

Shellshock' and 'PTSD': Two Different Conditions, Two Different ways of Understanding and Handling War Trauma

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Abstract

It is often thought by lay readers that Shellshock and the more contemporary PTSD are just different terms for the same condition, caused by the traumas of warfare. Yet this is inaccurate because it simplifies and homogenises them. This article reveals the complicated truth of each condition, in turn war trauma more generally, showing readers the lack of nuance in the above view by comparing and contrasting the ways each is understood and handled. Ultimately both are different conditions because they come from separate eras of human history, and the fact is that all health conditions are created by society, they are not objective of it. Comparing today's world of PTSD with the early 20th century trenches Shellshock emerged from, society has clearly changed. Simple answers are out of the question: To understand the far horizons of our minds, we must first understand how they work, and looking at it from the angle of war trauma is one way of doing so.

Keywords: [Click here to add keywords.]

Introductions

Shellshock and Post-Traumatic Stress Disorder (PTSD) are two well-known conditions which can occur during and/or after war trauma. Trauma is “a kind of wound” which originally referred to physical injury but has become attributed to psychological wounds over the past century (Garland, 1998: 9). Definitively, Shellshock is a nervous reaction in warfare significant enough to stop normal human functioning, coined by Dr Charles Myers during the First World War (WW1) (Shepherd, 2002 and Green, 2015). PTSD, included in ‘the Diagnostic and Statistical Manual of Mental

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Disorders' (the DSM), from 1980, is when debilitating symptoms appear after a soldier has seen horrific events, usually months or years later (Herzog, 2014: 128-129). Typically, both lead to long-lasting influences on the lives of the individuals affected. They can be compared and contrasted in numerous ways; in terms of historical origins, symptoms and causes, treatments, and criticisms against them, all of which will be covered in this essay. Additionally, this is an important aspect to investigate as it covers a gap in the research seldom referred to in other works on the subject, providing a deeper understanding of each condition and war trauma in general. Thus, despite space constraints, this essay aims to provide a concise comparison of the main points of Shellshock and PTSD, exploring how each is understood and dealt with, and concluding on whether or not they are the same disorder.

The Historical Context

A brief historical context is important because it provides some grounding for comparisons in the themes that will follow. Shellshock is considered the first partial acknowledgement of the psychological costs of warfare, whereas the dawn of PTSD is thought to signify the moment when veteran's suffering was fully realised and put into law (Wessely, 2006: 269). Each condition was formed in different environmental, social and medical contexts. For example, WW1 was an industrialised war, subjecting troops to static trench combat with shells constantly raining down on them, so the first physical and later psychological understandings of Shellshock developed in this context (Shepherd, 2002). Vietnam, however, was a long guerrilla war fought in hot and wet jungle conditions where the enemy was often unseen, so had immediately more psychological connotations (Shepherd, 2002). Additionally, psychiatry was in its infancy at the time of WW1, whereas by Vietnam, although PTSD was not yet official, military psychiatry was a more powerful force (Shepherd, 2002: 341).

During WW1, German Psychiatrists thought Shellshock was not a condition, but instead showed that the affected soldier was weak or lying, it was part of the "malingerer's charter" for a free war pension (Wessely, 2006: 271). The British had similar general views, believing soldiers who succumbed lacked the "moral fibre" to keep fighting: thus, psychiatric and medical diagnoses were

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avoided to reduce manpower wastage; Shellshock was nothing more than a cowardly excuse (Wessely, 2006: 271 and Shepherd, 2002). This was powered by Edwardian English and German traditional values, in which manliness, self-control and patriotism were paramount (Shepherd, 2002: 19). In complete contrast, PTSD is far more sympathetic and political: it developed after the Holocaust and Vietnam, enthused by psychiatrists like Robert J Lifton, Holocaust experts, Hiroshima survivors, Vietnam Veterans Against the War (VVAW) and many more (Herzog, 2014: 150). They campaigned for decades to obtain medical and social acknowledgement of psychologically wounded victims of wars and other traumatic events, pushing PTSD into the DSM and showing the public that trauma can be psychological, and thus exist without visible signs (Herzog, 2014: 150-152 & Shepherd, 2002: 366-367). Differing from Shellshock, PTSD was born out of massive social changes during the 1960s and 70s, including the civil rights movement, which led to changes in outlooks on trauma, so it was never limited by tradition (Shepherd, 2002). These historical understandings and ways of handling Shellshock and PTSD suggest they are not merely dissimilar ways of looking at the same condition, but that they are different conditions altogether.

The Symptoms and Causes

The many symptoms and causes of each condition are the main way to compare and contrast Shellshock and PTSD, revealing much about how they are understood. The first recorded case of Shellshock was a young soldier in 1914 who was almost killed by German artillery, immediately believing he was going blind despite the absence of physical injury (Shepherd, 2002: 1). He was seen by Charles Myers who coined the term Shellshock when others started coming down with symptoms, including the inability to smell, taste, hear, stand up or defecate properly, involuntary movements and vomiting, amnesia, nightmares, odd gaits and so on (Shepherd, 2002: 1, 73-74). Barry Heard, an Australian Vietnam veteran who suffered from PTSD years after the war, had comparable symptoms, including soiling himself in everyday situations, shaking and weeping uncontrollably, and amnesia- he could not remember the first months of his collapse, suggesting that they are similar disorders (Heard, 2008: 265-267, 263-264). One officer in WW1 had recurring nightmares of his mangled friend walking toward him; Heard also had frightening dreams, eventually collapsing with severe PTSD after a nightmare during which he returned to the Vietnamese jungle, causing symptoms of a severe heart attack (Rivers, 1920: 190-191 and Heard,

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2008: 261-264). Here it looks as though they are comparable conditions, yet, conversely, PTSD usually develops months or even decades later, as in Heard's case, it has a "delayed onset," whilst Shellshock symptoms can have immediate effects (Heard, 2008 and Young, 1995: 107-108).

Additionally, there are other differences, namely that accounts of Shellshock do not directly include the uncontrollable aggression and guilt that can be symptoms of PTSD. For instance, AJ, an ex-Royal Marine sniper suffering from PTSD after the war in Afghanistan, lost control when another car cut him off; chasing the driver and then getting out in the middle of the road shouting and swearing, despite the presence of his family (Green, 2015: 5). Furthermore, Heard felt incredibly guilty for making a mistake with his radio which meant some of his friends died before the medivac helicopter could save them, the situation he returned to in the nightmare (2008: 278-280). This guilt was arguably one of the causes of his symptoms, he could not let go of his error during the traumatic events of that day in Vietnam (Heard, 2008: 278-280). The distressing incident itself is the key causal understanding of PTSD, part of criterion A in the DSM-IV-TR, the fourth edition of the 'Diagnostic and Statistical Manual of Mental Disorders,' published in 2000 by the American Psychiatric Association, and providing global standard criteria for classifying mental disorders. (Hunt, 2010: 53). It is psychosomatic, the "traumatic memory" of the frightening and unforgettable event leads to a malfunction in the mind's ability to handle stress, causing mental and physical symptoms (Hunt, 2010: 53 and Shepherd, 2002: 389). This memory is permanently etched into the mind, hence the reason why AJ cannot forget the faces of two young Afghan police who bled to death during a firefight (Green, 2015: 1).

In opposition, Shellshock symptoms were initially thought to be caused by somatic damage to the nervous system resulting from shell blasts (Shepherd, 2002: 2-3). This is similar to the idea that Mild Traumatic Brain Injuries (MTBI's- concussions), which could happen after large explosions, might be a cause of PTSD: people with these injuries can suffer analogous symptoms, which led to Pentagon funded research (Green, 2015: 8). Otherwise, PTSD, distinct from Shellshock, is understood to be purely psychologically produced. Yet, understandings of Shellshock did shift to psychological ones, but the conventional view still differed from PTSD. For instance, connected to the historical perspectives on moral causes, prevalent military psychiatrists like Edgar Douglas

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Adrian and Lewis Yealland considered Shellshock to be the reaction of cowards, caused by “a weakness of the will...and the intellect, hyper-suggestibility and negativism” (Shepherd, 2002: 76). This is the understanding that Shellshock victims have fixed ideas which override the more positive suggestions of others, the resulting debilitating symptoms being a way to avoid the front (Shepherd, 2002: 76). Another perspective contrasting PTSD was based on the hereditary and personal predispositions of the soldier rather than what he witnessed; some being more susceptible to Shellshock than others (Young, 1995: 55). To illustrate, one account describes a soldier with Shellshock symptoms, the cause being put down to his father being an alcoholic, his excessive smoking habits- bringing in the moral element- and reports that he was a nervous loner at school (Young, 1995: 55).

Nonetheless, despite being virtually ignored and limited by the tradition-based military, some proposed the event was the cause of Shellshock, the precursor for the understandings of PTSD deliberated earlier. To illustrate, Rivers suggested symptoms are caused by repressed traumatic memories of highly stressful events (1920: 186). He thought that if these memories were repressed rather than properly faced, a behaviour fortified by the stiff upper-lip culture of the time, symptoms would become worse over the years (Rivers, 1920: 186). This parallels the delayed onset characterising PTSD and Heard's fear of being judged badly for his collapse, which took decades of avoidance to become severe (2008: 263-267). Linking to the politicised nature of PTSD, which contrasted Shellshock in the historical context, enormous social changes, alongside media coverage of the Vietnam War, led many Americans to mistreat already culture shocked veterans on their homecoming, worsening or triggering PTSD symptoms (Shepherd, 2002: 343-344, 358-359). Thus, Shellshock and PTSD have relatively similar symptoms, but mostly differ around causal understandings, meaning they cannot be defined as the same condition.

Ways of Treating Shellshock and PTSD

Treatments for each condition also highlight comparisons and contrasts. Reflecting the historical context, psychiatry was in its infancy during WW1, and so the military objective was to maintain manpower against cowardice. This meant most Shellshock treatments were primitive, pushing for

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quick recovery and immediate re-deployment (Shepherd, 2002). The average treatment for Shellshock was to tell the soldier there was nothing wrong with him and allow a few days rest (Shepherd, 2002: 57). Others were sent out to work on French farms for a month before returning to the front (Shepherd, 2002: 60). Adrian and Yealland, introduced in the last theme, had the quick fixes the military desired: they treated Shellshock by authoritative suggestion with the aid of faradic electricity (Shepherd, 2002: 76). Thus military discipline was brought into treatment: they would tell the Shellshock sufferer that they would recover when commanded, and would electrocute them until they obeyed, the voltage constantly increasing to excruciatingly painful levels (Shepherd, 2002: 76-77). They believed soldiers could be 're-educated' by suggestion, overcoming their supposedly weak intellect and its irrational reasoning, so they applied the same methods to every case (Shepherd, 2002: 77). Advocates of this treatment, such as Dr Arthur Hurst, claimed to be able to cure Shellshock in twenty-four hours (Shepherd, 2002: 79). Peer pressure was another useful method at the time, especially as Shellshock was highly stigmatised, leading soldiers to ignore their symptoms to avoid losing face (Shepherd, 2002: 57). Conversely, the military and charities encourage those with PTSD symptoms to come forward for treatment, differing from the subjective assumptions around Shellshock treatments (Green, 2015: 6-7).

Contrasting against the harsh approaches to Shellshock, PTSD treatments are gentle and advanced, including prescription drugs, cognitive behavioural therapy (CBT), psychodynamics and so forth, providing a gradual healing process rather than a short sharp fix (Shepherd, 2002 and Young, 1995). For example, Barry Heard joined a twelve month programme for PTSD sufferers at the Heidelberg Repatriation Hospital in Melbourne (2008: 272). It included exercise, lectures about PTSD, yoga and meditation, music, art, making friends with fellow victims, CBT and group therapy, all based on the acknowledgement that it takes time to heal and that some wounds never will (Heard, 2008: 272-278). In one of the group therapy sessions, Heard released the painful guilt of the radio incident; the discussion with the therapist and other sufferers helping him see the event in a fairer light, and to remember that he was only twenty-one at the time (Heard, 2008: 278-280). Accordingly, PTSD treatment involves a very understanding and compassionate environment, a far cry from the lonely tortures Shellshock casualties faced in Yealland's company. CBT teaches strategies for dealing with anxiety and stress, replacing negative thoughts with positive ones, in turn helping victims

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reinterpret traumatic events (Young, 1995: 177-179). Heard was taught breathing and muscle controlling techniques, the latter preventing him from soiling himself as often (2008: 283-284).

The marine sniper AJ tried “Eye Movement Desensitisation and Reprocessing” (EMDR) for his PTSD, which encourages sufferers to recollect traumatic memories in order to desensitise/objectify the emotions around them, which did not work for him (Green, 2015: 4). This underscores the understanding around PTSD that each person is affected differently, so particular combinations of treatments are tailored to the individual through regular discussions with them about what is working and what needs adjusting (Young, 1995: 179-186). Following on from Rivers understanding of Shellshock causes conferred earlier, PTSD treatment is consequently grounded in facing the traumatic event, contrasting the orthodox Shellshock ‘cures’ which ignored distressing memories in favour of overcoming reputed weaknesses: a quick fix for military efficiency.

Despite the vast contrasts, as with causes, PTSD treatments are somewhat similar to Rivers humane ones. As he understood the event to be the cause of the symptoms, he talked with victims to try and make them feel better about and accept what happened, to prevent unhealthy repression (Rivers, 1920). Myers used hypnosis for the same reason, to gently help Shellshock sufferers extricate themselves from the traumatic memory, and its symptoms, by calmly reliving it, similar to Heard’s experience in group therapy (Shepherd, 2002: 49). For example, returning to the Shellshocked officer with nightmares of his dead friend blown apart by a shell, Rivers highlighted the fact that he likely died instantly without suffering, something the officer took comfort in, leading him to find closure in a dream where he spoke to the friend, his health subsequently returning (1920: 190-192). Still, treatments like these were outweighed by the likes of Dr Gordon Holmes who thought Shellshock should be callously cut out to stem the flow of hysteria through the ranks, regardless of the underlying psychological causes (Shepherd, 2002: 48-49). Accordingly, the treatments contrast so much that it is impossible to argue that Shellshock and PTSD are merely different ways of understanding and handling the same condition.

The Criticisms of each Condition

Lastly some criticisms of Shellshock and PTSD reveal comparisons and contrasts between them, and emphasise others already mentioned. Although PTSD understandings and treatments are advantageously more sympathetic than Shellshock, any trauma, not just war, can be considered a cause, so someone can abuse it by faking symptoms (Shepherd, 2002 and Summerfield, 2001). It has become so wide ranging that it “lacks specificity,” and risks becoming “clinically meaningless” as anything from being mugged to childbirth and “verbal sexual harassment” are considered causes of PTSD (Summerfield, 2001: 96-97). To illustrate, in the western materialistic society an industry has formed around compensation claims in the UK and elsewhere, so people seek PTSD status to make money, even for minor incidents or normal job stress, one ambulance driver claiming £5000 because he saw people dying at work (Summerfield, 2001: 96 and Toolis, 2009). From previous discussion, this was never a problem with Shellshock as it was assumed those with it were cowards or malingerers who wanted to avoid being sent back to fight (Wessely, 2006: 271). Accordingly, the term PTSD can be considered too inclusive whilst Shellshock was never wide-ranging enough.

Nevertheless, analogous to the official understanding of Shellshock at the time, some believe PTSD is not a condition, but just a lie used by malingerers, a view promulgated by publications such as ‘Posttraumatic Stress Disorder: How to Apply for 100 Percent Total Disability,’ which encouraged faking symptoms to receive benefits (Shepherd, 2002: 387 & 395). Also, as touched on in parts of this essay, both have stigma in common, albeit on differing levels: Shellshock was stigmatised officially in the views of generals and psychiatrists such as Yealland, and unofficially as the peer pressure treatment emphasised (Shepherd, 2002). The stigma surrounding PTSD is mostly unofficial, deterring many from receiving treatment. To illustrate, Heard avoided his PTSD diagnosis because he feared being judged badly (2008: 267 and Green, 2015: 6). Clearly, with all these problems, a more specific understanding of war trauma is required; PTSD may eventually be replaced by something new, as occurred with Shellshock a century ago. Therefore, in terms of criticisms, Shellshock and PTSD are products of different times with their own problems, some of which are comparable, others contrasting. Despite a few similarities, they cannot be argued to be the same condition here.

Conclusions

Shellshock and PTSD are both born of war trauma, meaning that there are a few similarities, including Barry Heard's symptoms equating to Shellshock ones, the possibility of somatic causes, the stigma around them, and the views of Rivers and Myers that symptoms come from the traumatic event and require gentle treatments. Nevertheless, these are eclipsed by the differences between the two conditions, taking into account their separate historical contexts, the delayed onset of PTSD against the more immediate Shellshock, the way conventional Shellshock understandings focus on morality and predispositions whereas PTSD focuses on the traumatic event, Shellshock lacking the politicisation of PTSD, the quick fix aim of primitive Shellshock treatments versus the advanced healing process for PTSD victims, and so on. Further analysis is required in order to fully examine the themes discussed in this article, especially in terms of how each is diagnosed, Freud's views, and the many other thinkers that had to be missed out. Nevertheless, this comparison has shown that "there continues to be no consensus in the meaning of the story," there are many different hypothetical conditions which are all eventually replaced by something else, but war trauma itself continues to exist (Herzog, 2014: 155). Overall, looking at the ways Shellshock and Post-Traumatic stress disorder are understood and handled, the similarities, mostly concentrated in symptoms and the views of William Rivers, are heavily outweighed by the contrasts, so they cannot be considered the same condition.

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