was behind the railing!” He knows that Evans is dead, but his hallucination is so vivid he believes the dead man is coming for him. He immediately feels the need to flee from the gathering specters. “[T]hey must get away from people, he said [to Rezia] (jumping up)” (25). When Septimus feels Evans’s presence, he sees flames. For example, in the middle of dictating what he hallucinates Evans is saying, Septimus “would cry that he was falling down, down into flames!” (140-41) How
Evans died is never specified, but it is possible that flames were involved. Septimus also immersed himself in Dante after he returned from the war, perhaps making the flames into the Inferno itself – an association he makes but cannot express to others, or fully to himself. The crime of his stoic reaction at his friend’s death became the ironic punishment of an inability to feel.

War trauma, for Septimus, thus manifests itself as a problem of communication. Above all, Septimus wants Rezia to understand, and to help him understand, the message he feels he must communicate to the world. His inability to express himself is distressing to Septimus because “Communication is health; communication is happiness” (93). This phrase, which Septimus mutters to himself, reflects both Woolf’s views and the reason for his illness – he is unable to explain the impact of Evans’s death and therefore cannot process and integrate this trauma. Septimus scribbles notes on pieces of paper, or has Rezia write down what he dictates, but he is never able to get to the core of the truth because his relationship with Evans remains unacceptable to him and society (140). What he can write is incongruous: messages that reveal the beauty of the world. “[F]irst that trees are alive; next that there is no crime; next, universal love” (67).

The shame Septimus feels towards himself stems directly from his reaction to Evans’s death. It drives his belief that the world is bad and that he is unworthy. Septimus thinks to himself, “[H]uman beings have neither kindness, nor faith, nor charity beyond what serves to increase the pleasure of the moment…. They desert the fallen” (89). Septimus himself is all too human. Being unaffected by his friend’s

death gave Septimus pleasure, at the time. But he realizes that his inability to mourn is a form of desertion. “He had not cared when Evans was killed; that was the worst; but all other crimes raised their heads and shook their fingers and jeered… at [his] prostrate body which lay realising its degradation… and was so pocked and marked with vice that women shuddered when they saw him in the street” (91). Semptimus hallucinates that his self-declared crime is ruining his body, an echo of the rest cure that Sir William will prescribe for him. According to the doctor, the only way to become better is to gain weight: fixing the body to fix the mind (99).

Septimus often finds himself at the edge of being able to put his message into words, but is unable to express his guilt to his doctors, the personifications of social mores. He is aware of “this gradual drawing together of everything before his eyes, as if some horror had come almost to the surface,” (15) but it slips away at the last moment. He believes his message is important, destined for the men who run the country, who decided to engage in the war. When he is given the chance to communicate with Sir William, Septimus finds himself unable to remember what he must say. Though his message is again one of peace and “universal love,” (67) it becomes a confession to an unknown crime. At the moment when he must communicate, Septimus is overcome by guilt. “But if he confessed [to the doctor]? If he communicated? Would they let him off then, his torturers? … But what was his crime? He could not remember it…. what was his message?” (98). At the crucial time when he can admit his guilt – that he did not feel when Evans died – Septimus is unable to organize his thoughts and communicate.
His confusion is increased by the fact that his socially acceptable relationship, his marriage, is not as meaningful to him as Evans was. Septimus is unable to relate to his wife. The soldier married Rezia to seek refuge from the unrelenting numbness, to attempt to have a meaningful relationship that would be accepted by society. He needs Rezia to be a distraction from his inability to feel. He met his wife in Italy when he was stationed there, and felt that her joy in life gave him a refuge against his numbness (86). He asked Rezia to marry him to take this shield with him when he returned to England. However, because he cannot let himself explore his feelings towards Evans, he is unable to relate to Rezia. “His wife was crying, and he felt nothing; only each time she sobbed in this profound, this silent, this hopeless way, he descended another step into the pit” (90).

On occasion, he is seen to fight against his madness that also manifests as an overwhelming recognition of the beauty of the world. Without Rezia physically holding him down by placing her hand on his knee, the “excitement of the elm trees rising and falling, rising and falling… would have sent him mad. But he would not go mad. He would shut his eyes; he would see no more” (22). These symptoms come to a head when Septimus interacts with Dr. Holmes, the aforementioned representation of humanity. With this connection, Woolf implies that humanity at large believes there is nothing wrong with Septimus, he is choosing to be ill. Instead of helping him, Dr. Holmes’s advice feeds his paranoia. “Once you stumble, Septimus wrote on the back of a postcard, human nature is on you” (92). When Holmes comes to visit him, Septimus is overcome with fear that humankind will finally get him, and sentence him to death (91). In his ultimate act of avoidance, Septimus decides to kill himself.
rather than see Holmes. He jumps out the window, impaling himself on the railing below (149).

The War Office Committee and Treatment

Woolf’s discussion of the medical treatment Septimus receives should be examined against the background of the common knowledge about shell shock and its treatment when Woolf wrote Mrs. Dalloway. Woolf rejects the prevailing method of mental health treatment and paints her doctor characters in an arrogant light for believing so whole-heartedly in these guidelines. As we’ll see, Woolf’s portrait of Septimus’s treatment shows the futility of the methods prescribed by the War Office Committee and the damage done by the denial of his symptoms.

By 1916, the shell-shocked soldier had become a virtual cliché in the English press and continued to be in the news throughout the war.46 After the war, the War Office Committee attempted to find a standardized way to approach this growing problem and formed a committee for enquiry into shell shock. The resulting report was issued in 1922, but their conclusions show how out of touch medicine was with the needs of the soldier. The War Office Committee seemed to think that the Great War had been a test of morale and many of the soldiers had failed. Moreover, many of the sufferers were assumed to be malingerers.47

The Committee established that the phrase “shell shock” was a misnomer. It implied that the damage was caused by the concussive force of a shell exploding near

47 Ibid. 244.
the victim and damaging his spine or brain. This, they reasoned, was the cause of very few of the cases of war neuroses. The more troubling cases were due to “emotional disturbance,” broken down into two categories: exhaustion, and the loss of control of the nervous system.\textsuperscript{48} Officers were more prone to nervous exhaustion (neurasthenia) while enlisted men in the ranks lost control (hysteria) symptoms of which included physical twitches or mutism, as discussed in Chapter One. It was not the war that caused breakdowns, the committee suggested, it was men from inferior families who were predisposed. “Among general predisposing causes” of emotional shell shock in the ranks “were racial characteristics, education and social conditions and environments.”\textsuperscript{49} Some doctors who testified for the Committee declared that lower-class recruits suffered because of the horses used by the army. “They had never had anything to do with horses in civil life. They did not know one end of a horse from the other, and they were put to attend them and ride them.”\textsuperscript{50} Thus out of their element, their nervous constitution caused them to lose control. Furthermore, “a large number of men who two or three years after the war were still suffering from “shell-shock” symptoms were said to be bordering on lunacy before” the war began.\textsuperscript{51}

Shell shock was tied up in the notion of cowardice. In the section entitled, “Cowardice and Shell-Shock,” the Committee sought to discriminate between cowardice and the inability to do one’s duty brought about by war neuroses. Cowardice was a failure of willpower, of character, and if a soldier deserted due to cowardice, he was sentenced to death. The Committee, however, was unable to come


\textsuperscript{49} Ibid. 96.

\textsuperscript{50} G.C.B. Lord Southborough, "Shell-Shock," \textit{The Living Age} 315(1922). 73.

\textsuperscript{51} Committee, "Report of the War Office Committee of Enquiry into “Shell-Shock”." 50-51.
up with a clear definition of cowardice, noting that an expert was needed to
differentiate it from genuine mental breakdown.\textsuperscript{52} They could not define cowardice as
a mental disorder because, as a contemporaneous journal article says, “[t]he
admission of such a plea might possibly involve the disappearance of the discipline
and control of an army.”\textsuperscript{53} Regardless, the Committee was clear that loss of “nervous
or mental control” does not provide an honorable escape from the battlefield.\textsuperscript{54} It did
acknowledge that some of the soldiers punished for desertion at the beginning of the
war may have been suffering from shell shock and were not the effeminate, cowardly
men they had been assumed to be. Overall, the Committee recommended better
military training and screening as a way to prevent war neuroses, paying little heed to
the psychological trauma that has since been recognized as the cause of PTSD.

The doctors on the Committee subscribed to somatic theories of mental
illness, as do Woolf’s doctors. In other words, they understood the cause of shell
shock to be physiological, offering opportunities for medical precision, as opposed to
the “muddled categories of what was then called ‘emotional’ shell-shock.”\textsuperscript{55} Even if
the shell shock was emotional, it was thought that the best way to treat it was through
the body. The Committee therefore recommended a type of therapy that would focus
on physical care and include minor analysis. The patient should rest, allowing the
exhausted nervous system to recuperate and the “pathological” and “subjective
outlook” of the shell-shocked patient would be replaced by “a normal and objective

\textsuperscript{52} Ibid. 140.
\textsuperscript{53} Lord Southborough, "Shell-Shock." 72.
\textsuperscript{54} Committee, "Report of the War Office Committee of Enquiry into ‘Shell-Shock’," 190.
\textsuperscript{55} Bogacz, 'War Neurosis and Cultural Change in England, 1914-22: The Work of the War Office
Committee of Enquiry into 'Shell-Shock'." 240.
In addition to resting, the patient would be given a rudimentary bout of psychotherapy, consisting of explanation – the patient was told that he could be cured with his cooperation; suggestion helped reinforce his efforts by telling him that he was improving. Reeducation was the new zeal for social and civic duties the doctor helped the patient find. Finally, occupation – i.e., keeping the patient continually occupied during the process of reeducation – would be implemented to prevent brooding. The hospital staff must “construct a line of least resistance, so far as the patient is concerned, i.e., that of voluntary acquiescence.” In other words, if after all this the patient does not improve, it must be because he chose not to.

Woolf critiques the types of treatment recommended by the War Office Committee through her representation of Dr. Holmes and Sir William. Both employ facets of this treatment, putting very little emphasis on analysis. Instead of looking for the mental causes of symptoms, they concentrate on fixing the behavior. They believed that those suffering from shell shock had something off in the balance between their mind and their body. Dr. Holmes uses explanation to tell the Warren Smiths that there is nothing that can’t be fixed as long as Septimus cooperates, because, as Holmes says, “health is largely a matter in our own control” (91). Holmes believes Septimus is deciding to act this way by refusing to take an interest in things outside himself (21). He reminds Septimus of his place in society, asking him, “Didn’t one owe perhaps a duty to one’s wife?” (92) The utter ridiculousness of this treatment is made clear in Septimus’s thoughts: he is so overcome by trauma he can barely function, but the doctor never inquires about his mental state.

57 Ibid. 131.
To underscore the point that the patient himself has nothing to do with his diagnosis or treatment, Sir William Bradshaw diagnoses Septimus as soon as he lays eyes on him. “[H]e was certain directly when he saw the man; it was a case of extreme gravity. It was a case of complete breakdown – complete physical and nervous breakdown, with every symptom in advanced stage, he ascertained in two or three minutes” (95). The immediacy of diagnosis is alarming. Bradshaw doesn’t ask his patient a single question, though he does ask a few of Rezia (96). As discussed above, mental and physical states were inseparable and to treat the brain, you must treat the somatic processes. Sir William deplores Dr. Holmes’s method of explanation (95). He recommends that Septimus be put in a sanatorium under his care where they will “teach [him] to rest” (97).

Woolf’s portrayal of Sir William Bradshaw as a pompous fool who cares more about his renown than his patients makes it obvious that she detested this rest treatment, based on her own experiences as a mental patient. This rest cure was the treatment for women with neurasthenia before the war, most likely similar to the treatment Woolf went through when she was put in the care of a physician, the kind that she was in when World War I broke out. Bradshaw is a proponent of the social Darwinist view that was popular at the time. He is aware that those who still suffer from war neuroses three years after the war are likely afflicted by “lack of good blood” (102) and that there isn’t much he can do for them, besides try to “convert” them to be like him (100). “Sir William not only prospered himself but made England

59 Whitworth, Virginia Woolf. 170.
60 Ibid. 18.
prosper, secluded her lunatics, forbade childbirth, penalized despair, made it impossible for the unfit to propagate their views until they, too, shared his sense of proportion” (99). These soldiers are blights on society and Sir William a hero for removing them. Thus secured away, the patient would finally learn that what he felt on the inside was a moral failing, a lack of control. Through emulating the respectable doctor, he would be fixed. Sir William states that these men are sick because they have lost their sense of proportion and what they need is “rest in bed; rest in solitude; silence and rest; rest without friends, without books, without messages; six months’ rest; until a man who went in weighing seven stone six comes out weighing twelve” (99). Though Septimus feels that his sins are making his body waste away, (91) Woolf makes it clear that this treatment wouldn’t help him.

Septimus ultimately does not go the sanitarium. Rezia takes him home, displeased by Dr. Bradshaw’s claim that he must be away from loved ones in order to get better (96). Once there, visions of Bradshaw and Holmes haunt Septimus. They become judges deciding on the sentence for the crime he has committed, the crime of not being able to feel (148). It is at this inopportune time that Holmes comes to pay them a visit and when Rezia goes downstairs to waylay him Septimus realizes death is the only way out. He goes through many options before deciding on the

[R]ather melodramatic business of opening the window and throwing himself out. It was their idea of a tragedy, not his…. Holmes and Bradshaw like that sort of thing. (He sat on the sill.) But he would wait until the very last moment. He did not want to die. Life was good. The sun hot. Only human beings – what did they want? … Holmes was at the door. “I’ll give it you!” he cried, and flung himself vigorously, violently down on to Mrs. Filmer’s area railings (149).
For Woolf, death is better than treatment in an asylum, being shut up and not allowed to do anything. It is also better than being told that your symptoms have no meaning. Though Septimus admits that it is a “rather melodramatic” exit, it is the only way to get his message to mankind and to absolve his guilt. Clarissa Dalloway learns about his death (though he is identified as an unknown soldier) during her dinner party, the culmination of the book. She thinks to herself, “[d]eath was defiance. Death was an attempt to communicate” (184). Death is the only form of communication that allowed Septimus to be heard clearly. His message is received by Clarissa, a representation of the society that oppressed him. It is a message that condemns the society that could not recognize his loss and so could not help him recover from it.
Chapter Four
A Modern Take on War Neuroses

PTSD became a diagnosis in the DSM-III in 1980. To illustrate the impact the PTSD diagnosis had on the narrative of war neuroses in fiction about World War I, this chapter will focus on Pat Barker’s 1991 novel Regeneration. Set in 1917 at Craiglockhart War Hospital, Barker’s novel intertwines fact and fiction to talk about the treatment of mentally unsound soldiers during the Great War. PTSD was gaining traction and legitimacy at the time she was writing, illustrated by the fact that Judith Herman’s Trauma and Recovery was published the following year (1992).

If we can judge from Barker’s novel, knowing the diagnosis translates into clear, if not reductive causes portrayed in the fictional rendering of symptoms and an contributes to an overall simplicity in the writing. Barker gives her characters a clear narrative arc that is lacking in the novels from the interwar years, and the symptoms themselves are treated differently. But Barker also explores how writing can help a victim of trauma integrate a traumatic experience – as was discussed in the previous two chapters – by illustrating the efficacy of the talking cure. Barker picks and chooses what she wishes to include about her doctor characters, Rivers and Yealland, showing the former as a prophet of modern medicine. We will also see, however, that in doing so she simplifies history by leaving out important facts about each of the doctor’s ideologies.

Regeneration revolves around the historical meeting of the historical figures Sigfried Sassoon and W.H.R Rivers. Sassoon, a war hero turned pacifist, is sent to Craiglockhart because his refusal to fight is seen as a mental and moral disorder. In
July 1917, Sassoon sent a letter entitled *Finished with the War: A Soldier’s Declaration* to his commanding officer, expressing his distaste with how the war was proceeding, and saying that he believed it should end. Though he hoped to be court-martialed, Sassoon is instead sent to Craiglockhart. He is put into the care of RAMC captain William Halse Rivers, an anthropologist who uses the relatively new and uncommon Freudian techniques on his patients. In Rivers’s posthumously published book, *Conflict and Dreams*, Sassoon is referred to as Patient B. Barker most likely chose to focus on Rivers’s work because he used modern psychoanalytic techniques.

Barker places Billy Prior, a fictional character who is not based on Rivers’s case studies, within this framework of history. Prior, a textbook hysterics, comes to Craiglockhart unable to speak or to remember what happened to him. His constriction both protects and damages him, and Prior cannot get better until he finds his words and integrates his traumatic experience into his life. True to the time in which she is writing, Barker decides to show that this hysteria was, in fact, PTSD. Barker portrays the symptoms as stemming directly from a traumatic event and Rivers cures him using psychotherapy—helping him find the words to process his experience. Siegfried Sassoon is able to do this through writing poetry. Some of his writing is included in the book to show that he dealt with his war experiences by writing about them. Processing his surroundings makes Sassoon all too aware of the damaging effects of war, to the point of becoming a pacifist.

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These reality-based cases illustrate the way issues of mental breakdown were tied to pacifism and highlight WWI-era treatment for war neuroses. Rivers uses the talking cure and Yealland used electroshock on his patients, though he believed many were malingering. Barker also discusses the issue of masculinity and the stigma of cowardice attached to soldiers who break down.

**Remarque, Woolf and Barker**

Barker says that she wrote *Regeneration* because she had always wanted to talk about her step-grandfather’s war experiences – he had a bayonet wound but refused to discuss what he had been through. Remarque and Woolf, on the other hand, lived through the war itself. These authors knew that there was something wrong within themselves and their soldier-protagonists, but were never given a formal diagnosis or proper treatment. Their characters are confused, if not unsure if there is anything actually wrong with them. No one can guide them through their psychological struggles. While Remarque and Woolf based their character’s trauma on their own experiences with trauma and loss, Barker took a historical approach, structuring her novel around the poets Siegfried Sassoon and Wilfred Owen, in addition to W.H.R. Rivers. It was obvious to her that the poets had suffered from PTSD; she saw it in their work. By fictionalizing the events concerning the poems and case studies, she created a portrait of the psychologically wounded soldier in a way that those living at the time could not.

With the benefit of the PTSD diagnosis, Baker gave her soldiers the complete and cohesive storylines they lacked in Remarque and Woolf. Writing in 1990s,
Barker saw the emergence and legitimization of the PTSD diagnosis, and she makes it clear that Rivers can and will cure his patients by listening to them, giving them the narrative arc of identifying their past trauma, dealing with their present symptoms and working toward an integrated and mentally healthy future. Barker’s purely fictional character, Billy Prior, is an example of this arc that begins as his traumatic symptoms surface. He is brought to a good doctor, the doctor helps him identify and integrate his trauma and in the end, Billy is cured. This character is what places the book squarely in the *Trauma and Recovery* era, the era of understanding of and approach to a cure for PTSD. Prior is the most obviously shell-shocked of all of the soldiers Barker discusses. He comes in displaying hysterical mutism and amnesia, but with Rivers’s therapy and after finding a community, Prior is able to move on, showing that Rivers was correct in his method of treatment.

As we saw in the first chapter, during World War I, war trauma went by many different names with overlapping symptoms and cures were inadequate at best and cruel at worst. Remarque and Woolf were aware of this and thus their writing is tinged with the fear of the stigma of war trauma. Their soldier-protagonists therefore do not willingly seek help – they avoid doctors at all costs – and are denied the cure Barker’s characters are guaranteed. Remarque and Woolf suffered from this misunderstood illness and thus their stories about soldiers are a reflection of trauma in that they lack a definite narrative arc, mirroring the confusion regarding war neuroses during the WWI era. Their novels lack a definitive time scale – the soldiers are subject to flashbacks and the writing often changes tenses, making the trauma seem to
be in the eternal present. Barker’s characters are granted a world with structure, where traumatic symptoms can be identified and treated.

While Remarque and Woolf were trying to sort out their pasts to in order to critique the present, Barker’s book keeps a clear eye on the future. She focuses on the meeting between Sassoon and Owen, discussing how Sassoon helped Owen with his poetry. Owen worshiped Sassoon as a hero, and wrote to him after being discharged from Craiglockhart that Sassoon “had fixed [his] life – however short,” and of course influenced his poetry.62 Owen’s and Sassoon’s war poetry is still being read and is still influential, so it makes sense that Barker would emphasize their meeting. It follows that she would arrange her book around Sassoon’s doctor, one of the few to use Freudian methods that are similar to what is recommended to treat PTSD today. Though set in 1917, Barker’s novel is obviously a modern one.

**Masculinity and the War**

While Dr. Lewis Yealland – the character and the historical person – believes that men who break down were naturally predisposed to their illnesses, Rivers thinks the war is at fault. “[P]rolonged strain, immobility and helplessness [in the trenches]… did the damage, and not the sudden shocks or bizarre horrors that the patients themselves were inclined to point to as the explanation for their symptoms.” This also explains why women suffer from hysteria in peacetime, Rivers surmised, “since their relatively more confined lives gave them fewer opportunities of reacting to stress in active and constructive ways” (222). Rivers here echoes Woolf’s position

that trauma is shared among men and women. His view implies that the nature of the war is at fault for this damage, not the men’s heritable traits.

Craiglockhart, the setting for *Regeneration*, is near Edinburgh, Scotland, away from the fighting at the front. It is this distance that allows the more abstract conflicts about the war to come to the surface, including conflicts concerning masculinity. The book opens with Sassoon’s letter in protest of the war, which is what causes him to be sent to Craiglockhart. Though a brave and decorated soldier, this act of pacifism is judged to be a symptom of war neuroses: refusing to fight was seen to make him morally weak and in need of fixing. This issue of masculinity is complicated by the fact that Sassoon was gay, though this isn’t necessarily public knowledge. Rivers’s experimental treatment is a type of redefining of masculinity – in order to heal his patients, he encourages them to stop being stoic and to allow themselves to accept their reactions to traumatic events. Notions of masculinity condemned cowardice, which was tied to pacifism, homosexuality and breaking down. In *Regeneration*, Barker shows that all soldiers feared being stigmatized in this way and paints Rivers as a visionary who sees beyond these labels to the correct way to treat a shell-shocked soldier.

During World War I, English society required men to go forth and serve faithfully, without questioning their orders or their country. The sons who avoided sacrifice therefore were not proper men within the context of wartime codes of masculinity. Sassoon is a perfect example of the reaction to deviation from these norms. In his *Declaration*, the poet states that he is acting on behalf of all soldiers.

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They have been deceived by the government. He writes “that this war, upon which [he] entered as a war of defense and liberation, has now become a war of aggression and conquests.” He no longer wishes to help the government prolong the suffering of the troops. “[He is] not protesting against the conduct of the war, but against the political errors and insincerities for which the fighting men are being sacrificed” (3).

Because Sassoon is against the government, against all of England, the under-secretary for war believes that there must be something wrong with his nerves.64 Instead of being court-martialed, as he expected, he is sent to Craiglockhart where it was the war doctor’s duty to convert a patient from his pacifist error into a war-ready machine (178). Though Rivers surmised that there was nothing wrong with the poet, an effort had to be made to induced Sassoon to fight again (15).

Homosexuality and pacifism were punishable as crimes against country and crimes against nature, and Sassoon is regarded as guilty on both counts. The fear of being labeled as homosexual is underscored by the complicated nature of the relationships men form in the trenches, the type of relationship Septimus and Evans had, which Septimus could not let himself mourn.

“After all, in war you’ve got this enormous emphasis on love between men – comradeship – and everybody approves. But at the same time there’s always this little niggle of anxiety. Is it the right kind of love? Well, one of the ways you make sure it’s the right kind is to make it crystal clear what the penalties for the other kind are” (204).

Rivers says this in conversation with Sassoon after Sassoon has decided to serve again. To refuse to do so would be foolish, because there’s a black book going around “containing the names of…eminent people whose private lives might make their

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loyalty to their country suspect” (204). Both homosexuality and pacifism were seen as moral failures and an active stand against England. Sassoon insists, however, that his sexuality has nothing to do with his pacifism (54).

Perhaps because he knows he is gay, Sassoon is able to separate his relationship to men and to his country. Many of the soldiers under Rivers’s care, however, have been grappling with conflicting feelings about their relationships with the men in their platoons. The view that men cannot have deep feelings for other men is ingrained in English society and the soldiers’ notions of masculinity are at odds with their need to form intense relationships with other men in the trenches. Society ultimately proves oppressive and repressive. Rivers reflects,

One of the paradoxes of the war…was that this most brutal of conflicts should set up a relationship between officers and men that was…domestic. Caring….maternal…. The war that had promised so much in the way of “manly” activities had actually delivered “feminine” passivity, and on a scale their mothers and sisters had scarcely known. No wonder they broke down (107-8).

The conditions of the trenches caused behaviors conventionally regarded as unbecoming of manliness. The men in Craiglockhart worry about their sanity because of the feminine roles they played on the battlefield, or because of their shame in being cast as the “types” who break down – their manly undoing.

To treat these men, Rivers encourages the examination of their feelings, a sharp contrast to Sir William Bradshaw in Mrs. Dalloway, who tells Septimus not to think so much about himself.65 Rivers recognizes the emotional stunting the men have been raised with. “They’d been trained to identify emotional repression as the essence of manliness. Men who broke down, or cried, or admitted to feeling fear, were sissies,

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65 Woolf, Mrs. Dalloway. 98.
weaklings, and failures. Not men” (48). This quotation can be applied perfectly to Septimus’s condition, making him a dire illustration of the damage that can come from learned notions of masculinity.

Rivers is seen as a “male mother,” a term he hates, because “[h]e distrusted the implication that nurturing, even when done by a man, remains female” (107). This title is revealed right after Rivers has had a breakthrough with Billy Prior. Prior, through hypnosis, managed to remember the traumatic event that caused his symptoms, but feels that the event wasn’t important enough to trigger this level of dysfunction. He nevertheless puts his head in his hands and begins to cry.

Rivers waited a while, then walked round the desk and offered his handkerchief. Instead of taking it, Prior seized Rivers by the arms, and began butting him in the chest, hard enough to hurt. This was not an attack, Rivers realized, though it felt like one. It was the closest Prior could come to asking for physical contact…. Rivers held Prior’s shoulders, and after a while the butting stopped (104).

It is important to remember that this is not the real Dr. Rivers speaking, but Pat Barker’s Dr. Rivers and that this scene was written by Barker, not based on a case study. This scene exemplifies the kind of emotional crippling that happened to men on the battlefield and was made worse by societal gender norms. Prior craves physical comfort, but it barely occurs to Rivers to give it. Instead of asking for it, Prior resorts to a kind of pseudo-violence that is still within the realm of manly action.

The title of “male mother” is applicable to Remarque’s two characters, Ernst and Paul, who, like Prior, wish they could be held by their mother, but do not know how to ask. All three are in the no-man’s land between boyhood and manhood. Because these soldiers came of age and into their identity while fighting, they do not know how to react to these mother figures, as they were never allowed naturally to
outgrow their own. Rivers is able to guide Prior through his symptoms, and can therefore cure him. As we saw before, the naïveté of the mothers in Remarque’s books increases the soldiers’ symptoms. They so badly want to be understood, but do not know how to begin to explain. Rivers, because he is trained, male, and an authority, can guide his wards through.

Notions of masculinity also intersected with class delineations. It was expected that men from upper-class families would not break down because of their better blood and upbringing. This notion is upheld at Craiglockhart – officers are diagnosed with neurasthenia and enlisted men are diagnosed with hysteria. The character of Rivers gives an explanation for this, using the symptom of mutism, which he believes is much more common in enlisted men. Prior is an officer but enters the hospital suffering mutism and asks Rivers why so few men like himself get his particular symptoms. Rivers replies,

“Mutism seems to spring from a conflict between wanting to say something, and knowing that if you do say it the consequences will be disastrous. So you resolve it by making it physically impossible for yourself to speak. And for the private soldier the consequences of speaking his mind are always going to be far worse than they would be for an officer. What you tend to get in officers is stammering. And it’s not just mutism. All the physical symptoms: paralysis, blindness, deafness. They’re all common in private soldiers and rare in officers. It’s almost as if for the… laboring classes illness has to be physical’’ (96).

The laboring classes are uneducated and cannot understand something as delicate as the mind. Their symptoms therefore conform to their knowledge and have a physical presentation. Officers have much more control of themselves, in addition to more education and thus do not exhibit their symptoms in such a dramatic way. As discussed in Chapter One, however, this is a false distinction. Enlisted men and
officers suffered the same symptoms, but the diagnostic language related notions of class. These consequences are a function of the class system, not due to personal control, knowledge or upbringing.

Writing and Recognition

In previous chapters, this thesis explored the difficulty soldiers faced in trying to verbalize their trauma. Though *Regeneration* is about treating shell shock, it hinges on the act of writing, another way to combat symptoms. Barker juxtaposes the mute Billy Prior and the verbose Siegfried Sassoon, the two featured patients. Where Prior cannot face his traumatic experience and therefore cannot speak about it, Sassoon is the opposite – he is aware of his surroundings to the point of writing poetry about them and this leads him to take a pacifist stance. Sassoon influences Wilfred Owen, another war poet at Craiglockhart. While at the hospital, Owen ran a literary magazine called the *Hydra* in which Sassoon was published. Though Barker imagines what actually took place during the poets’ meetings, Sassoon’s handwriting was identified in the corrections on Owen’s poem “Anthem for Doomed Youth.” Barker uses the poets’ meeting as a plot point in both her book and in history – it is the moment when Owen begins to write about the war, following Sassoon’s suggestion.

Previously Owen had resisted writing poetry about the war, believing art should be separate from the carnage, (84) but eventually, he admits to Sassoon, “I think you’re right. It’s mad not to write about the war when it’s –” but he cannot find the words for what exactly it is because he has not yet integrated his experiences

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(123). Truly depicting the war makes it real and terrifying, something that is possible for Owen only in the relative safety of Craiglockhart, under Sassoon’s guidance. Though writing does not seem to help Owen’s stuttering – the nervous malady he suffers from – Barker shows his transition from an unconfident classical poet to a self-assured poet who writes about what he witnessed. Sassoon helps him edit his poem to become a true depiction of young men going to their slaughter, because Sassoon doesn’t “like the idea of… making it out to be less of a horror than it really is” (157).

Sassoon, on the other hand, does not need anyone to guide him. Writing serves as a form of self-analysis for him, protecting him from full-blown war neuroses while also making him aware of the terror that surrounds him, feeding his pacifist views. Rivers analyzes the poet and declares, “Sassoon’s poetry and his protest sprang from a single source, and each could be linked to his recovery from that terrible period of nightmares and hallucinations” (26). Sassoon began writing his war poetry on the battlefield itself. By immediately recording his trauma, he allows himself to understand his environment in a way the other soldier-protagonists cannot. But the poems have a detrimental effect as well. Because he lets himself think about the carnage and suffering, he recognizes the horror and protests against the prolongation of the war and is declared mentally unfit for duty. Writing poetry makes it difficult for Sassoon to develop the constricted affect that we’ve seen helped other soldiers cope while on the battlefield. Though this prevents full-blown war neuroses, it leaves him open to the horrors surrounding him.
On the other hand, writing serves as a cure for his hallucinations. While at Craiglockhart, these horrors manifest in a few minor nightmares about Sasson’s recently killed friend. Sassoon himself doesn’t refer to them as nightmares because he does not feel afraid when they happen, only guilty (189). To deal with his symptoms, he immediately writes a poem and presents it to Rivers. Through writing the poem, Sassoon reasons that the only way to stop his guilty feelings is to go back to the trenches and fight for his dead comrades. He ends his poem, “I think of the Battalion in the mud. / ’When are you going back to them again? / ’Are they not still your brothers through our blood?’” (189). Sassoon is able to persevere where Septimus fails – by writing about his reactions to the death of a friend, he can work through his feelings and integrate the death into his life so his visions stop haunting him. His writing helps him know himself and know that he can go back to the front while still maintaining his pacifist views.

Sassoon is ultimately a success story as well, though opposite to Prior. Sassoon does not give up his beliefs that the war should be ended and tells the Medical Board that he in fact believes it more strongly than he did originally. But he also feels it is his duty to go back and be a good soldier so as not to abandon his fallen comrades. His masculinity has been redefined to include both the warrior and the man who cares deeply for his brothers-in-arms. Returning to the trenches makes Sassoon’s case a success. Rivers behaved exactly as a wartime doctor was supposed to, *reeducating* his patient to see the error of his ways, and reminding him of his correct place on the battlefield. However, Rivers is confident in letting him return to the trenches not because Sassoon has been made aware of his duty, but rather because
Sassoon, under Rivers’s care, has come to know himself. Once again, Barker shows us, the Freudian method wins out and Sassoon can be declared a success.

**Treatments and History**

In *Regeneration* Barker depicts two different schools of treatment for cases of shell shock. She gives more attention to Rivers’s Freudian methods, but devotes a chapter near the end of her book to Dr. Lewis Yealland. Both doctors treat a case that presents with mutism. For Rivers, that patient is Billy Prior, the fictional soldier. Barker states that Dr. Yealland’s method of treatment is described in his book *Hysterical Disorders of Warfare* and Barker bases Private Callan, his patient, on “Case A1.”67 Barker crowns Rivers the humane advocate of the analytic method, while she paints Yealland as a cruel practitioner of the disciplinary method. Though it is true that both doctors were specialists in these methods, Barker creates selective portraits of each to give credence to Rivers’s analytic practice. It is important to remember that Barker wrote this novel relatively soon after the addition of PTSD into the *DSM* cannon. As discussed in the first chapter, before PTSD was codified, Vietnam veterans were treated ineffectually with electroshock therapy. This shows how the PTSD diagnosis shaped the way Barker portrayed the historical methods of treatment for war neuroses.

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Rivers is one of the few advocates of the analytic method prescribed by the RAMC. He describes the maddening way most other doctors tried to make soldiers forget their trauma, contrasted with his attempts to help his patients remember.

The typical patient, arriving at Craiglockhart, had usually been devoting considerable energy to the task of forgetting whatever traumatic events had precipitated his neurosis. Even if the patient recognized that the attempt was hopeless, he had usually been encouraged to persist in it by friends, relatives, even his previous medical advisers..... Rivers’s treatment sometimes consisted simply of encouraging the patient to abandon his hopeless attempt to forget, and advising him instead to spend part of every day remembering (25-26).

This change leads to a lessening of nightmares and the patient is able to integrate the trauma into his life story, allowing him to go back and fight. Rivers uses Freudian methods of hypnosis and psychoanalysis to help his patients get to the root of the trauma, in order to free them from it. In doing this, he fosters in his patients what he calls “autognosis,” or self-knowledge, in which the “unconscious experience has to be brought into relation with the general body of experience which is readily accessible to consciousness and so made a part of it.” In other words, he brings the parasitic memory into the conscious mind so it does not trouble the soldier any more. To be cured, the soldier must know exactly what is plaguing him. As Barker puts it in Regeneration, “those who had learned to know themselves, and to accept their emotions, were less likely to break down again” (48).

These methods are on full display when the character of Rivers treats Billy Prior, the officer who presents at Craiglockhart with mutism, amnesia and nightmares. Prior communicates with the staff by writing on a notepad, insisting that

68 Ibid.
he doesn’t remember what happened to him, and that “THERE’S NOTHING PHYSICALY [sic] WRONG” (41-42). In other words, there’s nothing wrong with him at all – he’s not a weak soldier who breaks down and his being here, presenting these symptoms must be a mistake. He eventually regains his voice, noting that it goes when “[he] get[s] upset” (49). Prior requests hypnosis and though Rivers is initially against it, fearing that Prior isn’t ready to uncover what caused his trauma, he eventually acquiesces. The repressed memory begins with Prior shoveling the detritus left in the trench after a shell explosion: “soil, flesh and splinters of blackened bone…. As he shoveled, he retched” (102). Prior looks down and finds “himself staring into an eye…. His fingers touched the smooth surface and slid before they managed to get a hold…. ‘What am I supposed to do with this gob-stopper?’” Prior remembers asking himself (103). The word that Barker uses is significant: the trauma of finding an eye literally blocks Prior’s mouth, rendering him unable to speak or to remember the trauma. The bottom half of his face goes numb directly after he deposits the eye into a bag (103). Prior himself is dissatisfied with the memory he uncovered, calling it nothing (104). Rivers counters, “You’re thinking of a breakdown as a reaction to a single traumatic event, but it’s not like that. It’s more a matter of…erosion” (105). Rivers responds to this uncovered memory without judgment, and in so doing allows Prior to integrate this unconscious memory into his conscious ones.

This fictional case study shows that Rivers’s Freudian methods, combined with the trauma theory coming out at the time of the book’s publication work to cure mentally anguished soldiers. Having integrated his memory, Prior is able to complete
what is now known as the final step in the PTSD recovery process – forming strong relationships with others. He meets a girl, Sarah, and decides not to tell her anything about the war. “She would never know, because he would never tell her. Somehow if she’d known the worst parts, she couldn’t have gone on being a haven for him” (216). He finds meaning in his life through this relationship. However, Prior is deemed unfit for return to the front lines and is granted permanent home leave, due to his asthma attacks, not his mental state. Though he is declared unfit for duty, he is a mental success as far as the War Office is concerned because he wishes to get back to France (206).

Before moving on to Barker’s descriptions of Dr. Lewis Yealland’s methods, let us compare Billy Prior to Septimus Warren Smith. Unlike Septimus’s inability to speak in Mrs. Dalloway, Prior’s mutism is seen as nothing more than a symptom of war neuroses. Because Woolf was writing at a time before PTSD, Septimus’s inability to speak is a symptom of the pressure of the larger cultural framework: doctors do not listen to him, he is prevented from examining his past relationships and thus cannot know himself. Writing at a time before diagnosis, Woolf was able to critique social morays by describing Septimus’s symptoms. For Barker, mutism is a continuation of these mores, though she approaches it more as a simple symptom to be cured. Writing in the era of PTSD, she takes mutism at face value, and Prior’s sufferings represent nothing more than a symptom to be treated.

Dr. Lewis Yealland also cures a case of mutism, but he follows the disciplinary method prescribed by the RAMC, using techniques akin to animal

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70 Herman, Trauma and Recovery. 205.
This method is illustrated in his session with a mute patient, Callan, based on Yealland’s real-life “Case A1.” “Lewis Yealland...believed that men who broke down were degenerates whose weaknesses would have caused them to break down, eventually, even in civilian life” (115). Yealland believes that the war environment brought out a latent defect in some men; it was not the war itself that caused breakdowns. Breaking down is a failure of will and of morals, and to be cured the patient must be punished into submission.

The regimental medical officer, trained to see nervous collapse as physiologically-based, either discovered an organic wound which was then treated or, failing that, forced the afflicted soldier to assume ‘responsibility’ for his condition and return to his unit.72

The reader learns about Yealland’s hospital through Rivers’s eyes. Contact with patients in the ward was restricted to a brief greeting, and no questions were asked about their psychological state, a stark difference from Rivers’s own conversational method. “Many of them, Rivers thought, showed signs of depression, but in every case the removal of the physical symptom was described as a cure” (224). Yealland relies on electroshock therapy whether it be to straighten out a hysterical bending of the spine, or to reverse mutism. He makes it very clear that the patient’s pain does not matter, the man must be punished until he learns to fix himself. Rivers sits in on a session with Callan, who had been deployed behind the lines when he suddenly fell and remained unconscious for five hours. When he “came round, he was shaking all over and was unable to speak” (226). His prior treatment is described to Rivers. “The patient had been strapped to a chair for periods

71 Young, The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder. 68.
of twenty minutes at a time, and very strong electric current applied to his neck and throat. Hot plates had been applied repeatedly to the back of the throat, and lighted cigarettes to the tongue.” But none of it “persevered with him.” Yealland wants to treat Callan himself because of the previously failed treatments, and he makes it clear that only one session with him is ever necessary. The patient always comes out cured, regardless of whether he wishes to be (227-28).

Yealland’s session with Callan is represented as horrific and morally disgusting because Rivers is there to pass judgment. The doctor straps the soldier into an electroshock chair, telling him, “A man who has been through so many battles should have a better control of himself…. Remember you must talk before you leave me” (230). Yealland is using reeducation to remind Callan of his proper place in the front lines. Once a hero, always a hero – what he endured once, he can endure again, if he stops resisting and cooperates (explanation). Yealland finally uses persuasion, encouraging Callan in any way possible, including physical threats, to take up his duty again. Yealland believes Callan is choosing not to talk, and each time Callan chooses not to speak during this session, Yealland shocks him using increasing voltages. When Callan finally mutters a syllable, Yealland tells him, “You must speak, but I shall not listen to anything you have to say” (231). As Callan is morally inferior, nothing that he has to say is even worth listening to. Through all of this, Yealland is trying to show Callan that life at the hospital could be much more unpleasant than

\[73\] Ibid. 243.
life in the trenches and he must give up his mutism and go back to the front. Callan is finally induced to talk (233).

Barker adds a final, cruel scene, in which Yealland asks if Callan is pleased to be cured. The patient responds with a smile. “I do not like your smile,’ Yealland said. ‘I find it most objectionable. Sit down’” (233). Yealland applies an electrode to the soldier’s mouth and shocked him until he learned that only appropriate response was, “Yes, sir.” Callan has now been shocked into compliance and made into a man capable of war and with that, Yealland is done with him. This is more indicative of common treatment for shell shock – Callan is never asked what is wrong with him, or anything at all. Once he is capable of following commands and aware of the punishment his disabilities bring, he is released. Rivers, as the voice of reason throughout the book, is duly horrified by this treatment, to the point where it mimics war neuroses – he is haunted by images of it and has a disturbing dream about it (236). The reader is not privy to what happens to Callan, but Rivers’s thoughts make it clear that he will not be as successfully recovered as Prior. Though he will be fit for duty, Rivers believes Callan will break down again.

In describing the two approaches to treating war neuroses, Barker creates a clear dichotomy between humane and inhumane methods. However, this picture is incomplete. By more thoroughly examining Rivers’s and Yealland’s work, a more nuanced portrait emerges. Barker casts certain lights on her medical characters in order to make the reader sympathetic to Rivers’s more modern treatment, and horrified at Yealland’s seemingly barbaric one. My point is not to condone treating

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war neuroses with electroshock therapy, but rather to point out that Barker let modern ideas about PTSD and its treatment color her representation of the WWI era.

For example, Barker decides to relay Yealland’s treatment through Rivers’s eyes. In reality, Yealland was alone during the treatment of A1, but inserting Rivers into the scene also inserts modern-day morality. Through descriptions of his interactions with patients, Barker established that Rivers’s methods and thinking are analogous to modern-day treatments, making the reader sympathize with the enlightened protagonist. With Rivers’s thoughts as the moral authority, Barker illustrates the cruelty inherent in Yealland’s method of treatment. Giving an account of Yealland’s session as Rivers sees it allows the reader to condemn Yealland. Barker makes it clear how different Yealland’s treatment is from Rivers’s – to Yealland, it does not matter what caused the trauma, or what the patient has been through as long as he is ultimately fit for duty.

Barker, however, does not give an accurate picture of Rivers, but rather portrays him as a hybrid: a Sassoon-Rivers, all of the doctor’s work viewed through the lens of his meeting with Sassoon.75 Rivers himself was indebted to John Hughlings Jackson, who believed that “mental states originate in the structures and processes of the nervous system, and that alterations in the nervous system effect changes in mental states.”76 In other words, though Barker paints him as a Freudian, Rivers’s views hearken back to the age of railway spine: war neuroses are caused by invisible, physical damage to the body, putting his views closer to those of Ribot.77

75 Ibid. 84.
76 Ibid. 47.
77 Ibid. 83.
Rivers underscored this when he testified to the War Office committee on shell shock in 1922, stating that he objected to the term “shell shock” because “so far as he could see the main factor had been stress, and the shock in most cases was merely the last straw. Any disturbance might have produced the same result.” In other words, it is not the traumatic memory that produces the physical and emotional symptoms, but rather that the symptoms account for the memory. Rivers-Sassoon, on the other hand, relied on uncovering the trauma itself, a Freudian method. Though this was the case when Rivers and Sassoon met, this was one instance of Rivers’s work, not the defining moment.

Facts about Yealland’s story were even more selectively chosen. Barker never clarifies that Yealland was a neurologist, not a psychologist and anthropologist like Rivers. This delineation is key in understanding Yealland and Rivers’s different approaches. Electricity had been established as a treatment for functional disorders long before the war and was in fact used as part of suggestion. An electric current will move a seemingly paralyzed limb or cause a person to speak, which is enough to convince a patient that he is able to move it on his own. However, for this to be successful, Yealland believed that “the patient must be convinced that the doctor understood his case and is able to cure him,” meaning that the best attitude is one of boredom and utter familiarity with the disorder. By omitting these reasons behind Yealland’s treatment, Barker paints him as a sadistic man with no moral resemblance to Rivers whatsoever, but Yealland deals in nerves, not memory.

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78 Committee, "Report of the War Office Committee of Enquiry into “Shell-Shock”." 56.
79 Young, The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder. 84.
80 Ibid. 72.
In addition, A1, Barker’s Private Callan, was an exceptional case, not the representation of Yealland’s work that Barker makes it out to be. Yealland believed that most patients who had never been treated with electricity could be cured by a minor current. A1’s treatment is so severe because of his failed prior treatments. In Yealland’s account of the treatment, the patient was grateful to be cured and the doctor nowhere near as sadistic – A1’s smile is welcome. The treatment room was stark, but the intention was to create a very specific environment so the patient could focus on his symptoms. These pieces of information lend depth to Yealland’s treatment method that the character of Rivers did not provide.

Rivers’s treatment method was objectively more humane than Yealland’s, but Barker shapes the way the reader interprets these doctors to create a true dichotomy. Because she does not explain the reasons behind Yealland’s methods and describes his cases through the eyes of a moral authority (Rivers) she paints a much darker picture than is accurate. In the age of the acceptance of the PTSD diagnosis, Barker was clearly against electroshock therapy and imbued her version of history with its evils.

Barker’s account of the meeting between Rivers and Sassoon cleaves close to the historical truth. However, the fictionalized parts of Regeneration show a history that is shaped by the PTSD diagnosis and the modern methods of treatment. Prior’s case is a neatly arced success story due to Rivers’s Freudian methods. Lewis Yealland is painted as a near-monster though he was following the theories of the day. This

81 Ibid.
82 Lewis Ralph Yealland, Hysterical Disorders of Warfare, by Lewis R. Yealland ... With a Preface by E. Farquhar Buzzard(1918). 14.
83 Edgar Adrian and Lewis Yealland, “The Treatment of Some Common War Neuroses,” The Lancet i(1917).
simplification of history illustrates how the PTSD diagnosis narrowed the way in which trauma was fictionalized.
Conclusion

I began this thesis hoping to show simply that PTSD existed in interwar literature and leave it at that. Finding a diagnosis seemed interesting enough to me in and of itself. However, as my advisor, my parents and I myself realized, being able to find something doesn’t prove anything besides its presence.

Nor is it realistic. People, whether they are real or well-written fictional characters, are not their diagnoses. Nor are diagnoses static entities to be picked out of novels like motifs or themes. The interwar novels of Remarque and Woolf show that a diagnosis is a product of its time. Treatments are products of their time. Symptoms, it seems, are timeless. However, sympathy for the mental disorders they point to seems to be the product of the era.

In the time before the PTSD diagnosis, novels acted as a mouthpiece for the psychologically wounded. Remarque and Woolf were able to criticize their societies in their novels, illuminating the harsh way the mentally addled but physically able-bodied were understood – or not – and treated. They drew attention to the fact that anyone could be suffering from this almost-formless traumatic reaction, be haunted by an ever-present past, but be unable to say anything. They were able to look past the seemingly normal exterior into the mental turmoil inside to find complex characters plagued by something unidentifiable. These novels gave language to their plight and though the language wasn’t a diagnosis, it shed light on the sufferings of others.

This is especially true for PTSD, a diagnosis that was so hard to pin down for so long. As our understanding of the causes, symptoms and outcomes of the disorder
grows, so too does public sympathy. The ways in which the two doctor characters in *Regeneration* are portrayed is enough to prove that. Yealland, defined by the methods of the past, is vilified. Rivers, bringer of the humane future, is the gentle healer. This is in no way to condone the type of treatment Yealland gave his patients, but rather to say that the presence of a diagnosis can simplify the ways in which the past is viewed and the ways in which disorders are considered.

I originally wanted to explore this kind of simplification – and I didn’t totally abandon it – but writing about novels made me realize that a diagnosis isn’t just a description of mental imbalance, it entails all of the cultural factors that come together to make a person the way he or she is, combined with the doctor’s personal ideology. It is the level of acceptance society has for others’ suffering. It is how much a patient feels he or she can admit and how much a doctor can read between the lines.

PTSD fascinated me because I realized it could affect anyone, could be caused by seemingly-quotidian occurrences: a car crash, learning about the death of a loved one, an abusive relationship left behind long ago. The idea that these events can haunt people is scary and perhaps part of the reason why the diagnosis took so long to solidify. But, to return to a theme of this thesis, these patients do not always *look* as if there is anything wrong with them. There isn’t always an immediate reaction to the traumatizing stimulus and it can therefore be hard for the patient to express what is wrong, or for the clinician to accept that anything is wrong.

That is why I want to end exactly where I started, in Bethesda, Maryland at the NIH Clinical Center. I am still floored that the patient the doctor and I were talking with for forty minutes had PTSD, because, for lack of a better phrase, she
seemed so normal. But as we have seen throughout this thesis, our expectations of others give little indication of the trauma beneath and people do not always look for symptoms they don’t expect. What I learned that day, and I hope I translated in this thesis, is that just because mental distress is unexpected or unapparent, doesn’t mean it isn’t there. I set out to find the presence of PTSD in interwar literature, but the environment, time, social expectations and biases that affect our view of and reactions to mental disorders turned out to be just as interesting.
Bibliography


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