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Pioneers

Charles Samuel Myers (1873-1946)

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The Great War, as the First World War was called at the time, involved millions of victims, among them many traumatized civilians and military personnel. For obvious reasons, psychiatry was mostly focused on the diagnosis and treatment of military victims, as manifested in the existence of various kinds of observational and treatment centres, both right behind the lines, the hinterland, and, for the British, back in the home country, as well as in a tsunami of related publications. Among the many psychiatric publications on war-related trauma, the few written by the British physician and psychologist Charles Samuel Myers have been found to be essential for our understanding and treatment of trauma-generated dissociation, whatever the type and context of traumatization (Myers, 1915, 1916a,b,c, 1919, 1920–21, 1940). Incidentally, it was Myers who first used the label *Shell Shock* in the medical literature, although he did not invent the term. However, he soon regretted using it (even though he continued to include the expression in his publications), as soldiers traumatized in circumstances other than exploding shells manifested the same symptoms. The British Army banned the term, which however is still used.

Myers' time in the British Army, including as a Consulting Psychologist, lasted four years and included many painful if not traumatic experiences in his professional life. I present a brief overview of his career, including his experiences during WWI. Ben Shephard's books (Shephard, 2000, 2014) were especially helpful in this regard. However, Shephard did not fully realize the importance of Myers' observations and treatment of trauma-induced dissociation, which will be discussed in this tribute.

1. Before World War I

Being considered to be the most important British psychologist of the first half of the twentieth century (Bunn, 2001), Myers, then based at Cambridge University, was first involved in anthropological fieldwork, including participating, together with W. H. R. Rivers, W. McDougall and C. Seligman, in the famous Torres Straits expedition, in 1898. Here he could realize his interest in hearing and music. He became qualified as a physician in 1902. Subsequently, he was an experimental psychologist at King's College, London, wrote *A Textbook of Experimental Psychology* (Myers, 1909), and held various important positions, including Editor of the British Journal of Psychology. In 1912 he set up the Cambridge Laboratory of Experimental Psychology, largely paid for from his own resources.

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2. During World War I

Shortly after the beginning of World War I, in 1914, Myers decided to join the army, in order to work in the field in France. To get accepted was not an easy feat because he was over the age limit; he started out as a hospital registrar, and he became, in 1916, a Psychological Consultant to the Army. He was inspired by the French policy of treating soldiers near the front, instead of sending them to the hinterland. This vision was met with strong resistance initially, as Shephard (2014) noted: "'We can't be lumbered with lunatics in Army areas', was the general RAMC (Royal Army Medical Corps) view" (p. 158), but it was accepted eventually. The programme was taken up by the American psychiatrist Thomas W. Salmon and became known as the 'Salmon plan.'

Indeed, during his army career in France, Myers ran into various difficulties and obstacles. As he testified in his 1940 book (see par. 3 below), his views clashed repeatedly with military narrow-mindedness and harsh attitudes toward traumatized soldiers. His nemesis was the higher-ranked neurologist Gordon Holmes, who "was renowned for his hostility to 'psychological approaches' to medicine and his contempt for hysterics" (Shephard, 2014, p. 170). Believing that army discipline was the proper medicine and stating that some of Myers' methods of treatment produced 'a sentimental introspective condition' which was 'decidedly opposed to any satisfactory military operation,' Holmes was instrumental in Myers' demotion from Psychological Consultant in the Army to Consulting Neurologist of a minor section only. Holmes retained overall control of the medical corps' dealings with mental and nervous cases. It was overlooked that Myers, as a psychologist, had pursued the goals of both fostering the military's efficiency and improving the mental health of traumatized soldiers.

In the course of 1917, it became clear that the overwhelming number of traumatized soldiers made it necessary to repatriate many of them back to Britain. In the autumn, an emergency conference was held at the War Office to determine how to stem the further loss of fighting men. Myers attended and was invited "to become involved in the handling of those shell-shock cases back in Britain" (Shephard, 2014, p. 174).

3. After World War I

After the war ended, Myers looked back, with intense frustration, at his experiences with the military system. Although he got well on with "the abler, more enlightened and more progressive members of

the Army Medical Service" (Myers, 1940, p. xi), according to Shephard (2014), he always remained culturally at odds with the military:

> an academic, intellectual and Jew in an alien world. It was probably the reluctance of military doctors to take decisions for themselves, their acceptance of the need to subordinate clinical judgements to the needs of their military masters, and their insistence on observing the regulations, that he found hardest to accept. (p. 156)

However, as indicated in the preface of Myers' 1940 book on shell shock, more than mere frustration may have been involved: he mentioned that he had decided to omit "certain exceptional personal difficulties with which I was confronted in one quarter in France" (pp. x–xi). Thus, except for his contribution to the discussion on "the revival of emotional memories and its therapeutic value" (Myers, 1920–21), following his discharge from the army, in 1920 and 1921, Myers declined invitations to discuss his work, including giving testimony to the War Office Committee on Shell Shock: "The recall of my past five years' work proved too painful" (1940, p. 141). It seems highly probable that he had been traumatized, which may have included having his efforts to save the lives of servicemen condemned to death for "desertion" neutralized and experiences of anti-semitism "that was endemic in the British Army at the time" (Shephard, 2014, p. 156).

Tom Pear, Myer's student at King's College before the war, who was very inspired by him, testified that he found Myers an attractive personality: "unusually many-sided: doctor, anthropologist, musician, Alpinist, traveller" (Pear, 1947; quoted by Shephard, 2014, p. 136). And in his overview of sixty years of psychology in Britain, Hearnshaw (1962) regarded Myers as "perhaps the ablest and most balanced mind among British psychologists of the twentieth century" (quoted by Shephard, 2014, p, 3). However, the impression he made after the war on his former student and protégé Frederic Bartlett (1965) seemed indeed to point to traumatization: Myers was never to be the same again after the war: "The radiant smile was seen less frequently, he tired more easily. Much of his natural buoyancy and liveliness had gone" (p. 5). Bartlett also noticed that he was at his best in the conversational manner and the small class. In front of a large audience, he often appeared ill at ease and vacant.

Having been confronted during the war with the real-life challenges for psychology, and having returned to Cambridge University, Myers wanted to move psychology out of the laboratory and apply it to human problems, such as in industry, education, and nervous breakdowns (Myers, 1918): "applied psychology" instead of "pure psychology" (Costal, 1998). In 1918, the British Psychological Society accepted his proposal to support sections of applied psychology and he was elected as the Society's first president. However, Myers' own focus on industrial psychology was not well received by his colleagues at Cambridge, and he moved to London, where he co-founded the National Institute of Industrial Psychology (NIIP). Here, he wanted to contribute to both organizations' efficiency and workers' well-being—which may have been a far echo of what he tried to accomplish in the Army during the war. However, in Cambridge the negative judgement of industrial psychology—"industrial relations were strictly off the agenda" (Costal, 2001, p. 464)—persisted. Thus, when his former student and protégé Bartlett and a colleague set up a new Applied Psychology Unit at Cambridge in 1944,

> they insisted that 'science' would set the agenda and that the researchers should keep a safe distance from industry. Nonetheless, like most psychologists since, they ultimately shared Myers' conception of applied psychology as a derivative activity, dependent on a more fundamental 'pure' psychology. (Costall, 2001, p. 464)

In 1939, Myers felt called upon to return to the subject of shell shock, when he heard that the Ministry of Pensions had summoned a group of experts to review experience in 1914–18 and draw up guidelines for official policy (Shephard, 2014). As he was not among the invited shell-shock doctors, together with three colleagues he submitted an unsolicited memorandum to the committee, setting out the line they thought ought to be followed. Shephard concluded that there was little difference between the official view and that taken by Myers' more 'psychologically-minded' group.

However, Myers' recommendation for psychological testing was rejected, only to be taken seriously when it became clear what happened when unsuitable men were let into the military. As for Myers, this episode motivated him to publish the report on shell shock that he had started to write in 1916 (Myers, 1940; see below). Shephard (2014) judged it a "muddled book," and it may well be an outcome of Myers' own reactivated trauma-induced dissociation: on the one hand, he described the humiliations and obstructions he had faced in his striving to provide better psychological treatment, as well as in his efforts to save men facing the death penalty, and, on the other, he offered clear, concise descriptions of shell shock, i.e., trauma-generated dissociation of the personality, and its treatment.

In 1946, a celebration of the twenty-fifth anniversary of the National Institute for Industrial Psychology, from which Myers had retired in 1939, took place, in which the institute's role in wartime was praised. Myers responded kindly. Four days later he died peacefully.

4. Myers' observations and treatment of trauma-generated dissociation in WWI service men

Myers' publications on "shell shock", with which he denoted the condition of trauma-generated dissociation in acutely or recently traumatized soldiers, are few in number and seem to deal with the essentials of this condition and its treatment. The dissociative nature of this condition has been far too much overlooked in the massive amount of publications on WWI combat trauma (with "shock" the term used in Britain and France as a synonym of "trauma"—hence, "war-shock" (Eder, 1917)). Still, as Myers conceded eventually, the name was a misnomer, as the same type of symptoms and the underlying dissociation of the personality were also present in soldiers who had been traumatized in situations where no shells exploded. Furthermore, as the label became all-too-enthusiastically adopted in the military, its use became prohibited by the army command in an attempt to reduce the growing numbers of service men complaining about being incapacitated because of it.

In Myers' case presentations, as in many more WWI clinical publications (cf., Van der Hart et al., 2000), it is striking that, apart from the psychoform (cognitive/affective) dissociative symptom of amnesia, somatoform (sensorimotor) symptoms are very much present. He related this dominance to the physical, life-threatening nature of the traumatizing situations the soldiers were in, as compared to "those whose disorder has a purely mental origin" (Myers, 1919, p. 51).

4.1. First contribution

In his first paper on "shell shock," Myers (1915) presented three cases of loss of memory, vision, smell, and taste, which he treated using suggestion and hypnosis. Although shells had indeed exploded nearby during the traumatizing events, he seemed, in this regard, to wonder about the nature of the symptom in these cases. He remarked that these instances

> appear to constitute a definite class among others arising from the effects of shell-shock. The shells in question appear to have burst with considerable noise, scattering much dust, but this was not

> attended by the production of odour. It is therefore difficult to understand why hearing should be (practically) unaffected, and the dissociated "complex" be confined to the senses of sight, smell, and taste (and memory). The close relation of these cases to those of "hysteria" appears fairly certain. (p. 320)

Although Myers did not refer to Janet, he seemed to confirm his view on hysteria as an (often trauma-generated) dissociative disorder (e.g., Janet, 1907).

4.2. Second contribution

Here, Myers (1916a) focused on the use of hypnosis in his treatment of patients with, respectively, total amnesia, rhythmic spasmodic movements, mutism, and localized amnesia. Apart from discussing possible complications affecting treatment course and outcome, Myers remarked that it may be taken for granted that

> the restoration to the normal self of the memories of scenes at one time dominant, now inhibited, and later tending to find occasional relief in abnormal states of consciousness or in disguised modes of expression—such restoration of past emotional scenes constituted a first step towards obtaining that volitional control over them which the individual must finally acquire if he is to be healed. (p. 69)

4.3. Third contribution

Myers dedicated this contribution to the study of over-reaction and "hyperaesthesia" and anaesthesia (including hemianaesthesia) (Myers, 1916b). He was able to trace successfully these localized symptoms to actual blows upon the bodily region in question by sandbags or other objects, or by the patient's fall after being lifted or pushed by the force of the concussion. However, "[i]n a considerable number of cases the site of the sensory disorder caused by the shock was determined by a previous history of pain in that region" (p. 610). Thus, Myers established that prior emotional experiences can be reactivated by current traumatizing events. Myers concluded: "Such phenomena are especially liable to occur when to the effects of shock conditions of previous long-continued anxiety and nervous exhaustion are superadded" (p. 612).

4.4. Fourth contribution

Myers (1916c) focused in this article on observations and treatment of speech disorders, in particular mutism and, in some cases, accompanying deafness, in patients who also suffered from loss of consciousness and amnesia. He believed that, in most patients suffering from mutism,

> [t]he amnesia complained of is almost always due to the onset of a semi-stuporose state, and that most cases of initial loss of consciousness are really the expression of, or, at all events subsequently pass into, a condition of confusion or stupor. (p. 461)

There may take place transitions from a most profound stupor, "in which all cerebral activity is inhibited save those processes that are essential for the continuance of life" (p. 464), to one of ordinary stupor. In this state, the patient's intelligence is active, but he is still absolutely unresponsive to the external world.

> The inhibitory processes, producing such excommunication, may be regarded as protecting the individual against further shock. (So, too, the pain or discomfort in the throat or tongue, or the severe headache, evoked by the mute's efforts to speak, tends to preserve the condition of mutism.) (pp. 464-465)

In this contribution, Myers hinted at the existence, in these traumatized patients, of a so-called disordered personality—which he subsequently also labelled as a "trance-like second personality," "ultra-emotional personality" (Myers, 1919) and, eventually, "emotional personality" (Myers, 1940). This emotional personality is dissociated from an apparently normal personality.[1] When the former is dominant, the inhibition characterizing the apparently normal personality in the form of mutism or other negative symptoms is, "so to speak, "caught off its guard"" (p. 467). Regarding the apparently normal personality, Myers stated that

> the claim may be fairly put forward that when a mute patient has recovered from a condition of stupor but is still amnesic in regard to some of the experiences through which he has passed, the restoration of his normal personality is apparent rather than real. If personality be viewed from a wide enough standpoint, no one can have a normal self so long as part of the activities of that self, once functional, are pathologically inhibited." (p. 467)

4.5. Fifth contribution

In what he at the time called his "final" contribution, Myers (1919) considered some "unsettled points needing investigation." He started out by stating that there was "a general agreement that the war neuroses are to be regarded as the result of functional dissociation arising from the loss of the highest controlling mental functions" (p. 678). In other words, we might add, these disorders involved a lowering of the mental level (Janet, 1907), an insufficient integrative capacity when confronted with extreme threat. However, Myers added, there existed considerable controversy as to how those controlling functions are lost, and precisely what occurs when they are lost. He argued against the views that the existence of posttraumatic symptoms were merely caused by suggestion or by the wish to escape danger. He emphasized the need for careful mental exploration in the waking or hypnotic state. "Without such exploration all such facile explanations as the wish to escape from an unpleasant situation, the habitual persistence of immobility, the desire for a pension or for discharge from the Army, are scientifically worthless" (p. 52).

As for therapy, Myers warned against the enthusiasm that may characterize devotees to one special mode of treatment, as this may make them prone to self-deception. He employed a wide range of interventions; in many cases they included, with or without the use of hypnosis, the lifting of dissociative amnesia and the "reintegration" of traumatic memories and the personality. As he also argued in a short follow-up article (Myers, 1920–21), Myers emphasized the prevention of excessive emotional expression (abreaction) during the integration of traumatic memories, as this could lead to further desintegration. However, his colleague William Brown (1920–21), "pursuing the same method" (Myers, 1919, p. 54), felt that abreaction was the key therapeutic principle (cf., Van der Hart, 2019; Van der Hart & Brown, 1992).

4.6. Final contribution

Apart from the unpublished 1939 memorandum, Myers' last contribution to the subject, was his book, *Shell Shock in France: 1914-18,*

[1] Based on the understanding that each individual has but one personality, however divided it may be, in more recent publications following Myers' distinction, these terms are slighty modified, that is, into "emotional part of the personality" (EP) and "apparently normal part of the personality" (ANP) (e.g., Nijenhuis, 2015; Van der Hart, 2008; Van der Hart et al., 2006).

based on a war diary, published in 1940: He wished the lessons learned from WWI to be applied to WWII. Apart from being an account of his experiences as a medical doctor and psychologist in the Royal Army, this book contains a comprehensive overview of his often-quoted observations of war trauma-generated dissociation of the personality, including its emphasis on the initial severe lowering of consciousness, the alternations between and characteristics of the emotional and the apparently normal personality. Myers (1940) formulated again the essence of its treatment:

> [T]he treatment to be recommended … consists in restoring the 'emotional' personality deprived of its pathological, distracted, uncontrolled character, and in effecting its union with the 'apparently normal' personality hitherto ignorant of the emotional [traumatic] experiences in question. When this re-integration has taken place, it becomes immediately obvious that the 'apparently normal' personality differed widely in physical appearance and behaviour, as well as mentally, from the completely normal personality thus at last obtained. Headaches and dreams disappear; the circulatory and digestive symptoms become normal; even the reflexes may change; and all hysteric [dissociative] symptoms are banished. (pp. 68-69)

5. Myers and Janet

While Myers' studies of trauma-generated dissociation of the personality contain scant references to the existing literature, one cannot but wonder how his views may have been influenced by Pierre Janet, the French master of dissociation: as indicated above, there are some indications of Janet's influence. As Myers testified in a 1918 lecture, the alternation between ANP and EP that he had witnessed in his patients "is strikingly exemplified in Professor Janet's well-known [1904] case of 'Irène,'" which he summarized. That Myers was well acquainted with Janet—who also started out as an experimental psychologist—and his pioneering studies, is evident from his 1939 testimony, in which he also acknowledged Janet's extraordinary observational skills (Myers, 1939):

> … Janet came to realise the psychological factor determining the non-neurological distribution of "functional" anaesthesias, and to attribute them in a "functional" *dissociation* of consciousness into two active currents, the one having no control over, and unaware of but influenced by the other. This principle of dissociation he came later to apply so fruitfully to amnesia, fixed ideas, somnambulism, double personality, etc. His realisation of the enormous influence of beliefs and of auto-suggestion in hysteria, of the weakening of mental resistance and synthesis due to emotional "traumata" and affected by such factors as exhaustion, organic disorders, social environment and heredity, his study of various pathological feelings, e.g. doubt, "incomplétude", fear of action, loss of reality, etc, etc., led him to try to formulate a "psychology of conduct" in the general terms of psychological "tension", "force and "energy", analogous to those which neurology may come to employ. (p. 480)

6. Conclusion

Myers' experiences as a psychologist in World War I led him to realize that psychology should not be limited to the laboratory, but should also be applied outside it. Perhaps it was, apart from his humanity, his open-mindedness and aversion to dogmatic theorizing (Bartlett, 1965), that enabled him to understand, and sympathize with, the suffering of traumatized soldiers in World War I, while also trying to contribute to the army's organizational needs/objectives. His attempts to bridge both domains were extremely challenging, hard to defend against those, even among medical staff, who regarded servicemen merely as material, not deserving any compassion. Myers fundamentally understood shell or war shock, and thus posttraumatic stress disorder (PTSD), as a dissociative disorder, and the way in which he formulated this understanding appears to be also relevant for the more complex dissociative disorders.

Declaration of Competing Interest

The author declares that he has no competing interest.

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