

SAMEER S KASSIM offers a sociological and historical perspective on the diagnosis and treatment of shellshock, and contrasts this with attitudes towards the modern classification, PTSD.



MILITARY PSYCHIATRY: a social and clinical examination of shellshock and post-traumatic stress disorder

Introduction

From ancient times, fatal injuries and casualties have been associated with the concept of waging war. However, as a result of the mechanisation and mass mobilisation of warfare during World War I, casualties with psychological damage have been increasingly reported, not only during the Great War itself, but also during World War II and numerous conflicts since.¹

Shellshock affected not only those at the front line, but also many servicemen at the rear, including medical corps personnel, commanding officers, and soldiers in divisional control units.^{2,3} It is the purpose of this paper to examine shellshock, by assessing the social and clinical aspects of the disorder as it existed during the Great War, as well as in subsequent conflicts up to the present day. It will be shown that the basic medical treatment of the men who experienced shellshock was inherently inappropriate, based on the idealised social norms and ingrained concepts of masculinity prevalent during the years leading up to the Great War. Clinical features will also be discussed, as well as the social milieu and its relevance to the treatment of both men and disease. Finally, a contemporary theory and its modern successor will be considered.

Diagnostic origins

WHR Rivers, one of the pioneers of modern British psychiatry, noted that the disorder known as shellshock began with what was thought to be a reaction to trauma received from the concussive effects of exploding mortar shells in the battlefield.⁴ However, it soon became apparent that most cases of shellshock were reported by men who had never come within range of any type of mortar fire, and so Rivers and his colleagues began to re-examine their hypothesis. As the Great War dragged on, the theory was revised to reflect mainly mental factors, which were “the spark which releases deep seated psychical [sic] forces due to the strains of warfare”.⁴ However, since any mentally deviant behaviour displayed by soldiers during the Great War was commonly termed ‘shellshock’,⁵ the term did not describe a particular disorder of war *per se*, but was rather a blanket diagnosis for a cluster of disordered symptoms.

This ambiguity in defining the disorder allowed general physicians and psychiatrists to diagnose numerous soldiers as suffering from the effects of shellshock. Early symptoms of the disorder were grouped into three common forms. The first group involved pseudo-neurological failures including: partial paralysis; loss of memory; and, disturbances in vision, speech, taste and smell.^{6,7} The second group of symptoms included cognitive distortions, such as: re-enactment or re-experiencing of the event;⁸ sluggishness in thinking, moving, or responding; fixation on details; extreme aggressiveness or fear; fatalistic beliefs; and, depression.² Further symptoms included sleep disturbances, social withdrawal, gastrointestinal ailments, hyper-vigilance, and some psychological co-morbidities, including drug addictions.^{2,9} However, of all these possible symptoms, neurological failures were of the greatest concern to most physicians – as well as to society at large – because of their association with the unmanly ‘female’ diagnosis of hysteria.¹⁰ Shellshock seemed to threaten society’s concept of the noble warrior, the muscular Christian, the valiant patriot, the ‘true man’.

The changing treatment of shellshock from the Great War to the present day has been influenced by the contemporary values and ideals of society, as can be seen from an assessment of its evolution through subsequent conflicts.

General social representations

During the early part of the 19th century, “European society represented itself through ideal types which came to symbolise each country’s values.”¹⁰ Central to this idea was the concept of the ‘true man’. The notion of the ‘true man’ involved an individual dedicated to upholding society’s norms and ideals, and laying down his life for them if necessary. He was a man of control, yet committed to moderation and liberal principles.¹⁰ Furthermore, he was a Christian, or at least a respecter of Christian values, a man of will and of willpower, a repository of courage, dignity, honour, and duty to home, country and his fellow man.^{1,6,10}

This whole concept was, of course, part of the great institution (or illusion) of Empire, for who but such fine individuals – true men who would willingly sacrifice their lives for a noble principle – would be qualified to rule impartially the vulnerable and disenfranchised masses of God’s people in distant lands? At home as in school, on the playing fields and in the great universities, this is what was taught.⁶ The allegiance was to an old ideal, one dating back to Athens, Sparta, Rome and far beyond: an ideal epitomised by one’s country, its values, its history, its survival and its contribution to the progress and civilisation of mankind. Any deviation from the acceptable role and behaviour of a ‘true man’ was seen not only as uncharacteristic, perverse, effeminate and feeble, but as a threat to the foundation of European imperial hegemony.¹⁰ Further, the distinction in roles for both men and women in society, as reflected in the accepted expectations of the ‘true man’, created distinctions in medical diagnosis and in the treatment of illness. It was thought that men could not be affected by women’s diseases, including hysteria (a mental disorder characterised by emotional excitability, and sometimes by amnesia or a physical deficit, such as paralysis, or a sensory deficit, without an organic cause). Clearly then, the pseudo-neurological symptoms of shellshock were an affront to society’s standards. Shellshock victims were often branded with the stigma of being weak, feeble-minded and of low class.^{6,10} Some people even felt that shellshock was a result of racial and genetic predispositions: it was thought by some that Jews had a racial inclination to hysteria, while Scots and Irishmen were prone to malingering.¹⁰ Thus it was all too common for men with genuine shellshock to be treated by reluctant doctors, examined by biased medical boards, and ostracised by society on their return to the country they had been fighting to preserve.^{6,11}

English perspective on masculinity and warfare

In the English context, war was seen as the supreme test of masculinity.¹⁰ A soldier in full control of his thoughts, behaviours and actions would be able to cope with the experience of battle and adjust to the harsh realities of war. What is more, he would face death with courage.¹⁰

This notion of masculinity, pervasive though it was, was not always lived out during the realities of combat, and individuals falling short of the ideal were often relegated to the ranks of the shell-shocked. From there, soldiers were seen, treated and reassigned to non-combat duties; when they were discharged, they were often regarded with rancour and disdain.¹² Most of the documented evidence of this type of mistreatment by superiors, society and physicians comes from the post-war era in the context of legal actions for medical treatment, monetary compensation and military pensions.

A physician writes, in 1942, that this “so-called ‘functional nervous disorder’ has not shown any tendency to decrease, thanks partly perhaps to the government’s generous policy of paying compensation so long as the symptoms are retained”. He adds, “one can heartily agree with ... the arguments in favour of lump sum compensation for such cases, as against the instalment method – a method which all too often tends to super add a ‘compensation

neurosis”.⁵ Clearly, this author regards government assistance in the form of an annual pension not only as prolonging the term of the illness but also increasing the numbers of malingers, a cohort that he thought was far in excess of those actually suffering from shellshock. This was a common view among physicians at the time and, what is more, it extended to military medical review boards in the post-war era, as described by Peter Leese in his 1997 paper ‘Problems returning home: the British psychological casualties of the Great War’.¹¹

Leese chronicles numerous examples of soldiers not receiving compensation when there was, in his opinion, a clear reason for them to do so.

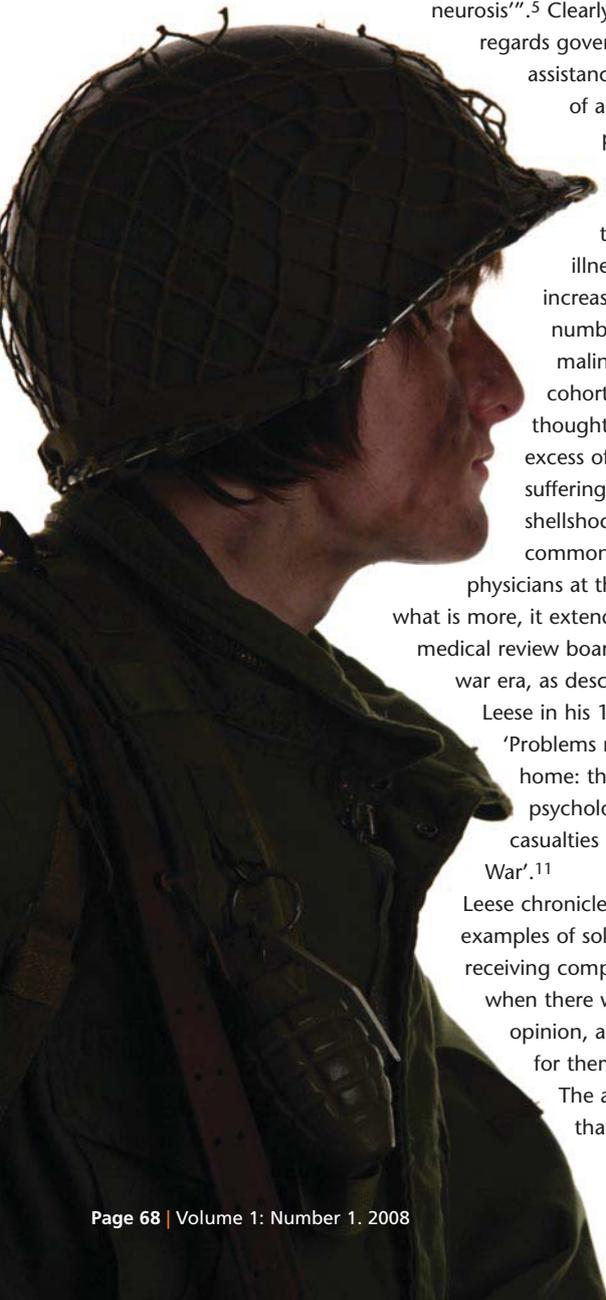
The author argues that the

authorities ignored the needs of ex-servicemen, failed to recognise mental disability as legitimate, and often displayed no sympathy for returning soldiers.¹¹ It is not unreasonable to ask why this was the case. According to Leese, Sir John Collie, author of *Malingering and Feigned Sickness*,¹³ and a noted sceptic regarding the pathological nature of shellshock, was primarily responsible. As chief medical advisor to the Ministry of Pensions he displayed and was well known for a heavy-handed approach to both mental illness and shellshock. The Ministry of Pensions’ selection of this individual as its chief medical advisor is now seen as cynically self-serving. Collie and his colleagues believed that hard and continuous work was the only way to be truly happy, as well as to salvage those who were suffering from the wasting disorder of shellshock. This reflected the popular concept of the ‘true man’ and was a crude attempt to put individuals who had jumped track back on the rails.¹¹

Reforms in medical nomenclature and diagnosis reshape shellshock. A number of social and philosophical changes occurred between World War II and the 1990s, opening the door for a more scientific approach to both psychology and trauma. During these years the American Psychological Association generated the Diagnostic and Statistical Manual (DSM) for use by clinicians, the better to identify, diagnose and research mental disorders. The DSM continued to change the names and taxonomy of the disorder of shellshock, reflecting social reforms between the 1950s and the 1990s. In the DSM-I, shellshock was known as ‘gross stress reaction’ and by the time the DSM-III was published in the 1980s this had metamorphosed into ‘post-traumatic stress disorder’ (PTSD) and was categorised as an anxiety disorder.^{7,14} This new disorder was incorporated into the DSM as a result of direct experience with patients from the wartime context of shellshock, and once again the disorder transitioned back into civilian territory. Non-military as well as military clinicians acknowledged that this disorder arose as a consequence of an interaction of: i) the stressor defined by the nature of the stressor and time exposed to it; ii) personality, coping and pre-belief systems; and, iii) the recovery environment, such as social support as shown following World War II.^{7,14} However, the new DSM-III classification criteria of PTSD allowed for people – women as well as men – who had experience with a broad spectrum of traumatic events to be brought under its umbrella. The new disorder thereby eliminated part of the stigma attached to men who would previously have been diagnosed with shellshock in the battlefield. Not only was the stigma of the disorder reduced, but so was the harsh medical and psychological management that characterised the condition during the world wars.

A retrospective comparison of socio-medical treatments then and now

A major priority for all military units involved in combat during the Great War and World War II was to keep troop strength at the maximum.^{1,2,12} Additionally, during the pre-PTSD era, the main medical treatments were reflective of the socio-cultural norms of the time. For instance, the English and the Americans believed in keeping their units functioning and returning soldiers to duty as



soon as possible. As a result, most soldiers were treated to rest and recuperation at or near the front for short periods of time. Only if the condition of the patient deteriorated was he moved to a divisional hospital or, in severe cases, sent home.^{1,2,12} Those that were sent home, and then succumbed to full-blown shellshock, were treated through short-term, drug-induced psychoanalytic procedures. Soldiers were administered sodium pentothal to induce a semi-narcotic state. Physicians would then probe soldiers' memories for the traumatic experiences and underlying emotions thought to be the cause of the pseudo-neurological symptoms of their shellshock. These impressions were used to create a memory that corresponded to the actual event in question. It was thought that the joining of the subconscious emotion to memories of the experience would alleviate the pseudo-neurological symptoms of the disorder.^{6,7,12} However, failing this treatment, soldiers were subjected to either insulin or electroshock therapies at hospitals in their home countries.¹² Currently, numerous treatment options are available for those suffering from PTSD. However, the two most prevalent forms of treatment are pharmacotherapy and cognitive-behavioural therapy (CBT). Often, anti-psychotics and antidepressants are employed to reduce the clinical features of PTSD.^{15,16} However, this therapy does not deal directly with the patient's emotions or feelings. CBT, on the other hand, requires the patient to meet a therapist. These patients may supplement their treatment with medication and they are subjected to a number of individualised therapies such as relaxation therapy (breathing and other exercises), cognitive challenges and flooding. These exercises are used by the therapist to change the mindset of the patient in relation to the trauma experienced and to introduce the aversive stimuli associated with the event in order to reduce the anxiety and fear associated with it.¹⁶ Neither of these therapies involves any gendered biases, nor

do they consider the ideology of the 'true man' (or 'true woman' for that matter). These treatment options consider only the personal aetiology of the trauma. Thus, in this respect, both men and women are treated equally, and no stigma is attached to either men or women regarding their ordeal.

Conclusion

In the end, soldiers who have given their lives in defence of their country have done the 'manly' thing. That is, they have made the ultimate sacrifice for their fellow citizens, they have guarded society's values and they have acted freely as well as rationally in choosing their own fate. This remains true. However, some individuals who have survived their wartime experiences carry a tremendous burden from the psychological scars they received. All too often in the past, society and the medical profession failed these soldiers, sailors and airmen: they were treated as cowards in the services and at home; and, they were denied proper medical care, adequate compensation, and the normal military pension. However, in time, society's values changed, the 'true man' evolved into 'everyman' and our understanding of psychiatric disorders increased. Now, both men and women suffering from the aftershocks of traumatic experiences can be treated physically, emotionally and socially without the stigma perpetrated by the old gender- and race-based ideology.

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