

*World War I Shell Shock To Afghanistan PTSD: Changing Symptoms As a
Result of a Changing Social Discourse*

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When focusing on post-traumatic stress disorder, there is a large emphasis on the initial moment of trauma that is associated with the diagnosis. This holds true for the diagnoses that came from the Vietnam War, from various peacekeeping missions, and now from Iraq and Afghanistan. Even before PTSD became a recognized diagnosis, the diagnosis of shell shock and war neurosis in World War I and II largely focused on the specific event that caused the soldiers to develop cases of ‘combat stress’. Although there may be a specific moment of trauma that can be related to a PTSD diagnosis, there are more elements that factor into a soldier being diagnosed with this disorder. That being said, when comparing cases of WWI shell shock and PTSD from combat in Afghanistan it can clearly be seen that the soldiers of each respective group display vastly different symptoms associated with their diagnosis. The symptoms of shell shock in WWI most often presented physically, such as mutism, deafness, and chest pains.¹ Comparatively, the commonly held symptoms of PTSD in Afghanistan veterans are re-experiencing, avoidance, and hyper arousal². Presented with these comparative symptoms, the question of why and how these symptoms present so differently arises. The research question that will be explored in this paper is: Why do the symptoms displayed by soldiers differ so greatly when looking at shell shock in World War I and PTSD in Afghanistan? After engaging in an exploration of milestone conflicts between WWI and Afghanistan it can be concluded that when looking at the veterans there are visible differences in shell shock

¹ Edgar Jones and Simon Wessely. *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (East Sussex: Psychology Press, 2005), 19.

² Gerald M. Rosen, *Posttraumatic Stress Disorder: Issues and Controversies*. (England: John Wiley & Sons, Ltd, 2004),16.

and PTSD symptoms displayed by each respective group. These differences can be attributed to the notion that symptoms are a product of the social discourse and the medical understanding of the diagnosis at the time of the conflict. In order to properly prove the presented thesis, this paper will be broken down into three sections, each outlining a landmark conflict with relation to the changing attitude towards PTSD. The first section will be centered on the understanding of shell shock during WWI, followed by a section on the post-Vietnam era in the United States, and ending with the current understanding of PTSD after Afghanistan. Each of these respective sections will explore the diagnosis at the time of the conflict, the treatments used, the symptoms, and will be brought together with a discussion on the social discourse of the diagnosis at the time. These three unique, but critical, conflicts will demonstrate that the visible difference in symptoms is the result of changing social dialogue towards the diagnosis, which stems from constant developments in the medical field towards PTSD. Before beginning with the exploration of these conflicts, it is important to outline the operational concepts that will be used in order to engage in an accurate analysis of the changing symptoms and diagnosis.

Operational Concepts

The first, and arguably most complex, term to define is “shell shock.” Due to the nature of the diagnosis, the definition of this concept needs to include both the physical and the psychological realm. First coined by Charles S. Meyers in 1915, the term had varied definitions throughout the course of the war however, it was mainly described as a diagnosis stemming from traumatic experiences in combat which was accompanied by

physical symptoms when no other organic injury could be seen.³ The second concept essential to the changing understanding of the diagnosis is ‘war neurosis.’ War neurosis is the term that replaced shell shock after the First World War and would be referred to continuously throughout the following decades when speaking about the stress that arose from combat. This concept is described as being a ‘form of hysteria or psychasthenia induced by the acute shock of war conditions on a sensitive nervous system.’⁴ Following the path of increased medical understanding regarding ‘war neurosis’ the next concept that requires definition is post-traumatic stress disorder (PTSD). In the fourth Diagnostic and Statistical Manual of Mental Disorders (DSM), PTSD is defined as an anxiety disorder in which an event’s “severity, duration, and proximity are the most important factors affecting the likelihood of developing the disorder,” thus explaining that it can “develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.”⁵ This concept is important to keep in mind as it ushers in the criteria from which the current understanding of PTSD is built upon. The final concept, which holds structural significance to the argument, is Rosen’s idea of ‘time- and culture-bound’ symptoms of PTSD. Through a demonstration of primarily sensory-motor symptoms from German soldiers in WWI to modern symptoms such as flashbacks and anger, Rosen introduces the term ‘time-and culture-bound’ which serves to demonstrate that while

³ Anthony Babington. *Shell-Shock: A History of the Changing Attitudes to War Neurosis* (South Yorkshire: Leo Cooper Publishers, 1997), 43-44.

⁴ Terry Copp and Mark Osborne Humphries *Combat Stress in the 20th Century: The Commonwealth Perspective* (Ontario: Canadian Defense Academy Press, 2010), 34.

⁵ Gerald M. Rosen, *Posttraumatic Stress Disorder: Issues and Controversies*. (England: John Wiley & Sons, Ltd, 2004),15.

armies often recognize a form of combat stress, the signs and symptoms vary with the place and time of the conflict.⁶ Taken together, these four concepts and terms serve to lay the groundwork for an analysis that will revolve around WWI shell shock, Post-Vietnam Syndrome, and PTSD after Afghanistan. Before beginning with the understanding of shell shock, a brief exploration of the societal impact and occurrences of trauma will serve to contextualize the understanding of shell shock that is to be presented.

Victorian Era Trauma

Before the introduction of shell shocked soldiers in World War I, society as a whole had already been experiencing modern-induced trauma for decades. With the occurrence of the industrial revolution, society had access to machines and technology never before seen. That being said, this overabundance of new technology also introduced problems that had never occurred in society. One of these problems came in the form of ‘railway spine’. In 1866, John Eric Erichsen, professor of surgery at University College Hospital in London, introduced the term ‘railway spine’ through a series of lectures.⁷ This term was introduced after decades of railway accidents had left many survivors diagnosed with a condition characterized by the manifestation of physical disorders in otherwise healthy individuals.⁸ Due to the medical understandings at the time these cases of ‘railway spine’ were seen as purely physical and therefore the causes of such a diagnosis were

⁶ Rosen, *Posttraumatic Stress Disorder: Issues and Controversies*, 16.

⁷ Bill Bynum, “Railway Spine”. *The Lancet* (2001): 339, accessed April 23rd, 2017, [http://doi.org.ezproxy.lib.ualgary.ca/10.1016/S0140-6736\(01\)05472-1](http://doi.org.ezproxy.lib.ualgary.ca/10.1016/S0140-6736(01)05472-1)

⁸ Mark Micale and Paul Lerner, *Traumatic Pasts: history, psychiatry, and trauma in the modern age, 1870-1930* (Cambridge: Cambridge University Press 2001), 32.

related back to the physical impact of the accident itself. The explanation of “spinal concussions” occurring from the jarring impact of the train was put forth as an explanation for primary symptoms such as broken bones, laceration, and burns, as well as secondary symptoms which included local paralysis, paraplegia, tingling and numbness of extremities, and functional lesions of the kidneys and bladder.⁹ The importance in the introduction of the term ‘railway spine’ arises not only from the introduction of modern trauma to society, but also modern psychology. Eric Caplan argues that observing, theorizing, and treating ‘railway spine’ in the 1880’s and 1890’s was an essential contribution to modern psychotherapeutics in the United States.¹⁰ When focusing on the next societal occurrence of trauma this introduction to “railway spine” is crucial as it serves as the decisive point when society was introduced to the idea of a collective trauma experience rather than independent occurrences seen in the past.¹¹

Shell Shock in the First World War

The onset of shell shock cases came unexpectedly, then all at once. Between April 1915 and April 1916 there had been 1,300 officers and 10,000 men admitted to special hospitals with shell shock symptoms.¹² These shell shocked men presented doctors with a array of different symptoms, which only served to further complicate the understanding of the diagnosis that was affecting all armies in such large numbers. The symptoms these

⁹ Micale and Lerner, *Traumatic Pasts*, 12, 40.

¹⁰ Micale and Lerner, *Traumatic Pasts*, 13.

¹¹ Micale and Lerner, *Traumatic Pasts*, 33.

¹² Fiona Reid, *Broken Men: Shell shock, Treatment, and Recovery in Britain, 1914-1930*, (London: Bloomsbury Publishing Plc, 2014), 13.

doctors, both military and voluntary civilians, were faced with included those which could be classified as physical and those which would now be understood as having a psychological classification. That being said, when reported, all groupings of symptoms seemed to take on a purely physical or organic nature, even if they were inherently psychological. This can be seen by engaging in an exploration of two cases presented by Charles S. Meyers in 1915 and 1916. The first, a private aged 23, developed a case of shell shock after he was blown off a heap of bricks 15-feet high when a shell exploded near him.¹³ After being admitted to the hospital and assessed by Charles Meyers, it was reported that his symptoms included weak legs, pain in precordial region, distant and blurred vision, delay of reflexes, muscle contractions, and affected sense of smell and taste.¹⁴ This overwhelming classification of psychical symptoms serves to demonstrate that the common understanding of the diagnosis at the time was physical in nature, and thus produced a large variety of physical symptoms. This is further supported by another case recorded by Meyers in which the patient developed irregular spasmodic movements of the head, arms, and legs, tremors and incoordination during voluntary movements, and visual hallucinations of bursting shells, after he was exposed to shell explosions three times during combat.¹⁵ The extent of this vast array of symptoms is difficult to grasp; however, it can be visually reinforced by footage from the Netley War Hospital in 1916.

¹³ Charles Myers, "A contribution to the Study of Shell Shock" *The Lancet* (1915), 316-317. Accessed April 19th, 2017. [https://doi.org/10.1016/S0140-6736\(00\)52916-X](https://doi.org/10.1016/S0140-6736(00)52916-X)

¹⁴ Charles Myers, "A contribution to the Study of Shell Shock" *The Lancet* (1915), 319-320. Accessed April 19th, 2017. [https://doi.org/10.1016/S0140-6736\(00\)52916-X](https://doi.org/10.1016/S0140-6736(00)52916-X)

¹⁵ Charles Myers, "Contributions to the Study of Shell Shock" *The Lancet* (1916), p.608. Accessed April 19th, 2017. [https://doi.org/10.1016/S0140-6736\(00\)75514-0](https://doi.org/10.1016/S0140-6736(00)75514-0)

Throughout the 28-minute film, individual cases are presented with a description of the traumatic incident that occurred, the symptoms they had upon admittance, and the current state of their recovery. Much of the footage illustrates the display of symptoms mentioned above as well as hysterical paralysis, rigidity of ankles, word blindness and deafness, facial spasms, lateral head tremors, constant swaying movement, and nose-wiping tics.¹⁶ That being said, what is of profound importance is the treatment that is displayed in this footage, which can be seen as examples of treatment that was widespread across the front.

The overwhelming amount of treatments, especially during the first two years of the war, can be seen as somewhat rudimentary and ineffective. Ineffective, for example, in that they only cured the physical symptoms of the soldier and did not bother to address the psychological aspects of this illness. This can be seen in footage from the Netley hospital in 1917. The footage boasts that most of these men were cured, or were well on their way to being cured within hours of arriving at the facility. The footage speaks of treatment in the form of electroshock therapy or 're-education' yet, the only footage of treatment the film shows is a doctor violently shaking the neck of a soldier with paralysis. It is important to note that the film measures the success rate of cured soldiers by how they are able to walk compared to when they came in. Although the footage shows tremendous success in this aspect, there is no mention of psychoanalysis or the patients' mental health status.

¹⁶ "War Neuroses: Netley Hospital, 1917" accessed April 24th, 2017. <https://archive.org/details/WarNeurosesNetleyHospital1917-wellcome>

Another example of treatments that were strictly based on the physical aspects are those of D. Lewis Yealland. Yealland was known for his prominent use of faradism (electric current) to cure shell shock.¹⁷ He was also widely known for using more controversial methods which attributed high success rates to fear driven ‘therapy’. He was known to strap soldiers to a chair and told them they could not leave until they were cured.¹⁸ As a part of this process he also used strong electric currents, hot plates, and lit cigarettes as a form of treatment.¹⁹ This demonstrates a skewed psychological understanding of shell shock even though it may have been successful in producing a high number of ‘cured’ patients who were able to return to the front.

Other common treatment options used in hospitals included isolation and persuasion or ‘re-education’. Isolation as a treatment option was mostly used in hysterical cases and was an accepted and preferred form of treatment because it presented the patient’s illness as an uncomfortable lonely state, promoting quick recovery.²⁰ Persuasion was a form of treatment that was used as a ‘re-education’ tool. The soldier was convinced by logical argument that the condition was not as severe as he thought it to be. The negative side to this is that soldiers were not able to comprehend that their diagnosis was a result of a mental state, not a physical disability.²¹ This brief exploration of popular treatment

¹⁷ Edgar Jones and Simon Wessely. *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (East Sussex: Psychology Press, 2005), 39.

¹⁸ Jones and Wessely, *Shell Shock to PTSD*, 39.

¹⁹ Jones and Wessely, *Shell Shock to PTSD*, 39.

²⁰ Terry Copp and Mark Osborne Humphries *Combat Stress in the 20th Century: The Commonwealth Perspective* (Ontario: Canadian Defense Academy Press, 2010), 56.

²¹ Copp and Humphries, *Combat Stress in the 20th Century*, 57.

options available to soldiers demonstrates that the majority of doctors and psychiatrists treated this diagnosis as one that was physical in nature.

That being said, there was a reason why the diagnosis was viewed as something that was created by the soldier and was able to be physically overcome. This view towards the diagnosis can be seen as a result of the social discourse that was common during the period. Shell shock can be seen as the logical culmination of medical diagnoses and social prejudices of the last half-century. In turn, this made the diagnosis a concept that was easily embraced by traditional social prejudices, making it easy to be understood by the civilian population.²² The beliefs that this prejudice was based upon can be seen by looking at the stereotypical male in society and what was demanded of him during everyday life and in times of conflict. A man had to embody true-manliness, making him in control of himself at all times. It was thought that a soldier who had ‘true-manliness’ would be able to cope with and adapt to his surroundings in war, furthermore any soldier who was not able to deal with this was abnormal, and did not possess will power or self-control.²³ Stemming from this idea of manliness, society also reinforced the belief that the loss of self-control, which eventually led to a soldier developing shell shock, could be prevented. This prevention came in the form of manhood education, such as building of character and support for marriage which, was seen as a way to control the debilitating sexual desires of males.²⁴ This preservation of manliness suggests that the social dis-

²² George L. Mosse “Shell-shock as a Social Disease”. *Journal of Contemporary History* (2000), 101, accessed April 22nd, 2017, <http://www.jstor.org/stable/261184>.

²³ Mosse, *Shell Shock as a Social Disease*, 104.

²⁴ Mosse, *Shell Shock as a Social Disease*, 104.

course of the time was that shell shock could be physically controlled by the soldier. This serves to reinforce the idea that during WWI shell shock was mostly seen as a physical diagnosis. Successful physical treatments and preventative measures could return a soldier to active duty. This idea of a soldier's physical control over shell shock is reinforced by Dr. Fenton's argument in 1927, which suggested that the relationship between shell shock and other disorders was in fact the crowding together of otherwise healthy males in an unfamiliar setting, which apart from shell shock also resulted in venereal diseases, and drug and alcohol addictions.²⁵ This exploration of societal norms, behaviors, and male expectations serves to demonstrate that the discourse at the time was centered around the idea of being able to physical control one's self, therefore, when looking at the symptoms that doctors observed from shell shock patients it is fitting that most of these symptoms would be classified as physical instead of psychological.

Vietnam: Turning Point For PTSD

After the First World War, each successive war had its own terms, definitions, symptoms, and treatments for war neurosis. That being said, no war played as important a role for the advancement of PTSD than the Vietnam War, especially the post-war era in America. Jones and Wessely suggest that the Vietnam War played a crucial role in altering society's ideas about war and psychological trauma.²⁶ What is crucial about this statement is the focus on the popular opinion over that of the medical community. This reinforces the argument that the change in PTSD opinions, and consequently the symp-

²⁵ Norman Fenton, "Shell Shock and Its Aftermath" *The Lancet* (1927), 1356, accessed April 24th, 2017. [https://doi.org/10.1016/S0140-6736\(00\)78138-4](https://doi.org/10.1016/S0140-6736(00)78138-4)

²⁶ Jones and Wessely, *Shell Shock to PTSD*, 128.

toms, are a result of the social discourse of the time period. During the Vietnam War, the psychiatric services that were available for treating combat stress in soldiers was based off the same PIE model (proximity to battle, immediacy of treatment, and expectancy of recovery) that was used during the First and Second World Wars.²⁷ This had remained the most popular treatment method throughout the last four decades as it kept the soldiers close to the front, making the treatment for the diagnosis less of a relief from duty. Due to this treatment option, the Vietnam War was thought to be a psychiatric success. This was due to the less than 6% of soldiers diagnosed with combat stress, which was thought to be possible through the continued use of forward psychiatry (PIE), and other factors such as a less intense nature of combat, better communication with home, and shorter tours of duty.²⁸ The American military community, along with the psychological community felt optimistic about the approaches it has been using up to this point and in turn, felt that they had a real understanding of the psychological element, which had become an epidemic just 41 years earlier. In 1970, Bourne stated that ‘psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone.’²⁹ This statement summarizes the popular belief in regards to the United States psychiatric military success during the Vietnam War.

There were still an large number of soldiers suffering from combat stress over the course of the war, and this suffering occurred no differently than during any other con-

²⁷ Jones and Wessely, *Shell Shock to PTSD*, 128.

²⁸ Jones and Wessely, *Shell Shock to PTSD*, 128.

²⁹ Jones and Wessely, *Shell Shock to PTSD*, 129.

flict. Although the soldiers of Vietnam had less encounters with shells to worry about, the civilian atrocities and widespread use of chemical warfare contributed to the trauma that was experienced by these soldiers. An example of this can be seen by looking at the case of Wayne Felde, who landed in Vietnam in March 1968 at the age of 19. Felde stated that he witnessed many horrors throughout the course of the war, such as his friends being napalmed and a 'gook abortion' which occurred when a GI sliced open the stomach of a pregnant Vietnamese woman.³⁰ Upon returning, Felde suffered from combat stress, his symptoms presenting in the form of nightmares, flashbacks, and drug and alcohol addictions.³¹ These symptoms, which were rarely recorded during the First World War, can be seen as being located less in the physical realm and instead moving more towards the psychological sphere. Other symptoms of combat stress during the war included apathy, depression, mistrust, insomnia, and nightmares.³² Looking back at the confident sentiment that was expressed by Bourne, it is to be concluded that there must have been things that made the oversight of these psychological casualties possible. Renner suggests that it can be attributed to the high rates of substance abuse and evacuations for behavior and character disorders that left these casualties unreported.³³

³⁰ Kyle Longley, *Grunts: The American Combat Soldier In Vietnam* (New York: M.E. Sharpe, 2008), 177.

³¹ Longley, *Grunts*, 177.

³² Todd Helmus and Russel Glenn, *Steeling The Mind: Combat Stress Reactions and Their Implications for Urban Warfare* (California: RAND Corporation, 2005), 26.

³³ Jones and Wessely, *Shell Shock to PTSD*, 130.

With a heightened awareness amongst the public towards what was known as ‘Post-Vietnam Syndrome’ there was an increased call for the war in Vietnam to be ended. Anti-war campaigners such as Charles Figely, Chaim Shatan, and John Wilson actively lobbied for an end to the war due to the combat stress it was responsible for in thousands of returning soldiers.³⁴ This active lobbying would not only switch the public opinion of the diagnosis, but would also alter and strengthen the opinion of medical boards across the country, with both sectors coming together to revolutionize the social discourse. In 1972, the American Psychiatric Association stated ‘we find it morally repugnant for any government to exact such heavy costs in human suffering for the sake of abstract concepts of national pride or honor.’³⁵ This sentiment would be highly unlikely only a generation earlier. This significant change in public understanding and opinion towards the soldiers of Vietnam would continue to be important for the eventual creation of post-traumatic stress disorder as an officially recognized term. Figely and Shatan knew that the American Psychiatric Association was about to release a new edition of the DSM, so they took to lobbying and delivered a presentation to the board in January 1978 recommending that the syndrome be included, thus post-traumatic stress disorder was included in DSM-III in the section outlining anxiety disorders.³⁶ Stemming from this milestone action, a change in precedence can be seen as the diagnosis moved away from the physical realm that was common in World War I and towards a more psychological standpoint

³⁴ Jones and Wessely, *Shell Shock to PTSD*, 130.

³⁵ Jones and Wessely, *Shell Shock to PTSD*, 135.

³⁶ Jones and Wessely, *Shell Shock to PTSD*, 130-131.

which would be the new norm, both in the public's opinion and in the medical field. Before it was said that if a soldier broke down in war and could not be returned to active duty by forward psychiatry then the war was just a trigger for a preexisting condition; however, Vietnam changed this and it was now argued that long-term health effects could be caused by short-term triggers experienced in the adult life, such as trauma from war.³⁷ The importance of this conflict comes not only from the public attitude towards the war that was moving in a more conflict-adverse manner, but also towards the sweeping change in psychosocial diagnoses that was made possible by the social rhetoric. Jones and Wessely argue that PTSD was one of the few politically driven psychiatric diagnoses due to lobbying, and go on to say that the origins of this change were located less in the jungles of Vietnam, and more in the sociopolitical climate of post-Vietnam America.³⁸ The idea of the sociopolitical climate in relation to the changing nature of views towards health advancements is crucial as it reflects the notion that the changing symptoms of PTSD are the product of the social discourse and the medical understanding at the time of the diagnosis. This sentiment is summed up by Jones and Wessely as they define the Vietnam conflict as an example of how post-conflict syndromes are constantly changing and adapting themselves as cultural views of health and illness change with them.³⁹

³⁷ Jones and Wessely, *Shell Shock to PTSD*, 135.

³⁸ Jones and Wessely, *Shell Shock to PTSD*, 131.

³⁹ Jones and Wessely, *Shell Shock to PTSD*, 212.

Afghanistan-The Arrival of Modern PTSD

The diagnosis of combat stress, now known as PTSD, continues to be ever present in the most current conflicts: the invasions of Iraq and Afghanistan. Since the invasion of Iraq in 2003, the subject of mental health has been at the center of social debates as 30,000 American soldier have been wounded, and 120, 000 have been diagnosed with PTSD.⁴⁰ What has also changed, along with the addition of the diagnosis into the public's vocabulary, is the understanding of what PTSD is both by the civilian population and the medical community. It is now understood that an individual can have a predisposition to PTSD based upon preexisting factors in people's biological, psychological, socio-emotional, and spiritual makeup, which are then activated due to war trauma.⁴¹ Adding to the ever-changing view of post-war syndromes is the current understanding that although there are, in fact physical symptoms associated with the diagnosis, the overwhelming amount of these symptoms are a result of psychological disturbances due to war trauma. When looking at the symptoms that are present in Iraq and Afghanistan veterans, it can be seen that common symptoms include flashbacks, hyper-vigilance, dejection, panic attacks, sub-depression, cycles of anxiety and guilt, and nightmares, which often lead to emotional numbing through the avoidance of stressors.⁴² The psychological or psychiatric aspects of these symptoms can also be seen by looking into the cluster symptoms that

⁴⁰ Erin Finley, *Fields of Combat: understanding PTSD Among Veterans of Iraq and Afghanistan* (New York: ILR Press, 2011), 2.

⁴¹ Daryl Paulson, Stanley Krippner, *Haunted By Combat: Understanding PTSD in War Veterans* (Lanham: Rowman & Littlefield, 2010), 10-11.

⁴² Paulson, Krippner, *Haunted By Combat*, 15-16.

are associated with the diagnoses, outlined in DSM-IV. Outlined in this addition are three groups into which symptoms of PTSD fall: re-experiencing the event, avoiding stimuli relating to the event, and hyper-arousal, which can be understood as having difficulty falling/staying asleep and displays of hyper-vigilance.⁴³ Although there has been much progress in the medical understanding of the diagnosis, this is not to say that the problem is under control, and being dealt with efficiently and appropriately. Similar to the initial onset of shell shock in WWI, American society is having difficulty with the reintegration of their soldiers.

“So in seven days, I went from getting shot at to sitting in my recliner” it went from “I’m here to what the hell do I do now?”⁴⁴ This is the sentiment expressed by Brain O’Neil, who served two tours as a combat medic for the U.S. Army Reserves. This feeling of ‘now what’ is held by many soldiers who return from Iraq and Afghanistan, and stems from a problem of re-integration into society, that is, going from a combat environment to a civilian life. This problem can be reiterated by looking at Chris, who returned to the U.S. after having a physical altercation with one of the prisoners he was escorting. Chris said, “When I got back from [Afghanistan] there was not even so much as a briefing that said, ‘Let us know if you’re having a problem.’ There wasn’t so much as a [phone] number. There was literally nothing.”⁴⁵ Common amongst many soldiers, the

⁴³ Terri Tanielian, Lisa Jaycox, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (California: RAND Cooperation, 2008), 37.

⁴⁴ Finley, *Fields of Combat*, 1.

⁴⁵ Finley, *Fields of Combat*, 99.

symptoms of PTSD usually only set in once the soldier has returned and has begun the journey of re-integration into the life they left. In a number of cases studied by Finley, it is suggested that soldiers only begin to seek help after a crisis has occurred, the most common being; persistent suicidal thoughts, domestic violence, drug and alcohol abuse, and panic attacks.⁴⁶ Just as society struggled to understand what shell shock was in WWI, and activists sought to include the diagnosis of PTSD in the DSM, modern society has another issue to deal with after Iraq and Afghanistan. This problem presents itself in the form of helping these soldiers re-integrate back into society and providing accessible treatment options. As the understanding of PTSD progresses, so too does the social discourse and reaction.

The concern regarding the treatment and re-integration of these soldiers stems from the families of the veterans, community health services, and government. In 2006, the Government Accountability Office voiced concern regarding adequate follow up and treatment, in which they cited low rates of referrals for mental health services and treatment among those who had positively screened for PTSD.⁴⁷ This high level of public concern illustrates the extent to which this new problem is being actively worked into the medical understanding and social conversation regarding PTSD. Another example of this high level of public concern can be seen by looking at the different levels of government becoming involved which include the Department of Defense, Department of Veterans Affairs, Congress, and the President, all of whom studied these issues in an attempt of

⁴⁶ Finley, *Fields of Combat*, 73.

⁴⁷ Tanielian, Jaycox, *Invisible Wounds of War*, 7.

issuing rapid recommendations relating to the detection and treatment of the diagnosis.⁴⁸ The extent to which all levels of society have become involved in this battle of PTSD treatment serves to demonstrate the effect society has upon the diagnosis itself, not just with the symptoms, as argued, but with the definition, acceptance, and treatment of post-traumatic stress disorder. Finley argues, “These professional battles are in the process of revolutionizing how the VA provides trauma care to veterans, with implications for re-defining the way PTSD itself is understood in the process.”⁴⁹

When looking at the symptoms presented by shell shocked soldiers in World War I and soldiers with PTSD after Afghanistan it can be seen that the display of these symptoms are vastly different. While the symptoms of shell shock presented more physical, the symptoms of PTSD now present with a more psychological focus. Throughout the course of this paper the argument has been put forth that these symptoms are a product of the changing social discourse towards combat stress. During the exploration of WWI symptoms and treatments it was seen that most of the treatments were physical in nature and, in turn, the effectiveness was physically measured. This focus on the physical aspects and on the soldier’s role in his own recovery, stemming from will power, can be attributed to the social rhetoric of ‘true-manliness’ that was common at the time. Moving forward into the Vietnam War, a precedent was set when the term ‘post-traumatic stress disorder’ was added into the DSM. This was a result of active lobbying by individuals who saw the traumatic effect the war had on returning soldiers. Accompanying this social change was

⁴⁸ Tanielian, Jaycox, *Invisible Wounds of War*, 7.

⁴⁹ Finley, *Fields of Combat*, 2.

the change in presented symptoms. The symptoms of Vietnam soldiers resembled what is now common to PTSD diagnoses such as anxiety, hyper-vigilance, substance addictions, and sleep problems. Finally, moving into the most modern conflict in which PTSD is part of the social conversation, the wars of Iraq and Afghanistan were examined. Throughout this exploration, it can be seen that although there has been much advancement in the psychological realm of the diagnosis, society is still presented with an issue. This time, the issue presents itself in the form of re-integrating soldiers back into society. Young argues, “PTSD is not timeless. Rather it is glued together by the practices. Technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources.”⁵⁰ This quote serves to reinforce the presented argument that post-conflict syndromes are constantly changing due to the social discourse and medical understanding of the time.

⁵⁰ Allan Young, *The Harmony of Illusions: Inventing Posttraumatic Stress Disorder* (Princeton: Princeton University Press, 1997), 5.

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