



War and Revolutions: Trauma and Violence from a Socio-Psychological Approach*

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World War I, which broke out more than 100 years ago, placed not only a tremendous material and physical burden on the citizens of the participating countries, military and civilians alike, but also a psychological one. The study of the psychological consequences of the war has been pushed somewhat into the background in comparison to the historical and political analyses, though the uses of psychology—and broadly speaking, of the so-called “psy” disciplines, i.e., psychiatry, psychoanalysis, psychotherapy, social psychology, psychotechnics, criminology, pedagogy, etc.—were a crucial part of the history of this war. However, a history of the “psy” disciplines would not be complete without some discussion of the fact that World War I and World War II (and subsequent conflicts) played a fundamental role in the development of these sciences. Arguably, World War led to the emergence—as a kind of “experimental laboratory”—of practices and methods of the application of violence, trauma management, intimidation, terror, manipulation, and propaganda which draw on (and contribute to) insights from these disciplines, not to mention new approaches to the management of subjectivity and the manipulation of sentiments, which proved effective both in times of war and peace.

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Introduction

The first modern war in world history—fought with new and formidable military technology, including machine guns, motorized vehicles, and poison gases—affected the lives of millions of people. The psychological consequences became the most clearly apparent in the case of soldiers doing armed service, who had to

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face challenges, constraints, threats, and perils that they had never or only rarely encountered before. In most cases, whether or not a soldier (who was reduced to machine responding to commands) survived depended far more on sheer luck rather than on personal heroism, courage, skill, or inventiveness. Soldiers were often subject to harsh physical punishment, humiliation, and aggression. The dehumanizing effects of the war and the experiences of violence and vulnerability created stressful conditions, giving rise to psychological disorders even in the cases of soldiers whose lives were not directly in danger or who were not subject to aggression, but who still witnessed the sufferings or deaths of their comrades and adversaries, not to mention soldiers who had perhaps participated, either as perpetrators or as eyewitnesses, in mass murders and reprisals. The psychological consequences of the war affected not only the soldiers fighting on the fronts, serving in the hinterland, or taken prisoner of war. They also affected families (both close and distant relatives) and a large segment of the civil population. The war, which involved the mobilization on a huge scale of material and human resources (and placed huge demands on people's physical and mental strength), dehumanized relations among people to an unprecedented extent. It was a war of both physical and psychological resources: a war of "nerves." War propaganda became an important military tool, which drew on modern mass-communication tools (print media, photography and film) and targeted not only enemy troops, but the entire civilian population of enemy countries, deploying the full array of hate speech rooted in conspiracy theories and cultural, national, ethnic, and religious prejudices and stereotypes. The psychological warfare used in World War I became a model for psychological wars and various forms of symbolic aggression which drew on mass emotions and urged the total annihilation of the enemy, and these forms of symbolic aggression were then used in later wars and even in times of peace.¹

World War I and its immediate aftermath (revolutions and counterrevolutions, territorial and demographic reshuffling, political and economic crises) became the starting point for a series of additional collective traumas and mass psychological crises, especially in the defeated countries. These traumas played a substantial part in the preparations for and outbreak, evolution, and impact of an even more brutal conflict, World War II. More and more forms of collective aggression reared their ugly heads, and these forms of aggression, both real and

1 With regard to the propaganda machine of World War I and its effects and afterlife, see, for example: Theweleit, *Männphantasien*; Kühne, *Kriegshysteriker*. See also Péter Bihari's recent book: *1914. A nagy háború száz éve*; and a study by Zsuzsanna Kiss, "Hősök és bűnbakok a weimari Németországban."

symbolic, served to cause trauma to certain individuals or groups. Genocide, terrorism, forced relocations and deportations, ethnic cleansing, physical and psychological torture, etc., were all techniques of intentional traumatization that were already largely present during World War I.²

War Neurosis as a Subject of Historical Research

Among the “psy” disciplines, it was psychiatry that had the closest connection to battlefield events. World War I was the first war in which psychiatry as a discipline was exploited on a mass level. The experience thus gathered had a major influence on approaches and methodologies used in psychiatry in peace times and during later wars.³

In recent years, the study of the psychiatric practices used during World War I, especially the diagnosis and treatment of the syndrome collectively referred to as “war neurosis,” and the role of military psychiatry on the front and in the hinterland have become equally important areas of research. Whereas study of this topic formerly took place mainly within the confines of medical history, more specifically the history of psychiatry, nowadays, it has become an intriguing domain for historical research as well. For social historians, the unearthing and the analysis of the practices of military psychiatry shed light on daily life during the war, the multitude of mentalities regarding corporal and psychological suffering, the operational mechanisms of militarized healthcare and mental hygiene institutions and organizations, dominant power relations of supremacy within their walls, and the conflicts that doctors who had been mobilized in the army had to face as a result of the contradictions between their duty to live up to their Hippocratic oath on the one hand and to obey commands on the other.⁴ The topics of military psychiatry and war neuroses have lately kindled interest among gender researchers as well, as the diagnosis and qualification of war neuroses were intertwined with the issue of “masculinity” and “femininity,” a fact which sheds some light on an important moment in the history of modern discourses related to “masculinity.”⁵

2 See Sironi, *Psychopathologie des violences collectives*.

3 Key books and papers summarizing this topic: Hofer, “Nervöse Zitterer”; Hofer, *Nervenschwäche und Krieg*; Kaufman, “Science as Cultural Practice”; Lerner, *Hysterical Men*; Micale and Lerner, *Traumatic Pasts*; Shephard, *A War of Nerves*; van Bergen, *Before My Helpless Sight*.

4 For more on this issue, see Michl, “Ethical Conflicts in Wartime Medicine.”

5 See, for example, Meyer, *Men of War*.

The scope of psychiatry was not limited to the treatment of the psychologically wounded during the war. Psychiatry was an essential part of the wartime power apparatus, the mechanism of violence, offering a seemingly scientific ideological and political foundation that made it possible to decide who was suffering from some kind of illness acquired on the front and who was only “faking.” The mentality of psychiatrists and other experts regarding war neuroses was determined by their preliminary knowledge, the dominant scientific and theoretical paradigms and categories of diagnosis, and their conceptions of “normal” and “deviant.” However, the methods of treatment provided or recommended by them and the direction, purpose, technique, duration, and location were also influenced to a great extent by the overt commands or expectations of the military leadership. The whole topic of war neuroses, which stretches far beyond World War I, is a perfect illustration of the intertwining of “psy-knowledge” and power. At the same time, the national and local cultural and historical backgrounds all played an important part in this, since despite their common features, there were significant differences between the various “treatment cultures” and the mentalities and styles of military psychiatrists operating in the British, French, American, German, and Austro-Hungarian militaries.⁶

The foundations for the contemporary, historical-cultural approach to the issue of war neurosis were chiefly laid by the scholarship of Michel Foucault, partly through his works on the history of mental illness and partly by his exploration of how the development of human sciences was connected to the birth of the modern tools, practices, and sites (hospitals, asylums, armies, prisons, detention centers, etc.) of discipline, punishment, and violence.⁷ The Foucauldian notion of *gouvernementalité* proved essential, since it referred to the organized practices (mentalities, rationalities, and techniques) that were used to assert and maintain hegemony over subjectivity, or the “governance of the soul.”⁸

Numerous historical works have been published since the 1970s that examine the characteristics of the operation of military psychiatry in detail in different countries. These historical works rely first and foremost on archival sources, the records of military health-care authorities and organizations, the reports issued by military doctors and hospital commanders, patient files, etc., but they also use articles published in medical journals, diaries, letters written

6 See Leese, *Traumatic Neurosis and the British Soldier*.

7 See Foucault, *Madness and Civilization*; Foucault, *Discipline and Punish*.

8 See Nikolas Rose’s seminal work on the social history of modern psychology: Rose, *Governing the Soul*.

by soldiers on the frontline, and other personal documents, as well as medical records, memoirs, and contemporary photos and films made by amateurs or for scientific purposes.⁹ Literary works are also important sources, since the psychological torments, traumas, and post-traumatic effects of the war were subjects and themes in countless artistic creations, theater plays, and films created over the course of the past 100 years.¹⁰ The “Great War” and the psychological ordeals to which it led have left an indelible mark in the cultural remembrance of the countries involved.¹¹

The most extensive historical research examines the military psychiatry performed in the British, German, and Austro-Hungarian armies. Paul Lerner’s seminal work¹² on “hysterical men” explores the trauma policy of imperial Germany, and Hans-Georg Hofer’s monography¹³ scrutinizes the dominant psychiatric practices of the Austro-Hungarian Empire’s military. Several pieces of scholarly literature focus on the methods of treatment applied by psychiatrists working in the British army and their institutional background.¹⁴ These writings give an in-depth account of how the individual states tackled the problematics surrounding war reparations, also referred to as “pension war,” i.e., the socio-political and financial crisis provoked by the mass demands for compensation (benefits, pensions, and other forms of assistance) and special needs (medical treatment and reintegration into the labor market) of the psychological victims of the war.¹⁵ Historians have demonstrated a special interest in the role and importance of psychoanalysis in the military psychiatry of World War I.¹⁶ The psychoanalytic approach to war neuroses and the wartime activities of psychoanalysts will be discussed below.

9 See first and foremost the groundbreaking work by Fischer-Homberger, *Die traumatische Neurose*. See also Davoine and Gaudillière, *History Beyond Trauma*; Leed, *No Man’s Land*; Ridesser and Verderber, *Maschinengewehre hinter der Front*.

10 See the special issue of *Journal of Literary Theory: Trauma and Literature* (2012). See also Bihari, *1914*, 549.

11 See, for example, Davies, “British culture and the Memory of the First World War.” See also Bihari: *1914*, 538–46.

12 Lerner, *Hysterical Men*.

13 Hofer, *Nervenschwäche und Krieg*.

14 See, for example, Leed, *No Man’s Land*; Shephard, *A War of Nerves*; van Bergen, *Before My Helpless Sight*.

15 See especially Bogacz, “War Neurosis and Cultural Change in England.” With regard to the “pension war,” see Lerner, *Hysterical Men*, 223–48.

16 Brunner, *Freud and the Politics of Psychoanalysis*; Brunner, “Psychiatry, Psychoanalysis and Politics during the First World War”; Danto, *Freud’s Free Clinics*; Hoffman, “War, Revolution, and Psychoanalysis”; Kaufman, “Science as Cultural Practice”; Malleiter, “Die Kriegsneurose in der Wiener Psychiatrie und Psychoanalyse.”

The Gray Zone of Psychiatry

Neurology and psychiatry as scientific disciplines (the two had not yet really separated at the time) underwent a tremendous evolution from the beginning of the second half of the nineteenth century. Their advancement was partly due to the radical transformation of the paradigms of the notions of mental disorder and changed social needs and partly to the latest neuroanatomical and neurophysiological discoveries and revelations, which heralded the solution to the classic philosophical problem of “the body and the soul” through the natural sciences. In the second half of the nineteenth century, the major psychiatric and psychopathological theoretical constructs were created, and diagnostic frameworks and categories were set up for the categorization of mental illnesses, such as the typology by Emil Kräpelin, which was considered the global standard for nearly a century up to the dissemination of the American classification system (The American Psychiatric Society’s *Diagnostic and Statistical Manual of Mental Disorders*, DSM). That was when large—and by contemporary standards modern—institutes of neurology and psychiatry were founded throughout Europe. It was also in these times that special neurological education was organized, the centers of which were university clinics with a focus on research, alongside specialized medical care.¹⁷

However, psychiatry still had a vast “gray zone,” meaning symptoms that could not be definitively classified under any of the diagnostic categories. These phenomena included “abnormal” psychological and behavioral manifestations (considered deviant), ranging from “perverted” or “aberrant” forms of sexuality through antisocial and criminal forms of behavior to various physical reactions, conditions, and symptoms that could not be traced back to any physical cause. Of these “abnormal” manifestations, the most important and the most disputed one was hysteria, the history of which goes back to Antiquity, to Galenical and Hippocratic medicine. For many centuries, hysteria was regarded as a satanic and demonic phenomenon, or a “feminine trouble,” a mysterious manifestation of female sexuality, and it was linked to the functioning of the uterus and its movement within the body. In the Middle Ages, diverse superstitions, beliefs, and myths related to witchcraft and malefice were attached to hysteria. Its medicalization, scientific examination, and “demythification” began only in the

17 See Ellenberger, *The Discovery of the Unconscious*; Schott and Tölle, *Geschichte der Psychiatrie*; Lafferton, “A magántéboljától az egyetemi klinikáig.”

second half of the nineteenth century, especially thanks to the scholarship of Jean-Martin Charcot, a Parisian professor of neurology.¹⁸

One of the major faults of contemporary psychiatry was connected to the dilemma of whether hysteria was an illness of organic or psychological origin. As Charcot repeatedly demonstrated, the various bodily symptoms of hysteria, such as paralysis of the limbs, could be overcome purely through psychological treatment (hypnosis), and they could equally be provoked in those individuals who were sensitive to this. Charcot hypothesized that unbearable external shocks may induce hypnosis-like mental conditions and dissociative symptoms in the patient. While Charcot continued to regard hysteria as a syndrome mostly typical of women and assumed that it could be ascribed to some kind of a physical or degenerative nervous disorder, one of his disciples, Sigmund Freud, universalized the concept of hysteria and extended it to men.¹⁹ He contended that behind the symptoms of hysteria there was some kind of latent massive suppression, subconscious fantasy, usually a sexual trauma or abuse suffered in childhood. Freud considered hysteria an illness, a genre of neurosis, and he distinguished between two symptomatic forms of hysteria: *hysterical conversion* (conversion disorder), in which the psychological conflict manifests itself in various corporal symptoms, and *anxiety hysteria*, in which the anxiety is related to some external object (like in the case of phobias). While Freud rejected the explanation of hysteria by suggestion and considered hysteria a genuine psychological disorder, Charcot's most influential French disciple, Pierre Janet, and his disciples proclaimed that hysteria was generated mostly by *auto-suggestion*, i.e., "simulation," although external causes could also contribute to its onset and evolution.

By the end of the nineteenth century, it had become generally accepted that the symptoms of hysteria were motivated by some kind of earlier or current trauma, though there was no agreement concerning the classification of these symptoms. The Greek term *trauma* ("wound," "injury") had been used in the medical literature since the middle of the seventeenth century, especially in traumatology. Its primary meaning denotes specific physical injuries that can be seen with the eye or detected by various diagnostic tools (see "traumatology"). The modern concept of *psychological* trauma transposed this meaning from the corporal sphere to the phenomena of the psyche, but it has maintained its place

18 On the history of the concept of hysteria, see first and foremost Csabai, *Tünetvándorlás*; Didi-Hubermann, *Invention of Hysteria*; Gilman, *The Case of Sigmund Freud*; Laplanche and Pontalis, *The Language of Psycho-analysis*.

19 See Gilman, *The Case of Sigmund Freud*, 11–68.

in the medical discourse to this day. A more specialized form of scientific interest in psychological trauma took shape in the 1870s, and it was nourished by two major sources: experiences and observations regarding, first, the psychological consequences manifested in the victims of domestic violence and sexual abuse and, second, the mental condition of survivors of disasters, military campaigns, and wars.²⁰ This was all closely related first to the fact that the contemporary power regimes and institutions (modern educational systems, health care institutions, bodies of public administration and justice, etc.) demanded much deeper insight into the privacy of individuals and families than before, or as Jean-Martin Charcot would have said it, into “the secrets of the alcove,” and they extended their control over this sphere as well. Second, it was inseparable from the rapid transformation of modernizing societies, urbanization, the development of transportation, industrialization, and the appearance of modern machines, police, and military tools, which meant a new and grave source of danger for masses of people both in times of peace and war and from a corporal and psychological perspective.²¹ The wars of the nineteenth century, such as the Crimean War, the American Civil War, the Franco-Prussian War, and the Balkan wars, and equally importantly the growing number of industrial and transportation accidents and disasters demonstrated that serious traumas could provoke certain bodily symptoms that somatic injuries could not explain or at least which could not be detected by the tools of contemporary medicine. Patients afflicted with such conditions were often classified as suffering from “traumatic neurosis” or “neurasthenia,” another term originally suggested by an American physician, George Bernard Beard. Although the terminology was extremely varied, neurotic women “with weak nerves” were mostly regarded as hysterical, whereas men were considered neurasthenic.²²

The recognition of such disorders as illnesses became a crucial issue not only as a medical issue but also from the perspective of social politics and insurance. The phenomenon of the so-called “railway spine,” a syndrome of particular corporal and mental disorders typical of survivors of train accidents, was first described by British doctor Eric Erichsen in 1866. This diagnosis allowed such patients to claim damages from railway and insurance companies. Germany introduced general sickness and personal accident insurance in the 1880s. The aim of these socio-political measures for Chancellor Bismarck was to take the wind out of the

20 See Leys, *Trauma: A Genealogy*; Herman, *Trauma and Recovery*; Kirmayer et al., *Understanding Trauma*.

21 Schivelbusch, *Railway Journey*.

22 Lerner, *Hysterical Men*, 15–39.

sails of the Social Democratic Party and the growing trade unions. At the end of the 1880s, the scope of social security was extended to traumatic neuroses caused by workplace and traffic accidents. This measure generated a huge debate and gave rise to conflicts among German doctors. One of the poles of the dispute was represented by neurologist and psychiatrist Hermann Oppenheim (1858–1919), who was one of the most distinguished German psychiatrists and head physician of the Charité Clinic in Berlin. As early as the 1880s, Oppenheim was of the opinion that it was somatic disorders in the nervous system that played a decisive role in the etiology of traumatic neuroses.²³ Others believed that most of the patients were only feigning these symptoms in the hopes of receiving some kind of compensation, benefit, or pension so that they could be relieved from further labor obligations as qualified invalids. In other words, they allegedly suffered from “benefit neurosis” or “profit neurosis” (*Begebrennsneurose*). A large proportion of German doctors, however, did not share Oppenheim’s views. (Their rejection of his ideas was influenced in part by the fact that Oppenheim was not considered “patriotic” enough due to his Jewish origins.) These debates are a perfect illustration of the two dominant and conflicting approaches of the age to hysterical or traumatic neuroses. According to one, the symptoms of these neuroses were the product of some kind of organic or genetic disorder, and thus, they were to be regarded as genuine illnesses “equivalent” to organic bodily disorders. According to the other, these symptoms were to be attributed to psychological processes that can be influenced with purely psychological means and hypnosis. In the latter case, one cannot talk about a real illness, but only faking or “hysteria” in the ordinary sense of the word. Freud’s great and innovative insight—i.e., his notion that hysterical or neurotic individuals were suffering as a result of their own memories, life stories, and internal subconscious conflicts and not because of some organic ailment, and that they were not merely “faking” their suffering—did not, however, substantially break through the wall of opposition to psychoanalysis.

Shell Shock and Traumatic Neurosis

Although cases of traumatic neurosis caused by wars, mass catastrophes, and workplace accidents were well-known, World War I “produced” psychologically wounded individuals in unprecedented numbers. However, what the term

23 Ibid.; Fischer-Homberger, *Die traumatische Neurose*.

“psychological damage” should denote was not as self-evident (nor is it today) as the kinds of injuries the human body might suffer in times of war, which ranged from milder wounds to debilitating injuries causing invalidity and long-term combat and work disability and various serious infections and contagious diseases (tuberculosis, sexual diseases, cholera, typhus, the Spanish flu at the end of the war, etc.) that exacted a death toll that was nearly as high as that of combat injuries. Despite the spectacular development of certain branches of psychiatry and neurology, the treatment of psychological disorders was still in its infancy at the time of World War I, at least in comparison to somatic medicine, which had a multitude of modern diagnostic and medical devices already. The Austro-Hungarian Empire was in the lead in this respect thanks to the medical school of Vienna, which had begun acquiring a remarkable international reputation in the second half of the nineteenth century.²⁴

The most frequent and most characteristic symptoms of psychological injuries caused by the war were quite diverse and diffuse: uncontrollable tremors, an abnormal gait, spasms, stomach and intestinal disorders, paralysis of the limbs or their insensitivity to pain, chronic depression, glassy, blank eyes, occasionally loss of speech, dullness, and even temporal loss of hearing or sight. English psychiatrist Charles Samuel Myers first described this syndrome, which he called “shell shock,” in a medical article in 1915. This designation was then adopted by German physicians.²⁵ The term “shock is caused by the exploding shells” captured the paralyzed, cramped body position which people suffering from this condition got into at the moment of the shock caused by the explosions: through their symptoms, they virtually relived the past trauma in the present.²⁶ These symptoms were especially severe in the case of soldiers who spent weeks or months in the trenches, where nothing meaningful would happen for a long time, and then the sounds of exploding grenades would catch them completely off guard. According to British data, by December 1914, the proportion of those suffering from shell shock out of all those wounded on the front was seven to ten percent among officers and three to four percent among soldiers of lower rank. During the war, about 200,000 people were allowed to leave the

24 On the history of the medical school of Vienna, see Schönbauer, *Das Medizinische Wien*; Lesky, *Die Wiener medizinische Schule im 19. Jahrhundert*. See also Sablik, “Die österreichische medizinische Forschung.”

25 Lerner, *Hysterical Men*, 15–39.

26 On reliving experiences of trauma, see Leys, *Trauma: A Genealogy*; Caruth, *Unclaimed Experience*; Caruth, *Trauma: Explorations in Memory*.

army due to shell shock, and 65,000 were receiving pension as invalids in 1921.²⁷ The frequent occurrence of shell shock went against certain initial expectations already at the beginning of the war. Numerous psychiatrists, neurologists, and other physicians on both sides believed that the “storm of steel” of the war (Ernst Jünger) would teach even the weak-nerved, weak-willed, and unmanly youth the importance of discipline, virile behavior, and self-sacrifice.²⁸ In Thomas Mann’s novel, *The Magic Mountain*, war was supposed to “coerce” masculinity from the protagonist Hans Castorp, a “humanist *bel esprit*” and a “simple, spoiled child of life.”

Military doctors who encountered such cases early on in the war first attributed these symptoms to mere exhaustion, and they thought that a few days of rest would help. However, as the war progressed, the doctors serving on the front were less and less able to cope with the problem of “neurasthenics” in this way. Thus, the medical and health-care authorities of the Monarchy, Germany, England, and France were forced to make war-related psychological damage a priority issue. When World War I broke out, most belligerent countries, hence Germany, the Austro-Hungarian Empire, France, and Great Britain, possessed a relatively advanced and organized health-care infrastructure offering treatment for injuries and illnesses of the body—infrastructure that could be mobilized quickly for war purposes as well. They had everything from military doctors on the front offering direct treatment through squads accompanying ambulance units, hospital trains, temporary camp hospitals, barrack hospitals, and garrison and war hospitals to specialized hospitals, university clinics, and post-treatment institutions and sanatoriums.²⁹ Germany alone mobilized 24,000 doctors, while the western Entente Powers mobilized 29,000.³⁰ Since Germany and the Austro-Hungarian Empire recognized the strategic importance of this area and the possibilities to apply the health-care and organizational experience thus acquired in the post-war period, the Ministries of War in these countries set up a carefully constructed hierarchy of bureaucratic institutions for health-care management. The latter was also facilitated by the fact that in these countries, the health care system had been run in a semi-military style based on a strict hierarchy even prior to the war.

27 Rose, *Governing the Soul*, 20–21.

28 See, for example, Binswanger, *Die seelischen Wirkungen des Krieges*.

29 See *A Hadlörténelmi Levéltár katonaegészségügyi iratainak repertóriumá 1740–1980*.

30 Michl, “Ethical conflicts in wartime medicine.”

Dealing with illnesses of psychological or neurological origin was also one of the general tasks of military health services. However, special neurological or psychiatric treatment was only provided on higher levels, i.e., at the neurological departments at certain hospitals and neurological clinics. Most of the psychiatrists and neurologists who had been enlisted in the army (among them several qualified psychoanalysts and registrars) were on duty as general practitioners with troops or in war hospitals, and only a few of them were later admitted to neurological departments.

Oppenheim and his Opponents: The 1916 debate in Munich

How can the symptoms of combat neurosis be integrated into the system of the existing medical/psychiatric knowledge and diagnostic categories? In December 1914, at the beginning of the war, the abovementioned Hermann Oppenheim was commissioned to direct the 200-bed neurological department at the temporary military hospital set up at the Museum of Anthropology in Berlin. The experiences he acquired on the job seemed to confirm his earlier views about traumatic neurosis. His opinion, however, was not shared by most of his fellow neurologists and psychiatrists. Rekindling the debate that had already been on the agenda in German medical circles in the 1880s and 1890s regarding the entitlement to compensation and so-called “benefit neuroses,” Oppenheim’s opponents insisted again that the vast majority of combat neurotics—intentionally or subconsciously—were producing these symptoms in order to evade their obligations, receive some kind of temporary or permanent exemption from military service, and claim some form of compensation, disability pension, etc. Accordingly, those suffering from traumatic neurosis were “hysterical” in the ordinary, non-Freudian sense of the word, which in contemporary medical jargon was the equivalent of hypochondria, cowardice, lack of moral fiber and will, and even treason, not to mention an allegedly weak, unmanly, “effeminate” character.³¹ The stigmatization of hysterical patients also included the idea of “racial supremacy.” Alois Alzheimer, a professor of medicine from Breslau, for instance, attributed hysterical behavior, which he claimed was unworthy of German soldiers, to so-called *psychopathia gallica*, i.e., to “French psychopathy.”³²

31 On the demonization of war hysterics and the use of them as scapegoats, see Kiss, “Hősök és bűnbakok a weimari Németországban.”

32 Alzheimer, *Der Krieg und die Nerven*. On the racist theoretical aspects of the portrayal of the enemy on both sides, see Bihari, 1914, 230–32.

The victims of “war hysteria” were increasingly treated as scapegoats, and they were stigmatized even if they had earlier been recognized for their heroic acts. Already at that time, proposals were made to filter out the handicapped, the mentally handicapped, the homosexual, and so on, which then turned into brutal reality within the framework of the Nazi “euthanasia program.”³³

The German Association for Psychiatry conference on war neurosis was held in Munich in September 1916 and was attended by 241 doctors, among them the leading authorities of psychiatry in Germany and Austria-Hungary.³⁴ Oppenheim and his followers were in the minority compared to Professor Robert Gaupp from Tübingen, Professor Max Nonne from Hamburg, and other influential psychiatrists. One of the Hungarian participants, Artúr Sarbó,³⁵ supported Oppenheim, but most of those present, who considered war neuroses simply a form of hysteria—not only questioned Oppenheim’s approach but also proposed new strategies of treatment. One of the methods was hypnosis and suggestion, the effects of which Nonne had already demonstrated in his presentation given in Hamburg in 1915, but at that time, this form of treatment was rejected with the argument that “such methods are unworthy of German soldiers” because they resuscitated “medieval mysticism.”³⁶ However, after the 1916 conference, hypnosis also came widely into use, though it was combined with other methods. Thus, they tried the administration of drugs, isolation, keeping patients in a dark chamber, and various physical methods of “active therapy”—e.g., electric shock, hot or cold water cures, etc.—which were clearly punitive, humiliating, and painful. The proponent and best-known user of the electric shock treatment was German military doctor Fritz Kaufmann, who termed his procedure a “surprise cure,” during which faradic currents were briefly fed into the body of the patient-victim, causing tremendous pain.³⁷ The different varieties of electric shock treatment became widespread not only in Germany and in Austria-Hungary. They were generally used on the other side as well in the French, British, and American armies.³⁸

33 See Cocks, *Psychoanalysis in the Third Reich*.

34 Hofer, *Nervenschwäche und Krieg*, 244–54; Lerner, *Hysterical Men*, 75–81.

35 Sarbó, “Über den sogenannten Nervenschock nach Granat- und Schrapnellexplosionen.”

36 Brunner, “Psychiatry, Psychoanalysis and Politics,” 354.

37 Faradic electricity had been in use since the 1860s as a treatment for various neurological symptoms, following the example of American neurologist George Bernard Beard and German neurologist Wilhelm Erb. See Hofer, *Nervenschwäche und Krieg*, 283–338; Lerner, *Hysterical Men*, 86–123.

38 Leese, *Traumatic Neurosis and the British Soldier*; W.H.R. Rivers and Myers, *Psychology and Politics*.

Some neurologists attributed the disappearance of symptoms—at least seemingly—in the majority of the cases of war neurosis after a few electric shocks exclusively to the direct physical effect of these shocks, while others ascribed this to the suggestive force of the doctor’s person and the therapy or the combination of physical and psychological effects. The use of these methods was justified as a necessary means to combat the plague-like spread of war neurosis, and the physicians were expected to make the patients thus treated able to return in short order to the battlefield or at least to restore their ability to work, thus relieving the state budget of any potential obligation to pay them a pension. That was what both the Austro-Hungarian and the German military leadership expected of psychiatrists, especially because, after the enormous losses suffered beginning in 1916, there was an increased demand for the maximum exploitation of human and financial resources. As the German Association for Psychiatry officially declared, “we must never forget that we as doctors have to put our work in the service of a single mission: the service of the army and our homeland.”³⁹ Erwin Stransky, the president of the Association for Psychiatry in Vienna, affirmed that “in these times of hardship, our main focus should be the glory of our armies fighting in tight alliance, and not the wellbeing of the individual.”⁴⁰ Thus, those affected by war neurosis, who were regarded as malingerers and deserters, were more and more frequently faced with a court martial. In many cases, such soldiers received a death sentence as a deterrent, and not only in the Austro-Hungarian and German armies, but also in the French and British armed forces.

The Centralization of Psychiatric Care

In order to increase the speed and efficiency of the methods of treatment, special neurological departments, so-called “nerve stations” (*Nervenstationen*), were established in the territory of Germany and the Monarchy beginning in 1916. In its ordinance⁴¹ of July 10, 1916, the Ministry of Defense of the Austro-Hungarian Empire ordered that members of the military who were suffering from neurological conditions were to be treated only in special neurological institutions or other medical institutions with experienced and qualified neurologists. At the same time, it urged the regional commands located on

39 Quoted in Brunner, “Psychiatry, Psychoanalysis and Politics,” 358.

40 Ibid.

41 ÖStA KA, KM Präs Nr. 13. 756 /14.Abt. 15–25/155.

the territory of Austria-Hungary to designate those institutions that satisfied these conditions. Furthermore, the ministerial decree stipulated that the internal order in the neurological departments and institutions be made stricter, that the personal freedoms of the patients be limited, that previously issued exemptions be reviewed, and that recidivists be taken back to the same institution where they had been originally treated. The military command in Budapest reported on August 29 that there was no *separate* neurological institute for the treatment of war neurotics for the time being, and that the existing health-care establishments were not suitable for admitting further neurological patients. Thus, they requested authorization from the ministry to open a special medical facility planned in Újpest that would allow for “modern electric shock treatment” as well.⁴² In its ordinance⁴³ of October 3, the Austro-Hungarian Ministry of Defense approved the creation of the facility in Újpest. At the same time, the ministerial decree concentrated the treatment of the neurologically wounded in the following institutions on the territory of Hungary at the time: in the region of the military command of Budapest, the facility in Újpest; in the region of the command of Pozsony (Bratislava, Slovakia), the supplementary hospital in Nagyszombat (Trnava, Slovakia) and the state hospital in Pozsony; in the region of the command of Kassa (Košice, Slovakia), the medical institution of Rózsahegy (Ružomberok, Slovakia) of the Hungarian Royal Authority for Invalid Affairs; in the region of the command of Temesvár (Timișoara, Romania), the university clinic of Kolozsvár (Cluj-Napoca, Romania).

“The Ice Age of Perils”: Psychoanalysis in World War I

The war affected the careers of the individual members of the psychoanalytic movement just as dramatically as the movement itself. It encumbered or severed international relations, destroyed the majority of the barely formed networks, limited organizational life, and most of all, compelled the practitioners of psychoanalysis to confront their own assumptions, theoretical conceptions, and therapeutic practice with crude reality, which included the immeasurable sufferings and losses caused by the war and all the social and historical traumas that led to the disintegration and annihilation of the “world of yesteryear” (to borrow from Stefan Zweig). At the same time, war as a large-scale “natural

42 K. u. K. Militärkommando Budapest. M.A. Nr. 84028. ÖStA KA, KM 1916. Präs. 15–25/155–3.

43 ÖStA KA, KM Präs. Nr. 22.639/14. Abt. 15–25/155.

experiment” offered new opportunities for the application and scientific and official legitimation of the results of psychoanalysis. Sigmund Freud reflected on the socio-psychological problems raised by the war at the beginning of World War I in his essay “Reflections on War and Death.”⁴⁴ As Freud put it,

It is obvious that the war must brush aside this conventional treatment of death. Death is no longer to be denied; we are compelled to believe in it. People really die and no longer one by one, but in large numbers, often ten thousand in one day. It is no longer an accident. Of course, it still seems accidental whether a particular bullet strikes this man or that but the survivor may easily be struck down by a second bullet, and the accumulation of deaths ends the impression of accident. Life has indeed become interesting again; it has once more received its full significance.⁴⁵

Similar thoughts were put forward by Hungarian psychoanalyst Sándor Ferenczi in his article published in the periodical *Nyugat* under the title “The Ice Age of Perils”:

There might be a perspective from which even horrible and thrilling events seem only large-scale experiments of experimental psychology. A kind of “Natureexperiment” that a scholar cannot conduct in his study, or in the atelier of his mind at the most. War is such a cosmic laboratory experiment [...] In times of peace, it can be shown only by scrutinizing the dreams, nervous symptoms, artistic creations, and religion of the individual with an intricate method (and even then one’s findings are scarcely given credit) that the human psyche has multiple layers and that culture is just a nicely ornamented showcase while more primitive goods are stocked in the back of the shop. The war has stripped off this masque with one tug, and revealed man in his inner, more genuine nature; it has shown the child, the savage and the caveman in man. [...] The war has catapulted us back into the Ice Age, or to be more precise: it has disclosed those deep traces which that age had left imprinted in the psyche of humanity.⁴⁶

Ferenczi was detailed to the Hungarian hussars as an assistant doctor at the beginning of the war. He joined the 7th Hussar Regiment on October 26,

44 Freud, “Thoughts for the Times on War and Death.”

45 Ibid., 279.

46 Ferenczi, “The Ice Age of Catastrophes,” 125.

1914, in Pápa, and on January 4, 1916, he became the head of the neurological department of the Imperial and Royal Mária Valéria Barracks Hospital of Budapest.⁴⁷ He served in the army until the end of the war, along with several fellow Hungarian and foreign psychoanalyst doctors. It was in the barracks hospital of Budapest that he came across masses of physical and psychological victims of the war. On January 24, 1916, he gave an account to Freud of his first case of psychotherapy:

I analyzed [...] a sufferer from war trauma for an hour. Unfortunately, it turned out that the year before the shock of the war he had lost a father, two brothers (through the war), and a wife through unfaithfulness. When such a man then has to lie for twenty-four hours underneath a corpse, it is difficult to say how much of his neurosis is due to war trauma. (He trembles and speaks in a mumble.)⁴⁸

Ferenczi also wrote of his experiences in the barracks hospital in his article published in the medical journal *Gyógyászat* (Therapeutics).⁴⁹ As he writes, he observed approximately 200 cases of war neurosis. According to Ferenczi, the symptoms (general tremors, abnormal gait, spastic paralysis, etc.) of such illnesses are caused by psychological traumas; and traumatic neuroses can be fundamentally classified into two groups—hysterical conversion (conversion disorder) and anxiety hysteria. This conception added a new alternative to the debate sparked at the time among military psychiatrists (Oppenheim and his opponents) at the psychiatric congress in Munich, where, as noted above, one of the camps attributed such neuroses to an organic (especially degenerative, neurasthenic) background, while the other camp qualified those suffering from traumatic neurosis as “hysterical” in the pre-Freudian, ordinary sense of the word, that is, as malingerers and “effeminate.”

Ferenczi was not the only one to have experimented with psychoanalytical methods in the medical treatment of war neurotics. Karl Abraham, his fellow psychoanalyst from Berlin, also founded a department dealing with war neurosis and other mental disorders in 1916 in Eastern Prussia at the military hospital

47 On Ferenczi's activities as a military physician, see Erős, *Trauma és történelem*, 104–20; Erős et al., “Pszichoanalízis a hadseregben.”

48 Falzeder and Brabant, *The Correspondence of Sigmund Freud and Sándor Ferenczi*, 107–8.

49 Ferenczi, “Előzetes megjegyzések a háborús neurosis némely típusáról.” The article was published in English in 1916 under the title “Two Types of War Neurosis,” reprinted in Ferenczi, *Selected Writings*, 129–44.

in Allenstein (Olsztyn, Poland).⁵⁰ Another German analyst, Ernst Simmel, the head physician at the “nervous station” of Posen (Poznań, Poland), combined psychoanalysis with hypnosis (as opposed to Abraham and Ferenczi, who disapproved of suggestive methods). He published a book of great interest about his achievements.⁵¹ On the other side, in England, experiments were also conducted using dynamic methods with a psychoanalytical orientation that were focused on exposing and understanding the suppressed mental conflicts and subconscious psychological contents of the patients without coercive interventions. The instigator of this treatment was British anthropologist and physician W.H.R. Rivers, who was working in cooperation with his colleagues C. S. Myers and William McDougall at Maghull Military Hospital near Liverpool.⁵² They elaborated group methods that allowed for the development of solidarity, assistance, shared responsibility, and empathy instead of blind obedience. Similar initiatives were launched by Wilfried Bion, John Rickman, Donald W. Winnicott, and other British psychoanalysts, who elaborated new group psychotherapeutic methods within the British army during World War II. These methods were introduced at the Tavistock Clinic in London in the 1950s and became known as the “Tavistock model.” Similar methods were experimented with in the United States as well, especially at the Menninger Clinic in Topeka, Kansas.⁵³

Torture or Treatment?

Electric shock was also the prevailing procedure at the Mária Valéria Barrack Hospital. It was even more typical of the abovementioned medical institution in Újpest to which Ferenczi was unexpectedly detailed by his superiors in May 1917. There, he met one of the renowned Hungarian practitioners and enthusiasts of electric shock treatment, Dr. Viktor Gonda, whose method had attracted a great deal of attention all over the Austro-Hungarian Empire in military health circles and among the general public.⁵⁴ As Ferenczi wrote to Freud in one of

50 Abraham, “Symposium on Psychoanalysis and the War Neurosis.”

51 Simmel, *Kriegsneurosen und “psychisches Trauma.”* On the activities of Simmel and the German psychoanalysts during World War I, see also Lerner, *Hysterical Men*, 163–89.

52 Leese, *Traumatic Neurosis and the British Soldier*, 81–84.

53 Rose, *Governing the Soul*, 40–55.

54 Viktor Gonda was born in 1889 in Ungvár (Užhorod, Ukraine). He obtained his medical degree in Budapest in 1911 and then worked as a physician at the Liget Sanatorium. In 1916, he started to work at the medical facility of the Hungarian Royal Authority for Invalid Affairs in Rózsahegy as a neurologist. In 1917, he was transferred to Újpest. After the war, he worked in Romania for a time, and at the end of the

his letters in 1917, “[Dr. Gonda] is spreading himself around more and more here, is having column-length articles written about his miracle cures (in daily newspapers), and all the naive folk, from archduke to university professors on down, are coming to our hospital to observe the miracle together.”⁵⁵

What Gonda’s method consisted of is described in one of his articles from 1916: he placed electrodes on the legs of the patient, who “cries out in pain, my assistant holds down his arms because the patient would automatically try to defend himself and would push off the electrodes. I do not turn off the electricity at the first cries, but only after about half a minute.” Gonda’s article continued as follows:

By turning the electricity on and off, I repeat this procedure eight to ten times, accompanied by verbal suggestion. One or two attempts suffice for the patient suffering from the pain to become utterly willing to obey my command and properly express his will to try to walk. However, I do not satisfy his wish, but usually with the excuse that his little finger is not moving properly yet, I continue the administration of electricity, which becomes more and more painful for one or two minutes. In the meantime, I even turn up the current, and in order to increase the pain, I turn the electricity on and off. Under the effect of the latter, I have the patient bend and stretch his legs repeatedly. If this motion is carried out perfectly, I make the patient sit on the edge of the bed: he has to stand up upon my command uttered in a strong voice (after some pause when his panting and pulse have gone back to normal), and do that without any external help. After standing briefly, the patient has to take some steps while counting. Again, there is a short pause, then comes the walking and running exercise, when it is especially important that the motion be perfect and exempt from all trembling.⁵⁶

Similar procedures and results were reported by medical Lieutenant-Colonel Dr. Taussig from the sanatorium on Rózsáhegy⁵⁷ and by Dr. Ignác Kemény, the medical director of patient department I/b of the Hungarian Royal Garrison Hospital of Budapest.⁵⁸ Nonetheless, the views of doctors were divided over

1920s, he emigrated to the United States, where he later worked as a professor of neurology in Chicago. He played a major role in propagating the use of electro-convulsive treatment in America. He died in 1959 in Palo Alto, California. See Kiss, “Rózsáhegytől Chicagóig.”

55 Falzeder and Brabant, *The Correspondence of Sigmund Freud and Sándor Ferenczi*, 243.

56 Gonda, “Rasche Heilung der Symptome der im Kriege entstandenen ‘traumatischen Neurose’.”

57 K. u. K. Sanitäts-Chef in Kassa, E. No. 9294 K. u. K. Sanitäts-Chef in Kassa, E. No. 9294. 1916 Präs 15 25/155–3.

58 ÖStA KA 1917 14A 48-20 1–2.

Gonda's cure and similar treatments: they did not have the unanimous approval of old-school neurologists either. There is a letter, for instance, in the Vienna Archives of Military History that was written by Professor Károly Hoór, the dean of the Faculty of Medicine of the Royal Hungarian University of Budapest, to the *K. u. K. Militärsanitätskomite* (the chief military health care authority of the Monarchy), in which Hoór harshly criticizes Gonda's methods. Professor Hoór pointed out that there was nothing new in Gonda's therapy: similar methods had been in use for a long time at the University Neurological Clinic in Budapest, where thousands of war neurotics (allegedly) had been successfully treated since the breakout of the war. Gonda's method was well-known and applied by German and French military doctors as well. The method, however, was far from safe: increasing the current dramatically led to a pulse of 180 and even death in several instances, including among Gonda's patients. The dean also explained that the treatment was primarily based on a highly intensive suggestive effect.⁵⁹

On the other hand, the effort of the health authorities of Austria-Hungary (also represented by Dr. Gonda) to get the treatment of war neurotics over with so that the patients could be sent back to the front as soon as possible was met with fervent protests. The Vienna Archives also contain a letter dated December 5, 1916 and written by the national medical superintendent of handicapped affairs of the Kingdom of Hungary (Baron Sándor Korányi) in which Korányi protests against the customary treatment of traumatic neuroses:

The treatment of traumatic neurosis is a psychological treatment that can only be successful in a supportive milieu. Anyone who has ever visited hospitals behind the frontline must know very well that their restless atmosphere, the rigid military régime which reigns inside them as well as their proximity to the place of acquiring the illness will present barely surmountable obstacles to the creation of this milieu. It is also undoubtable that after the psychological trauma having caused the illness, a certain time period will be needed until healing can take place so that the impression having provoked the illness could be dimmed enough to allow for the success of the treatment. It is a misconception of the essence of traumatic neurosis that gives ground to the exaggerated hope vested in healing and the suggestion that patients having recovered should not be given leave, but should be sent back to serve on the frontline.⁶⁰

59 ÖStA KA 1917 14a 43 – 20/14.

60 ÖStA KA 1917 43 20/1.

“In Cold Blood and with Calm Nerves”

By 1917, the penultimate year of the war, war neurotics constituted an increasingly serious problem for the Austro-Hungarian military leadership. As Austrian Prime Minister Count Czernin declared in a speech delivered in Budapest on October 2, 1917, the war must be continued “in cold blood and with calm nerves,” and victory must be secured.⁶¹ A few days later, the Austro-Hungarian military leadership—under the pretext of a German-Austrian-Hungarian fraternal reunion—convened a meeting in Baden near Vienna in order to discuss the most important measures to take regarding war neuroses. Some of the military doctors who spoke at the conference reported on the “tremendous successes” of electric shock treatment. Viktor Gonda cited 4,000 patients who allegedly had been successfully treated, and Ernst Jellinek, a psychiatrist from Vienna, reported as many as 56,000 successful therapies.⁶² However, this “success propaganda” could not conceal the fact that the soldiers (and civilians) who had suffered battle neurosis or other psychological damage as a result of the senseless war constituted a growing and increasingly unmanageable crowd.

Military neurology and psychiatry, which had a fundamental role in the mobilization, preparation, rehabilitation, and replacement of the “human resources” of the modern war, were less and less able to cope with the traumatic neuroses massively affecting the armies of the Central Powers, and protests were becoming increasingly vehement against the conditions reigning at the neurological departments of military hospitals, the violence to which they had recourse, the harsh treatment to which patients were subjected, and the often cruel and inhumane methods that were used. With the collapse just around the corner, the question of the treatment and rehabilitation of the psychologically wounded who were engulfing the military hospitals became completely unsolvable. The Austro-Hungarian, Hungarian, and Prussian military leadership had every reason to fear that war neurotics who were reentering civil life and inundating the streets of the big cities would prove fertile ground for pacifist, revolutionary, and anti-militarist propaganda. Military leaders were also increasingly concerned that soldiers would disobey their superiors, even by “overperforming” commands (cf. the “Švejk phenomenon”).

According to Emil Kraepelin, one of the most renowned German psychiatrists, the reasons for defeat in the war were the “psychopathic leaders of the revolution”

61 Quoted in Hofer, *Nervenschwäche und Krieg*, 358.

62 *Ibid.*, 359–67.

who turned the mass hysteria prevailing among the population to their profit.⁶³ The criminalization and stigmatization of war neurotics appeared not only in psychiatry but also in politics. Shell-shocked and psychologically wounded soldiers or so-called “war hysterics,” whom, as seen above, the majority of psychiatrists stigmatized as cowardly malingerers, were made the scapegoats of the military defeat and accomplices responsible for the “stab in the back” of Germany. Women, spouses and mothers, and the “feminine pacifism” of the hinterland were also rebuked. As a consequence, most war neurotics were stripped of their old-age or disability pension after the war, and they were, again, labelled “benefit neurotics.”⁶⁴

The War Is Over?

According to some estimates, by autumn 1918, the number of “war neurotics” reached 180,000 in Vienna alone, and revolutionary agitation thus fell on fertile ground. The general atmosphere was precisely described by Karl Kraus’ observations concerning military doctors. In *The Last Days of Mankind*, Karl Kraus portrayed the military doctor as a diabolic figure who becomes “less fit for service the more people he declares fit to fight, so securing a greater chance of survival for himself. [...] they secure the survival of the wounded—to be sent back to the front, where they won’t survive.”⁶⁵

The failure of the therapeutic methods espoused and used by Gonda, Kaufmann, and others and the vacuum thus created also contributed to the fact that the military health authorities of the Central Powers began to look for new approaches and alternative treatments, especially towards the end of 1917, after the conference in Baden. Ferenczi, Abraham, and other psychoanalyst military doctors recognized that the moment had come when military health authorities or their individual representatives could perhaps be convinced about the applicability of psychoanalysis as an alternative cure. They stressed that psychoanalysis promised, in the words of Karl Abraham, “to go deeper in understanding the structure of war neuroses than any of the methods so far.”⁶⁶

The Fifth International Psychoanalytical Congress was convened in that spirit in Breslau (Wrocław, Poland) at the beginning of September 1918, and the representatives of the military health authorities were also invited. However, the

63 Kiss, *Hősök és bűnbakok a weimari Németországban*.

64 Van der Kolk, Bessel, “Soldiers and Psychoanalysts.”

65 Kraus, *The Last Days of Mankind*, 1919.

66 Abraham, “Symposium on Psychoanalysis.”

plans for the conference quickly went up in smoke because, due to the war chaos and travel difficulties, the Silesian town could no longer be approached. Nonetheless, at Ferenczi's initiative, the conference was still held. The date and place of the event were moved to September 28–29 in Budapest. The Austro-Hungarian, Hungarian, and Prussian ministries of defense sent their delegates to the congress in the persons of some military doctors of higher rank.⁶⁷ The high point of the congress, which Freud attended, was the debate on war neuroses, the keynote speech for which was delivered by Ferenczi himself (Ferenczi 1919),⁶⁸ who had developed and completed his earlier study from 1916 on “Two Types of War Neurosis.” Ferenczi's two discussants—Karl Abraham and Ernst Simmel—represented the Berlin Association for Psychoanalysis.⁶⁹ In his presentation, Ferenczi drew a parallel between the materialist view of history and the organic-mechanistic neurological explanations. The latter, which according to him corresponded to the materialist view in sociology, failed completely: “The mass-experiment of the war has produced various severe neuroses, including neuroses in which there could be no question of a mechanical influence, and the neurologists have likewise been forced to recognize that something was missing in their calculations, and this something was again—the psyche.”⁷⁰ After that, Ferenczi reproached neurologists for having needed the horrendous experiences of the war to recognize the significance of psychoanalysis.

However, Ferenczi, Freud, and the other participants in the congress were also concerned about the future of psychoanalysis and its postwar perspectives, as they looked for a new, civilian role for psychoanalysts returning to civilian life. They formulated proposals and plans about how to use their experiences regarding war neuroses in peace times with a view to the mass healing of neurotics (whose number obviously would be increased by the masses of psychologically wounded victims of the war returning to their civilian lives). In accordance with these proposals, free psychoanalytical clinics were set up, first in Berlin (1920) and then in Vienna (1922), as well as training institutions.⁷¹

67 The joint Austrian-Hungarian Ministry of War was represented by medical Colonel Dr. Pausz and medical Lieutenant-Colonel Dr. Valek. The Hungarian Ministry of Defense delegated medical Lieutenant-Colonel Dr. Szepessy, medical Major Professor Németh and medical Major Dr. Hollósy. The Prussian Minister of War delegated medical major Dr. Holm and medical Major Professor Casten. On the command ordering medical colonel Dr. Pausz to attend the event, see ÖStA KA 1918. 14. Appendix no. 29021.

68 Ferenczi, “Der Psychoanalyse der Kriegsneurosen.”

69 The talks on war neurosis delivered at the nominally international congress were also published in a separate booklet, completed with a paper by the absent Ernest Jones. Freud, Ferenczi, Abraham, Simmel, and Jones, *Zur Psychoanalyse der Kriegsneurosen*.

70 Ferenczi, “Symposium on Psychoanalysis and the War Neurosis.”

71 Erős, *Trauma és történelem*; Danto, *Freud's Free Clinics*.

For the moment, however, they were forced to cooperate with the disintegrating *ancien régime*, which was able to run its bureaucracy to the last breath. In the shadow of impending defeat, the Austro-Hungarian Ministry of War was still planning additional measures for a more efficient management of the problem of war neurotics. In this spirit, further neurological departments were organized so that, in accordance with total mobilization, war neurotics could at least be put to productive work, even if they were unfit to serve on the front.⁷² It was with this objective in mind that the joint Ministry of War issued its decree on October 9, 1918 regarding “further construction of nerve stations and treatment of war neurotics.”⁷³ In accordance with the therapies applied until that time, the decree recommended “electric, hydriatic, and mechanotherapeutical treatments,” as well as suggestive hypnosis. It prescribed, among other things, bedrest, isolation and a ban on hospital visits, an “arousing diet,” and smoking. It also put strong emphasis on work therapy. Physicians needed to do all of the above in a manner that ensured that “the patient never get the impression of being pointlessly tortured.” The decree also stipulated that “those patients who have already resisted the doctor’s efforts at several neurological stations should be transferred to such stations where healing is attempted through psychoanalysis.” A few weeks before the collapse of the Monarchy, this prescription had little practical significance. However, it was all the more significant *symbolically*, for it constituted an acknowledgment of psychoanalysis—if only as a last resort—as the treatment of war neurotics who had shown resistance to all other therapies. Plans were also made by the Prussian Ministry of War to set up similar neurological departments that would be open to psychoanalytic treatment, but obviously there was no time for their implementation.⁷⁴

The medical treatment of soldiers affected by war neurosis is one of the most controversial chapters in the history of modern warfare and modern

72 See Hofer, *Nervenschwäche und Krieg*, 566–76.

73 The German draft of the decree can be found at the Kriegsarchiv in Vienna (ÖStA KA 18. 14. A. 43–51). The Hungarian version of the document was registered at the Hungarian Royal Ministry of Defense on October 12, 1918. The document can be found in the Museum and Archives of Military History (HIM HL 1918 Eü. oszt. 641 cs. 569480.12.) The transcription of the latter was published unabridged by Erős et al., *Pszichoanalízis a hadseregben*, 144–46.

74 The International Psychoanalytic Society, of which Ferenczi was elected president at the congress, expressed its gratitude in its letter of October 12, 1918, to the Royal Prussian Ministry of War for the work of their delegation at the congress and pledged to remain at the disposal of the ministry for the treatment and aftercare of war neurotics through the president of the German group, Dr. Karl Abraham (The Archives of the British Psychoanalytic Society, GO7/BA/PO/6/05).

psychiatry. In this history, psychoanalysis undoubtedly played a humanizing role, under circumstances in which the majority of psychiatrists regarded the psychologically wounded of the war as “hysterical” and “malingerers” and considered it their principal duty to restore as swiftly as possible the ability of the soldiers to fight. The early initiatives pertaining to psychoanalytical theory and therapy connected to war neuroses aimed to understand symptoms and interpret the connections within the patient’s life story. Thus, they became precursors to the modern approach to individual and collective psychological traumas, though also sources of eventual heated debates and conflicts.⁷⁵ At the same time, the bulk of psychoanalysts did not question the political and military goals of the war. Although they often voiced their reservations and fears in their private correspondence, as is clearly reflected in the letters exchanged by Freud and Ferenczi,⁷⁶ they nonetheless identified with the powers that sent millions of soldiers into the trenches. Their efforts and involvement were primarily aimed at proposing new tools that seemed more efficient and more humane than the existing ones—which proved to be insufficient and caused unnecessary suffering to the patient—and to restore the mental health of soldiers suffering from psychological traumas for the sake of their “normalization.”

The famous Viennese professor of neurology Julius Wagner-Jauregg, who later received a Nobel Prize, was accused based on a complaint filed by one of his former patients affected by war neurosis of overseeing the harsh and even cruel treatment of war neurotics and regarding them as mere hypochondriacs or deserters at the institution that he directed. A committee of inquiry was set up in which Freud, serving as an expert member, expressed his professional disapproval of these methods of treating war neuroses. He thought that these procedures were brutal and merciless, yet he did not unequivocally condemn them. He even spoke highly of the professional and human qualities of Professor Wagner-Jauregg. As Freud explained to the committee, each neurotic was, in fact, a malingerer, but they were so without being aware of it, and this was precisely the core of their illness.⁷⁷ Thus the psychoanalytical treatment did not offer a way out of the Catch-22 situation of stigmatization in which war neurotics found themselves: “If you heal my symptoms, you send me back into death, to the battlefield. If you do not, I will be mentally handicapped all my life.” This paradox has always characterized the basic condition of people suffering from

75 Erős, *Trauma és történelem*, 13–26.

76 See Erős, *Kultuszok a pszichoanalízis történetében*, 127–147.

77 Eissler, *Freud und Wagner-Jauregg*.

combat fatigue, war neurosis, or trauma caused by other shocking events—from World War I through World War II to the Vietnam War, the Yugoslav Wars, the wars in the Middle East, and other conflicts.

In any case, psychoanalysis was the current that first tried to systematize and embed the experiences related to war neuroses in a theoretical framework, setting the tone for the discourse that would have a decisive impact on subsequent conceptions and research orientations regarding the phenomena of psychological trauma and post-trauma stress conditions. However, more specific research on traumas due to war and other severe shocks started only in the 1940s, after World War II had broken out. The pioneer of this more complex approach was American psychoanalyst Abram Kardiner, a former disciple of Freud.⁷⁸ Kardiner emphasized that traumatic neurosis was a “stand-by state of mind” that served the defense of the ego by trying to eliminate and ward off potential dangers, and it was fixed to these situations as if the stimuli which triggered it were still present. The traumatized person may exclude these recollections from his or her memory or suppress them, but they continue to live on in his or her dreams, fantasies, hallucinations, and anxieties. Detailed examination of the latter conditions began only after the end of World War II, especially in relation to the traumatic experiences of Holocaust survivors. This was not independent of the question concerning the extent to which Holocaust survivors who suffered psychological damage and the relatives of the victims were entitled to compensation; and in general, to what extent their psychological torments would be recognized as a reality equal to physical suffering. The examination of the long-term traumatogenic effects of World War II, which still has resonance today, would go beyond the scope of this study. The professional and also social debate concerning the status of psychological disorders caused by war acts, the antecedents of which—as seen above—date back to pre-World War I times, continued. Post-trauma neurosis or post-traumatic stress disorder (PTSD) gained full recognition as a legitimate psychiatric diagnostic category only after the Vietnam War, and it was first included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association in 1980. PTSD as a diagnostic category continued to generate debates, as a result of which the symptoms and limits of the disorder have been defined over and over again in the subsequent editions of the manual as part of the attempt to strike a delicate balance between treatment and stigmatization.⁷⁹

⁷⁸ Kardiner, *The Traumatic Neuroses of War*.

⁷⁹ See Csabai, *Tűntetőáldorlás*, 113–140; Erős, *Trauma és történelem*, 13–26; Herman, *Trauma and Recovery*.

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