THE EVOLUTION OF POSTTRAUMATIC STRESS AND WAR THROUGH AMERICAN HISTORY

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Laura Rieder

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CHAPTER ONE: INTRODUCTION

Due to the stigma often associated with diagnosis exact numbers are difficult to verify, but the United States Department of Veteran Affairs estimates that upwards of twenty percent of American military veterans who were deployed in Iraq during Operations Iraqi Freedom and Operations Enduring Freedom have Post-traumatic Stress Disorder (PTSD).[1] This diagnosis in the modern world is familiar to most as it has gained considerable notoriety in the past few decades. It has become the focus of many films and works of literature which have brought the disorder, its etiology, and symptoms more to the forefront of society.

Posttraumatic Stress Disorder (PTSD) became an official diagnosis when it was first introduced into the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980.[2] Classified as an anxiety disorder with similar panic-type symptoms, the diagnostic criteria were relatively vague, however it was vital for one to experience an external catastrophe, such as war or rape, in order to be labeled with the diagnosis. Many believed this to be a great advancement in the field of psychiatry, closing a gap

[1] "PTSD: National Center for PTSD." How Common Is PTSD? -. Accessed November 02, 2016. http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp.

[2] Dean, Eric T. *Shook over Hell: Post-traumatic Stress, Vietnam, and the Civil War*. (Cambridge, MA: Harvard University Press, 1997), 27

that left many veterans with severe mental illnesses, almost entirely untreated for hundreds of years.[3]

In the thirty three years since its initial adaptation, PTSD has been reclassified and the diagnostic criteria revised. No longer considered an anxiety disorder, PTSD is currently one of several "stress-related and trauma-related disorders" that requires a history of exposure to a traumatic event as well as the experience of several symptoms, not attributable to a substance or other medical condition, from four clusters for a period of at least one month to be diagnosed. The symptom clusters include: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity.[4] Intrusion references the uncontrolled and repetitive nature of thoughts centering around the trauma. Sufferers will often avoid triggers and experiences that remind them of the event and may cause anxiety or other symptoms to intensify. Many also experience changes in their thinking patterns, emotional and physical state that inhibits their ability to function productively in society.[5] It is based on these criteria that current soldiers are judged against to receive a diagnosis and treatment for PTSD.

Early American history often glorified the soldier. Our history brags of brave men who felt it was their responsibility to defend this land, who sacrificed their well-

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[3] "PTSD: National Center for PTSD." PTSD History and Overview.

[4] Dean, Eric T. *Shook over Hell,* 27.

[5] *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, D.C.: American Psychiatric Association, 2013.

being to fight for their country with eagerness and valor.[6] Rarely had society looked beyond their courageousness and pure will to evaluate the state of the heroes that returned home. The media and popular culture helped shed light on this flawed perception of soldiers in the years during and following the Vietnam War. The media especially played a role in highlighting the symptoms that many of these soldiers returned home with. Symptoms which we now clearly recognize as PTSD even before PTSD officially existed. Due to the narrative they created many associate PTSD exclusively with the Vietnam War, but Vietnam is not unique in illustrating the psychological effects of war. Symptoms of PTSD have been present for centuries prior to any official diagnosis.

Dating back to ancient times, historians have identified evidence of symptoms we now associate with PTSD, most notably, depression and nightmares, in historical texts. "[C]hroniclers, sensitive to unusual behavior in their heros, reported isolated cases of agitation or stupor sometimes associated with terrifying nightmares."[7] For instance, within the *Epic of Gilgamesh*, the author describes the profound despair and intrusive recollections Gilgamesh experiences after witnessing the death of a friend, highlighting the traumatic nature of war as well as the mental anguish experienced by the survivors.

> 'I wept for him seven days and nights till the worm fastened on him. Because of my brother I am afraid of death, because of my brother I stray through the wilderness. His fate lies heavy upon me. How can I be silent, how can I rest? He

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[6] Brokaw, Tom. *The greatest generation*. New York: Random House, Paw Prints (imprint of Baker & Taylor Books), 2010, 112.

[7] Birmes, Philippe, Leah Hatton, Alain Brunet, and Laurent Schmitt. "Early Historical Literature for Post-traumatic Symptomatology." *Stress and Health* 19, no. 1 (2003): 17-26. doi:10.1002/smi.952, 18.

> is dust and I too shall die and be laid in the earth forever. I am afraid of death. . .'[8]

Survivor guilt was commonplace among many soldiers. It often served as an added tormentor beyond the mere witnessing of atrocities serving to intensify the trauma experienced in war and contributing to many sleepless nights, fatigue, and depression. As described in Homer's *Iliad,* Achilles is plagued by his recollections of loss and in turn is left to deal with the ramifications.

> 'But Achilles went on grieving for his friend, whom he could not banish from his mind, and all-conquering sleep refused to visit him. He tossed to one side and the other, thing always of his loss, of Patroclus' manliness and spirit. . . As memories crowded in on him, the warm tears poured down his cheeks.'[9]

Many of these ancient depictions demonstrate the intensity with which survivors experience these symptoms and the negative impact they have on their overall functioning during times of war. These depictions may lead one to believe that they are only experienced while under the stressors of combat as they fight to endure the death that both surrounds and chases them. The extent to which these experiences can linger within a soldier has been a topic of debate even in more modern years. However, even this question has been addressed in the writings of Decartes in the 17th century, well over a hundred years before the formation of the United States of America. While reflecting on his research and writings in *The Passions of the Soul,* Decartes articulates

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[8] Birmes, Philippe, Leah Hatton, Alain Brunet, and Laurent Schmitt. "Early Historical Literature for Post-traumatic Symptomatology." *Stress and Health* 19, no. 1 (2003): 17-26. doi:10.1002/smi.952, 18.

[9] Ibid.,19.

"events causing fear can affect human behavior long after their occurrence."[10] This suggestion that traumatic events can create psychological effects that linger beyond the events themselves was prophetic of the complexities of psychological trauma experienced by American soldiers in future wars.

Prior to formally analyzing the effects of combat in the behavior and health of more modern soldiers, symptoms similar to PTSD were witnessed in the general population. Physicians referred to the condition as "Railway Spine" because it was commonly evident in survivors of railway accidents who sustained head and spinal injuries during the nineteenth century. Symptoms included sleep disturbances, fear and anxiety in the presence of environmental triggers, depression, fatigue, changes in sexual motivation, lethargy, and stuttering.[11] As railroads began quickly sprouting across American soil, more and more accidents occurred as rail workers continued to fine tune this growing technology. With increasing cases of Railway Spine, physicians eventually noticed similar symptoms in combat soldiers and abuse victims.[12] It would be years before doctors began reflecting on possible etiological similarities.

Beginning during the Civil War and continuing on through the war in Iraq and Afghanistan, there have been many names for the soldier's condition, such as nostalgia,

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[10] Birmes, Philippe, Leah Hatton, Alain Brunet, and Laurent Schmitt. "Early Historical Literature for Post-traumatic Symptomatology.", 18.

[11] Dean, Eric T. *Shook over Hell*, 27.

[12] Purtle, Jonathon . "'Railway spine'? 'Soldier's heart'? Try 'PTSD.'." *The Inquirer Daily News*. http://www.philly.com/philly/blogs/public_health/Railway-spine-Soldiers-heart-Try-PTSD.html.

irritable heart, shell shock, and combat fatigue. Though they have distinct names, the symptoms and characteristics that define them are similar. This paper seeks to investigate how our understanding, recognition and response to what we now refer to as Posttraumatic Stress Disorder has evolved through American military conflicts. It is important to note, however, that the wars evaluated in this paper is not comprehensive and although American involvement in conflicts such as the Spanish-American War, the Philippine-American War, and Korean War are not analyzed does not imply they are free of evidence of PTSD among their veterans.

CHAPTER TWO: THE CIVIL WAR

The Civil War was not the first major military campaign in American history, but it is considered the first modern and industrialized war for the manner in which it was fought. For much the same reason, it is often considered one of the deadliest as well. "[M]achinery such as locomotives and rifled muskets or ironclad warships and naval torpedoes were engaged"[13] enabling significant differences in destructiveness and casualties compared to earlier wars that relied on comparatively primitive military weaponry. For instance, despite an eight year span, the Revolutionary War claimed approximately 25,000 casualties[14], compared to the conservative estimate of 620,000 for the Civil War[15] in part due to the military tactics employed. Soldiers fought in primarily hand to hand combat with single shot rifles with bayonets. Although deadly, it can not produce casualties to the same degree as the technology and methods employed during the Civil War.

The Civil War was fraught with physical hardships. Although modern in weaponry, the soldiers travelled primarily on foot, averaging ten miles a day, carrying

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[13] Dean, Eric T. *Shook over Hell*, 46.

[14] "FAQ about the American Revolutionary War." Campaign 1776, 2014, Accessed November 04, 2016, http://www.campaign1776.org/revolutionary-war/facts-of-the-american.html?referrer=https://www.google.com/.

[15] Schaller, Barry R. *Veterans on Trial: The Coming Court Battles over PTSD*.)Washington, D.C.: Potomac Books, 2012), 56.

considerable weight in supplies and through harsh weather.[16] In addition, soldiers were often forced to endure dwindling rations and combating disease, which is made even more difficult considering an overall lack of medical knowledge of such diseases at the time. "Medicine was still in its dark ages during the Civil War era, and the great advances in sanitation, germ theory, medical education and medical training, as well as the emergence of the hospital a the modern technological palace of healing, were all in the future."[17] In total, the stressors Civil War soldiers endured were significant, but none more remarkable than the terror of battle that blossomed during this modern war. Firsthand accounts from the front lines paint a vivid picture of the atrocities endured by the average infantryman. "The booming of cannon, the bursting of bombs, the rattle of musketry, the shrieking of shells, the whizzing of bullets. . . the falling of men in their struggle for victory, all made a scene of surpassing terror and awful grandeur."[18] The gruesome firsthand account of William T. Sherman, a General in the Union Army, questioned the ability of civilians to truly understand the severity of what Civil War soldiers were forced to endure.

> Who but a living witness can adequately portray those scenes of Shiloh's fields, when our wounded men, mingled with rebels, charred and blackened by the burning tents and underbrush, were crawling about, begging for someone to end their misery? Who can describe the plunging shot shattering the strong oak as with a thunderbolt, and beating down horse and rider to the ground? Who but one who has heard them can describe the peculiar sizzing of the minie ball, or the crash and roar of a volley fire? Who can describe the last look of the stricken soldier as he appeals for help that no man can give or describe the dread scene of

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[16] Dean, Eric T. *Shook over Hell*, 47.

[17] Ibid., 51.

[18] Ibid, 57.

the surgeon's work, or the burial trench?[19]

Many soldiers would struggle to accurately describe the monstrosity of the war they endured. "Of the sights and sounds of battle, one Northerner concluded: 'The half can never be told -- language is all too tame to convey the horror and the meaning of it all.'"[20] It is no surprise considering the horrors these soldiers withstood that it was during this war the most significant developments in psychiatric evidence began to appear.

With such frequent exposure to such horrific sights, by today's understanding it is no wonder that so many Civil War Soldiers began to suffer from a variety of psychiatric problems. Unfortunately, the Civil War generation's understanding of the complexity of stress-related illness was exceedingly limited.

> Prior to the nineteenth century, in fact, the insane were usually lumped together with other socially dependent groups such as paupers, widows, or the physically disabled, and supported within the local community. . . However, by mid-century, the diagnosis of insanity was not as well-defined or as meaningful . . . as it was to become in the twentieth century.[21]

This narrow interpretation was in part the result of a lack of psychiatric science at the time and prohibited Civil War Veterans from receiving appropriate attention and care. During the Civil War, soldiers would write home and use a variety of non-scientific terms to describe the mental state of the soldiers around them including "disheartened,"

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[19] Hess, Earl J. *The Union Soldier in Battle: Enduring the Ordeal of Combat*. Lawrence, KS: University Press of Kansas, 1997.

[20] Dean, Eric T. *Shook over Hell, 57*.

[21] Ibid., 139-140.

"rattled," "nervous," and "depressed."[22] Despite a lack of psychiatric knowledge, the military required very specific terminology when describing the mental state of soldiers since those declared insane were eligible medical leave or potentially discharge. However, that declaration was based on the relatively antiquated definitions of insanity. "The concept of insanity was still governed by the ancient Greek diagnostic system of "mania" (anxiety/agitation), "melancholia" (depression, lethargy), and "dementia" (thinking disorder)".[23] Many of these symptoms, especially mania and melancholia began to emerge as soldiers entered combat and endured the horrors of war. The sights these men witnessed created hysteria like symptoms that often made them incapable of properly serving their army.

> "Another man almost struck by a shell fragment which narrowly missed his head 'went all to pieces, instantly' and was described as completely 'demoralized, panic-stricken and frantic with terror.' In a similar incident, a man who had been chattering away before a shell shrieked overhead and landed nearby was left completely speechless. . . Perhaps the most striking case, however, is that of Albert Frank. . . [he] offered a drink from his canteen to a man sitting next to him. . . but at just this moment a shell decapitated the other man, splattering blood and brain fragments on Frank. . . That evening, Albert Frank began to act strangely. . . His fellow soldiers . . . found him huddled in fear. . . On the way back to Union lines he seemed to go mad. . . Because he had completely lost control, his comrades tied him up that night to restrain him and took him to the doctor the next day. There he was declared insane, and sent to the Government Hospital for the Insane in Washington, D.C."[24]

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[22] Schaller, Barry R. *Veterans on Trial: The Coming Court Battles over PTSD*. (Washington, D.C.: Potomac Books, 2012), 59.

[23] Ibid., 59.

[24] Dean, Eric T. *Shook over Hell*, 65-66.

As more and more soldiers exhibited similar symptoms during their tour of duty, the military was forced to address their mental health and the growing concerns of how it may impact the overall functioning of the troops.

"Nostalgia" was the term used to describe the disordered behavior of American Civil War soldiers suffering from what we would describe today as PTSD. "Physical and psychological exhaustion were associated with the disorder, with a large proportion of victims experiencing conversion reactions."[25] Many credit the first attempt to methodically observe and reference nostalgia to a Civil War physician, Weir Mitchel. He "described symptoms of lethargy, withdrawal and fits of hysterics with excessive emotionality, some of which are recognized to be clinical symptoms of PTSD."[26] Eventually this disorder, of which 5,200 Union soldiers required hospitalization for, would be included among other dischargeable diseases.[27] "In the United States, this became an accepted category of disease, and was included in *A Manual of Instructions for Enlisting and Discharging Soldiers* that was issued to medical officers in the Union Army."[28] In addition to nostalgia, "Civil War surgeons pioneered the study of what was then called 'irritable heart'. . . which was a manifestation of stress. . . the 'muscular

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[25] Birmes, Philippe,"Early Historical Literature for Post-traumatic Symptomatology", 20.

[26] Ibid.

[27] Schaller, Barry R. *Veterans on Trial*, 56.

[28] Dean, Eric T. "We Will All Be Lost and Destroyed": Post-Traumatic Stress Disorder and the Civil War." (*Civil War History* 37, no. 2 (1991): 138-53. doi:10.1353/cwh.1991.0078), 141

exhaustion of the heart' caused by continued overexertion without sufficient rest."[29] Both nostalgia and irritable heart were identified by the exhibition of symptoms that by today's standards would be classified as stress-related. Symptoms included both psychological and physical complaints such as fear and/or anxiety in the presence of environmental triggers, sleep disturbances, depression, fatigue, lethargy, headache, paralysis, chronic diarrhea, and social withdrawal.[30] Once these symptoms were recognized and classified, many physicians began hypothesizing potential etiological variables in hopes of controlling the impact of these outbreaks.

The conditions endured during the Civil War were so deplorable, it was difficult to clearly identify, with certainty, the etiology of conditions such as nostalgia and irritable heart. Physicians were hesitant to label these as mental conditions when the environment lent itself to potential physical causes especially considering psychiatric sciences were in its infancy. The initial explanation for these breakdowns assumed malingering as a result of a personal weakness and feebleness. Soldiers exhibited a wide array of symptoms, but many were seen as cowards seeking to avoid duty, unless they suffered a breakdown so severe they required immediate removal from combat.[31] It is estimated, due to the horrors of war, that 200,000 Union soldiers deserted their posts[32]

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[29] Dean, Eric T. "We Will All Be Lost and Destroyed": Post-Traumatic Stress Disorder and the Civil War, 141.

[30] Ibid., 142.

[31] Ibid. 143.

[32] Schaller, Barry R. *Veterans on Trial*, 56.

and as a result the military, in the hopes of controlling this desertion, created elaborate and terrifying ceremonies in which they were publicly executed.[33]

> When executions were staged, the men in the regiment were lined up on three sides, and the condemned man was placed on top of his coffin and brought to the ground by wagon; after the man was shot to death by the firing squad, the entire company of men was paraded by the bullet-riddled body. . . On most occasions, men who were forced to witness these executions were appalled and deeply disturbed.[34]

It is unknown with any certainty how effective this tactic was in discouraging desertion, however, it was surely ineffective in reducing the emergence of stress-related illnesses during the war. In fact it may have simply unnerved them.

During the Civil War and in the years that followed, many physicians who were observing and treating thousands of disabled soldiers urged military officials to consider other etiological possibilities for nostalgia and irritable heart beyond cowardice and malingering. They stressed the possibility of organic causes, such as brain damage stemming from combat, similar to what had been observed in civilian cases of railway spine and traumatic neuroses, a disease "initially thought to be a purely organic. . . caused by brain concussion. . . first identified in the 19th century in connection with the after-effects of railway crashes".[35]

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[33] Dean, Eric T. *Shook over Hell*, 68.

[34] Ibid., 68-69

[35] Birmes, Philippe,"Early Historical Literature for Post-traumatic Symptomatology", 17.

The treatment methods utilized on these Civil War soldiers were severely impaired by the lack of understanding of the disease itself. Physicians were unprepared to provide appropriate care due in part to the novelty of the conditions themselves. "Short of actual discharge from the military, some soldiers who were no longer fit for combat were organized into the Invalid Corps (later called the Veteran Reserve Corps) to perform various duties around camp … [S]ometimes soldiers who were suffering from mental stress or combat reactions were excused from actual combat duty, but were not formally inducted into the Veteran Reserve Corps."[36] Many soldiers were left to their own devices to manage their symptoms. Given access to morphine and opium to treat physical wounds, many may have begun to use these drugs as a means of gaining relief of their psychological pain. In fact addiction to drugs like morphine became so prevalent that, "[I]n the United States after the Civil War [it] was known as 'the army disease.'"[37] Many survivors with symptoms of stress-related disorders turned to alcohol as a means of self-medicating as well, which further contributed to the perception of these men as weak and lacking virtue.[38]

Although the military had specific terminology to refer to the symptoms exhibited by these soldiers, there was not yet an official diagnosis or an accurate understanding of its etiology. Both of these factors contributed to significant problems

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[36] Dean, Eric T. "We Will All Be Lost And Destroyed", 143.

[37] Ibid.,149.

[38] Schaller, Barry R. *Veterans on Trial*, 60.

in providing adequate care to those afflicted and any attempts to control and reduce future outbreaks.

CHAPTER THREE: WORLD WAR ONE

By the time World War I began, many changes to the psychiatric community had occurred. Sigmund Freud's view of the mind had gained in acceptance paving the way for the initial development of the science of mental health. Freud's notoriety was accompanied by an acceptance of the possibility that our behavior is an expression of unseen, and potentially unknown, unconscious drives, or instincts as Freud contended. The development of this new field played a role in the evolution of how stress responses to combat were explained and the response they received.

World War I brought a new kind of war. Marked by mechanized combat, it witnessed horrors and casualties at an unprecedented rate.

> The men and women who served in the First World War endured some of the most brutal forms of warfare ever known. Millions were sent to fight away from home for months, even years at a time, and underwent a series of terrible physical and emotional experiences. The new technologies available to First World War armies combined with the huge number of men mobilised made the battlefields of 1914-18 horrific, deadly and terrifying places.[39]

The development of tactically defensive combat wherein soldiers dug ditches and set up machine guns created deadly areas very close in proximity to fighting

[39] Wilcox, Vanda. "Combat and the Soldier's Experience in World War One." The British Library. 2014. Accessed November 09, 2016. https://www.bl.uk/world-war-one/articles/combat-and-soldiers-experiences.

soldiers. The constant development of new weapons, such as poison gas, made World War I combat much more unpredictable than previous wars. Soldiers spent large amounts of time waiting in the trenches, with the constant hum of artillery waiting for the orders to "go over the top" of the trenches with their weapons and fight, knowing the rate of survival to be incredibly low. Men were often forced to leave their dead comrades behind, unable to be buried, unless there was a break in the fighting.[40] "Robert Kee has characterized the trenches as the concentration camps of World War I, in which long docile lines of young men, shoddily uniformed, heavily burdened, numbered about their necks, plodded forward across a featureless landscape to their own extermination."[41] Casualties reached epic proportions and it is no wonder that physicians during World War I soon observed staggering numbers of soldiers suffering from stress-related problems. In fact, men began pouring into military hospitals as early as the fall of 1914, exhibiting symptoms of what would be called *shell shock* or *war neurosis* throughout the war. "[B]y 1916, as many as 40 percent of casualties were shell-shocked men."[42]

As more and more men were admitted to military hospitals, physicians were able to create a clearer description of what shell-shock meant for combat soldiers. A shell-shocked soldier experienced a variety of specific symptoms including anxiety,

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[40] Wilcox, Vanda. "Combat and the Soldier's Experience in World War One."

[41] Dean, Eric T. *Shook over Hell: Post-traumatic Stress, Vietnam, and the Civil War*. (Cambridge, MA: Harvard University Press, 1997), 29.

[42] Ibid., 30.

depression, startle reactions, inability to concentrate, memory problems, nightmares, fear, panic attacks, and a variety of psychosomatic symptoms such as mutism, blindness, paralysis, and amnesia.[43] "Of those who saw direct combat, the rate of psychiatric breakdown was 27.7 percent. … [A]ll in all, about 42 percent of the actual combat force suffered some level of psychiatric problems serious enough to warrant treatment."[44] The necessity of treatment was of specific concern for many military officials who struggled to keep their side of the war armed with fully functioning soldiers. At the rate that men were dying and being seriously wounded, losing physically healthy soldiers to mental ailments was particularly frustrating and incapacitating. In fact, the military developed a method of treatment called *forward psychiatry* with the hopes of quickly returning shell-shocked soldiers to combat.

Forward psychiatry was the most preferred method employed by the military and was eventually referred to as PIE (proximity, immediacy, expectation of recovery) units. These methods were considered highly advantageous during World War I as the death toll continued to climb at an alarming rate, it became imperative that all surviving soldiers were able to return to the front lines as quickly as possible. The focus of these units was to provide immediate care to soldiers in a safe location, not far from the front, to enable them to quickly return when cleared for combat. Many of the military

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[43] Dean, Eric T. *Shook over Hell: Post-traumatic Stress, Vietnam, and the Civil War*, 30.

[44] Schaller, Barry R. *Veterans on Trial*, 60-61.

physicians reported overwhelmingly successful return rates, nearing eighty percent.[45] On the surface these results are impressive, however many contradictory reports later suggested that these military doctors may have inflated their results to prevent any negative effects the actual results may have had on their career and the morale of the war effort.[46]

At the onset of World War I, within the military, the etiology of shell-shock remained that of a personal weakness. Military officials continued to believe that shell-shock was a result of cowardice and an attempt to be relieved of their duties. Physicians and other medical professionals, especially those outside of the military disagreed. Initially, many believed the cause to be organic, the result of "physical lesions of the brain brought about in some way by carbon monoxide or changes in atmospheric pressure resulting from the commotional effects of artillery explosions."[47] However, the sheer numbers of affected soldiers during World War I enabled physicians and psychiatrists the opportunity to make the first large-scale observations and studies of those exhibiting the symptoms of shell-shock and ultimately, opposing the theory of concussional etiology.[48] As empirical science developed and the scientific study of shell-shock grew, physicians struggled to find physical changes within the brain to

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[45] Jones, Edgar, and Simon Wessely. ""Forward Psychiatry" in the Military: Its Origins and Effectiveness." *Journal of Traumatic Stress J. Traum. Stress* 16, no. 4 (2004): 411

[46] Ibid., 413.

[47] Dean, Eric T. *Shook over Hell*, 30.

[48] Birmes, Philippe, "Early Historical Literature for Post-traumatic Symptomatology", 20.

explain the behavioral symptoms exhibited in shell-shocked soldiers. Gradually, a functional, or emotional, etiology began to gain support.[49]

Although executions for perceived deserters, some of whom may have been shell-shocked, still occurred within the military, the shift in etiological opinions also caused a shift in treatment methods for soldiers. This new approach to war-related stress reactions lacked a thorough understanding and with the need of returning as many shaken soldiers to combat as possible, many were treated with the *rest cure.* Developed by Silas Mitchell, and initially used to treat hysterical women, the rest cure was used to help calm the shell-shocked population. The regimen included a period of isolation, enforced bed rest, a high-protein diet and electrotherapy and massage.[50] Some therapies administered at the time would be considered controversial by today's standards, especially the use of electricity. "The therapeutic arsenal strove to be therapeutic, but also coercive, with the use of isolation in a dark room and electric shock treatment. . . [s]ometimes so painful that many soldiers preferred to return unhealed to the front after being passed as sound."[51]

The most preferred method employed by the military was eventually referred to as PIE (proximity, immediacy, expectation of recovery) units. These methods were considered highly advantageous during World War I as the death toll continued to climb

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[49] Dean, Eric T. *Shook over Hell*, 28.

[50] Stiles, Anne. "Go Rest, Young Man." *APA Monitor*, December 2012, 32.

[51] Birmes, Philippe. "Early Historical Literature for Post-traumatic Symptomatology", 20.

at an alarming rate and it became imperative that all surviving soldiers were able to return to the front lines as quickly as possible. The focus of these units was to provide immediate care to soldiers in a safe location, not far from the front, to enable them to quickly return when cleared for combat. Many of the military physicians reported overwhelmingly successful return rates, nearing eighty percent.[52] On the surface these results are impressive, however many contradictory reports later suggested that these military doctors may have inflated their results to prevent any negative effects the actual results may have had on their career and the morale of the war effort.[53] Recovered personal records kept by some military psychiatrists drastically differed from the results they published reflecting return to combat rates at approximately fifteen percent after relapses were taken into account. Further, of the fifteen percent that remained in active duty, very few actually were capable of returning to fighting units, most returning instead to support roles.[54]

For servicemen considered incapable of returning to combat, yet still requiring medical attention, especially those afflicted with some of the most profound symptoms, such as blindness, paralysis, and shock, treatments in psychiatric hospitals, often on the home front, was made available. The treatments utilized in these facilities varied greatly depending on the etiological philosophies the attending physicians ascribed to.

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[52] Jones, Edgar, and Simon Wessely. "Forward Psychiatry" in the Military: Its Origins and Effectiveness." *Journal of Traumatic Stress J. Traum. Stress* 16, no. 4 (2004): 411

[53] Ibid., 413.

[54] Ibid., 414

By far one of the most well-known, highly practiced, and effective method was a type of talk therapy, utilized by many, but most famously by Dr. William Rivers at Craiglockhart, a hospital made famous by well-known World War I soldiers and poets Wilfred Owen and Siegfried Sassoon. At Craiglockhart, Dr. Rivers, among others, emphasized the psychological and environmental impact of the war on the development of shell-shock and their treatment methods reflected that belief. "The necessities of coping with an epidemic of psychological casualties in the context of the war allowed some fundamental aspects of Freud's ideas regarding repression and the unconscious to gain greater acceptance and currency in the medical profession."[55] Many of the techniques were based on Freudian principles popular at the time and include elements of modern methods of today's cognitive-behavioral therapy, which emphasizes a restructuring of illogical thoughts in addition to developing specific strategies or actions to address their current problems.[56] During the early twentieth century most psychotherapy reflected the beliefs of Sigmund Freud and as such the focus of many talk sessions would address the possible impact of childhood trauma and repressed, unconscious drives that created a vulnerability to stress in adulthood.

> The shell-shocked needed, in his view, to rediscover their links with an environment from which they had become detached. . . Perhaps [their] most important tool, was *The Hydra*, the hospital magazine. . . The magazine was a

[55] Webb, T. E F. "'Dottyville'--Craiglockhart War Hospital and Shell-shock Treatment in the First World War." *Journal of the Royal Society of Medicine* 99 (2006): 342.

[56] "What is Cognitive Behavior Therapy | Beck Institute." Beck Institute for Cognitive Behavior Therapy. Accessed March 21, 2017. https://www.beckinstitute.org/get-informed/what-is-cognitive-therapy/.

> vehicle through which the patients could express and share their experiences, as well as learn about the hospital ethos and activities.[57]

The form of talk therapy utilized at Craiglockhart was undoubtedly a precursor to the modern treatments of stressor-related mental illnesses employed today despite a rather lackluster report of success. Records of World War I soldier, poet, and patient, Siegfried Sassoon, suggest that most patients, despite signs of improvement are discharged from the hospital and expected to return to war. Most were either discharged from active military duty or to non-combat related light duties.

Despite great efforts towards rehabilitation throughout the war, thousands of shell-shocked servicemen remained in asylums in the years that following the conclusion of World War I. In fact, many remained institutionalized for the remainder of their lives.[58] Of those who were discharged from institutional care, many struggled to return to everyday life.

> Young soldiers, with little or no adult existence outside the army, idealized home and found it difficult to retain a sense of identity outside the war. . . Unlike most fictional shell-shocked victims, thousands of mentally damaged men were faced with the mundane task of finding jobs, maintaining their families and trying to recreate their domestic lives after the war.[59]

The government did very little to assist in the transition to home life or in the financial needs they may have required to continue to seek treatment for their mental sensitivity and conditions following their release from the hospitals. Many were forced to rely on

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[57] Webb, T. E F. "'Dottyville'--Craiglockhart War Hospital and Shell-shock Treatment in the First World War.", 344.

[58] Reid, Fiona. "'His Nerves Gave Way': Shell Shock, History and the Memory of the First World War in Britain." *Endeavour* 38, no. 2 (2014): 98.

[59] Ibid.

charity to get the support they, in some cases, very desperately needed. Support was sometimes very difficult to come by in part, due to the complacency of many civilians. "[M]embers of the public in the postwar society were eager to move on and leave the memory of the war behind. People did not encourage veterans to remind them of their continuing mental distress. As one commentator put it, veterans were trapped between fixation and repression."[60] Following the war, thousands of veterans required continued psychiatric care. The number continued to climb in the decade that followed, in so that over 11,000 veterans were receiving care by 1931 and government spending associated with their care began to skyrocket as well.[61]

World War One left a lasting impact on many facets of the world, including psychiatry. It forever changed the field as well as its explanations and outlook on mental health. In addition to the development of military "front-line" treatment methods such as P.I.E., the war initiated a drastic change in treatment methods back home as well. Likely in part due to the tremendous influx of patients requiring psychiatric care following the war, many psychiatric professionals began to reconsider the inpatient methods associated with asylum care. Essentially, World War One enabled a reform of the psychiatric asylums traditionally relied upon for the mentally unwell, shifting instead toward outpatient, community based care. With this reform came the development of and expansion of the field, including the need for additional professions beyond the psychiatrist including nurses and social workers who specialize in this

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[60] Schaller, Barry R. *Veterans on Trial*, 61.

[61] Dean, Eric T. *Shook over Hell*, 39.

discipline.[62] This development continued to flourish in the coming decades and helped to create the robust field many benefit from today. Most notably for the development of PTSD, however, was the shift in etiological models toward the end of the war. Gradually, based on significant research, doctors began accepting the psychological impact of combat on the individual psyche. Throughout the war "shell shock" became a common term and diagnosis however the etiological explanation was contested. As the number of afflicted grew and became accessible for comparison and study the general consensus of the relationship between psychological trauma and the observable symptoms of shell shock, even delayed symptoms, became much more apparent. This shift likely enabled other (non-Freudian) psychological schools of thought to develop, such as behaviorism, many of which provide a clearer explanation as to the development of stress-related ailments.[63] In the long term, these changes within the field served as a stepping stone on the path to a clear definition for PTSD, but in the short term, it helped to provide better care to the veterans of World War One and the soldiers of future wars to come.

[62] Dean, Eric T. *Shook over Hell*, 39.

[63] Ibid., 32-33.

CHAPTER FOUR: WORLD WAR TWO

At the conclusion of World War I, most doctors acknowledged the potential impact of psychological trauma on an individual's functioning, especially the trauma of military combat. What to do with this newly acquired consensus at the onset of World War II created a new area for debate and consideration. Although most professionals agreed that the trauma of war could result in shell shock, many questioned why some soldiers would eventually be afflicted by its symptoms while others escape war symptom free. As preparations for World War II began, a popular belief to explain the variation in traumatic effects was an inherent vulnerability within the individual. Those with shell shock were believed to have some psychological deficiency that made them more vulnerable to the effects of war. Here, the remnants of Freudian psychology is apparent. Freud's suggestion that childhood trauma results in psychological illness later in life accounts, in part for this perceived vulnerability.

> "In this early . . . clinical formulation (e.g., *Aetiology of Neuroses,* 1896) Freud stated that during childhood development there was a range of traumatic experiences or an emergency type of event that could be profoundly distressing to an individual. As a result of the degree of threat experienced to the ego and the subsequent anxiety experienced, the victim typically used repression as an ego-defense to remove from awareness unpleasant memories and emotions of the traumatic event."[64]

[64] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV.", 683.

Freud would suggest that many of the symptoms of shell shock such as memory loss, catharsis, and paralysis are manifestations of repression, and other defense mechanisms utilized by the ego to persevere through past and current traumas.[65] Although Freudian psychology was beginning to receive criticism within the field, many of these ideas were used to support the suggestion that individual weaknesses could account for the development of shell shock. The result of this assumption was a later attempt to control the development of the disorder in the coming war.[66]

As World War II grew nearer, military officials sought to avoid the shell shock catastrophe experienced throughout World War I. Believing shell shock to occur as a result of an individual's vulnerability, officials and recruiters sought to screen out potentially defective soldiers and seek those who may be more resilient to the trauma of war.

> After World War I, the idea of forward treatment seemed to fade with the memory of the war, and the theory that childhood trauma was the origin of mental disorders dominated psychiatric thinking. As a result, the idea of screening out - excluding - from service people who showed evidence of such trauma gained in popularity.[67]

This entire program centered around a desire to seek out men who would be of strong body *and* mind, who would be most resilient when confronted with the horrors of battle. The assumption of the program suggested that "sturdy, well-adjusted soldiers of strong

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[65] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV." *Journal of Traumatic Stress J. Trauma. Stress* 7, no. 4 (1994): 684.

[66] Schaller, Barry R. *Veterans on Trial*, 63.

[67] Ibid.

character would be able to withstand the stresses of war."[68] Military officials held hopes that by preventing weak-minded soldiers from enlisting they could control the numbers of shell-shocked soldiers and those who would require a medical discharge during combat. Many leading American psychiatrists hoped to contribute to the war effort by developing these screening programs. One such contributor was Henry Stack Sullivan, a psychoanalyst. He believed in addition to mental illness and neurosis, recruits should be evaluated for maladjustment and homosexuality as well. He, as well as others in the field, believed that these qualities "destroyed combat effectiveness and morale."[69]

The military took a very aggressive approach to this process. In fact, approximately 1.6 million of the 20 million soldiers examined for enlistment were rejected as ineffective, nearly 12.5 percent. This reflects a rejection rate significantly higher than that of World War I enlistees.[70] Unfortunately, this practice proved futile as "the psychiatric discharge rate turned out to be nearly two and a half times that of the previous war."[71] In fact, many of the problems faced during World War I returned with a vengeance during World War II. In addition, the continuous need for manpower during the war eventually required the admission of many recruits who were initially recommended for rejection in the screening process. "Of this group, a mere 18% was

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[68] Schaller, Barry R. *Veterans on Trial*, 64.

[69] Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-142.

[70] Dean, Eric T. *Shook over Hell*, 35.

[71] Schaller, Barry R. *Veterans on Trial*, 64.

later discharged on neuropsychiatric grounds. Of the remaining group, a surprising 80% gave satisfactory service."[72] Its poor predictive validity, among other reasons, led to this type of psychiatric screening being eliminated in 1944. A bulletin from the War Department was issued on the twenty-first of April which stated

> [R]ejection for neuropsychiatric reasons should only be made in 'those cases in which the history and examination clearly indicate the existence in the past and/or present of a personality disorder of partially or completely incapacitating degree' and established that 'individuals with minor personality defects and neurotic trends could be of service'.[73]

By the spring of 1944 it was more than apparent that the military could no longer turn away physically capable men based on these measures. Many argued the measures were imprecise and difficult to quantify. Before long, clinicians would argue that it is not the state of an individual's pre-service psyche and personality that contributes to the development of combat exhaustion, but the intensity of the combat they endure. "A study by Brill and Beebe found that the majority of US servicemen admitted with psychiatric diagnoses in 1942-43 had pre-existing emotional disorders, but by 1944-45, most admissions for psychoneurosis were as a result of exposure to combat, and 50% were soldiers who had been assessed as clinically normal at entry."[74] These screenings were ineffective because they sought to predict a breakdown that is caused by events that have not yet occurred.

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[72] Pol and Oak,WAR & Military Mental Health, 2132-142

[73] Jones, Edgar, and Simon Wessely. *Shell shock to PTSD: military psychiatry from 1900 to the Gulf War*. Hove: Psychology Press, 2005, 106.

[74] Ibid., 109.

The experiences of the First World War enabled better insight into the understanding of the shell-shocked soldier. During the Second World War there was still no official diagnosis for their symptoms, however the nomenclature did evolve. "Shell-shock" became a term of the past, associated with World War I and relatively unscientific explanations for symptoms such as concussions. With a better understanding of the disorder and more accurate etiology, "shell-shocked" was later replaced by broader, yet more descriptive term, "combat exhaustion".

The symptoms of combat exhaustion were similar to many of the shell-shocked soldiers of the previous war such as "psychophysiological reactions and loss of impulse control."[75] However, this broad term of combat exhaustion enabled more varied experiences to be accounted for.

> [O]ne report noted that 'dreams and nightmares of killing and catastrophe were common. . . Continued and severe shellfire and 'screaming meemies' [mortar fire] produced an anxiety that was not easily cured as long as the threat of returning remained. These patients were tremulous and tense. They would jump at slight stimuli, be dazed, mentally confused, with feelings of intense anxiety and apprehension, and their sleep was disturbed with battle dreams and persistent recollections of traumas. They would develop crying spells, lose their appetites, and have severe heart palpitations, or become depressed and oblivious of everything.[76]

More so than the previous wars, professionals unequivocally linked combat experiences to a wide range of psychosomatic symptoms. Recognizing a wide array of symptoms than previously enabled doctors to better assess and treat soldiers suffering as a result of

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[75] Birmes, Philippe, Leah Hatton, Alain Brunet, and Laurent Schmitt. "Early Historical Literature for Post-traumatic Symptomatology." *Stress and Health* 19, no. 1 (2003): 31.

[76] Dean, Eric T. *Shook over Hell*, 36.

the war and provide better, more efficient treatment methods. In total, approximately 1.3 million soldiers during the Second World War received some form of treatment for "combat fatigue."[77]

The treatment methods utilized during World War II were largely based on the insights developed about war neurosis during the preceding war. Although many professionals had previously identified a link between combat and mental instability, military officials during World War II began to recognize specific variables in combat that could account for an individual's mental troubles.

> World War II psychiatrists did learn about the epidemiology of combat stress casualties, namely, the relationship to intensity of combat and the social factors such as morale and unit cohesion. Psychiatrists also learned important information about what contributed to the vulnerability of soldiers. They learned, for example, that soldiers new to battle were more vulnerable than experienced ones but also that soldiers exposed to combat for a long time were likely candidates for breakdown.[78]

This more thorough understanding of these breakdowns helped propel efforts toward developing more effective treatments than were previously utilized. Most military psychiatrists, as they did during World War I, continued to emphasize immediate treatment, most notably brief periods of rest, near the combat zone with the hopes of efficiently returning soldiers to battle. This goal emphasized efficiency and often glossed over the severity of the problems brewing beneath the surface. This time period marked the introduction of new methods hoped to prove more successful than those

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[77] Palmer, Greg. "The Perilous Fight - The Mental Toll." PBS. 2003. http://www.pbs.org/perilousfight/psychology/the_mental_toll/.

[78] Schaller, Barry R. *Veterans on Trial*, 67.

employed during the previous war, however many of the methods merely placed a figurative Band-Aid over a deep wound.

Although initially unutilized in the hopes that psychiatric screening would eradicate the need for extensive mental health care for soldiers, eventually military psychiatrists turned once again to forward psychiatry and rest to assist those on the brink of a breakdown. Neurologist Frederick Hanson suggested that a combination of "rest, good food, hot showers, and sedation" effectively returned soldiers to the front lines within a few days.[79] One new method, developed by Roy Grinker and John Spiegel, to be used in conjunction with rest and emotional support was the use of injected pentathol, a barbiturate that depresses the nervous system. In a process referred to as "pentothal abreaction" patients were injected with the goal of altering their consciousness and guiding them through confronting their unconscious fears.[80] The intention of the treatment was to enable these men to overcome the anxieties that have developed as a result of combat and return to battle free of any fears or inhibitions. "Grinker and Spiegel claimed that the stuporous become alert, the mute can talk, the deaf can hear, the paralyzed can move, and the terror-stricken psychotics become well-organized individuals."[81]

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[79] Hanson Frederick, ed., *Combat Psychiatry: Experiences in the North African and Mediterranean Theaters of Operation, American Ground Forces, World War II*, vol 9 supplement, *Bulletin of the US Army Medical Department* (Washington, DC, 1949).

[80] Dean, Eric T. *Shook over Hell*, 36.

[81] Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-142. doi:10.2105/ajph.2006.090910.

Unfortunately, these techniques based on fading Freudian ideals proved ineffective. Many soldiers, even under the influence of the pentothal expressed strong concerns regarding a return to combat, many begging not to return, even under the influence of the drug. Although this treatment method did not have miraculous results, both Grinker and Spiegel helped shed light on the atrocities of war and recognize that "soldiers who broke down after extended exposure to battle were neither cowards nor weaklings—rather, they were normal individuals who could no longer cope with the unremitting and horrendous stresses of war. They argued that 'it would seem to be a more rational question to ask why the soldier does not succumb to anxiety, rather than why he does.'"[82] This type of one-on-one Freudian therapy also proved incredibly time consuming considering the numbers of men who required care and rehabilitation. It is in part, due to this struggle to attend to the growing demand for a very limited supply of physicians that the use of group therapy was employed. [P]sychiatrists such as Jones, Rickman and Foulkes sought to introduce analytical ideas without the luxury of individual therapy . . . they discovered that this method enabled them to explore relationships and social dynamics in a manner not available to the therapist who worked with single patients."[83]

> The British in World War I believed that their soldiers were good for several hundred days before inevitably becoming a psychiatric casualty. But this was made possible only by the British policy of rotating men out of combat for four days of rest after approximately twelve days of combat, as opposed to America's

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[82] Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-142. doi:10.2105/ajph.2006.090910.

[83] Jones, Edgar, and Simon Wessely. *Shell shock to PTSD: military psychiatry from 1900 to the Gulf War*. Hove: Psychology Press, 2005, 95.

> World War II policy of leaving soldiers in combat for up to eighty days at a stretch.[84]

Based on observations gathered throughout World War I and II, physicians recognized the effects of combat stressors. Psychiatric staff of American troops observed a marked decrease in a soldier's general effectiveness in combat following one hundred days of combat. After two hundred days they were at a significant risk for mental breakdown and young soldiers with less combat experience were observed to experience fewer problems than older, more experienced men. For instance approximately one in six thousand young men, aged eighteen and nineteen experienced neurotic symptoms compared to forty-five in one thousand men aged thirty-six and thirty-seven.[85] As a result of these observations, during the Second World War physicians suggested that prolonged exposure to combat be avoided to allow for rest and periodic breaks from the front lines.[86] Intermittent rest was a necessary component of maintaining effectiveness in the field. "Swank and Marchand's much-cited World War II study determined that after sixty days of *continuous* combat, 98 percent of all surviving soldiers will have become psychiatric causalities of one kind or another."[87] Their study suggested that within the range of ten and thirty days of continuous combat

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[84] Grossman, David. On killing: the psychological cost of learning to kill in war and society. Boston: Little, Brown, 1996, 44.

[85] Dean, Eric T. *Shook over Hell*, 37.

[86] Ibid.

[87] Grossman, David. On killing: the psychological cost of learning to kill in war and society. Boston: Little, Brown, 1996, 43.

is ideal for maximum efficiency in the field, but anything beyond that leaves margin for carelessness and exhaustion.[88]

Despite best efforts to drastically decrease the number of breakdowns and men who required psychiatric care from that during the first World War, most of the treatment methods employed during World War II proved unsuccessful in both effectively treating soldiers and reducing the number of discharged soldiers resulting from psychiatric neuroses. Only about fifteen percent of soldiers who were removed from the frontlines for treatment of combat exhaustion ever returned to combat.[89]

The fifteen percent of soldiers who received treatment and were returned to the front lines were believed to be fully recovered from their neuroses. Many assumed that adequate functioning during war meant they had overcome their fatigue. Although these soldiers were able to complete their service they were not necessarily free of mental health problems. Many clinicians "mistakenly concluded that recovery during wartime and return to combat meant that there would be no long-term consequences."[90] Longitudinal studies on what would be labeled "veteran's chronic stress syndrome" found persistent problems and symptoms in World War II veterans in the years following the conclusion of the war. For twenty years, researchers tracked a series of stress symptoms, such as tension, depression, and nightmares. Many veterans were

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[88] Grossman, David. On killing: the psychological cost of learning to kill in war and society. Boston: Little, Brown, 1996, 44.

[89] Dean, Eric T. *Shook over Hell*, 37.

[90] Schaller, Barry R. *Veterans on Trial*, 67.

observed to experience severe, often psychotic, reactions to combat triggers. This clinical portrait created a bridge linking the casual observations of "combat fatigued" veterans by military physicians and a systematic approach to diagnosing combat related stress responses.[91] In the post-war years, not only were veterans who struggled with stress-related symptoms during their tour of duty experience continued symptoms when they returned home, but many who appeared healthy and well-adjusted initially experienced a delayed onset of symptoms in the years that followed. "R.R. Grinker noted in 1945, '[the] majority of psychiatric admissions among returnees are not men who have returned with war neuroses, but those who develop signs of illness after completing a full term of duty."[92] Awareness of the immediate and long-term consequences of combat were becoming more clear, and impossible to evade. Veterans continued to struggle readjusting to civilian life while combating, what was for some, debilitating symptoms. It was becoming clearer to the psychiatric community that they could no longer ignore the impact of stress on an individual's mental state.

World War II had a lasting impact on the field of psychiatry. The rise of mental illness, especially in the United States, following their involvement in the war sparked rapid development in clinical work, especially those de-emphasizing Freudian theory with a preference toward behavioral psychology. This shift coupled with the observations of veterans in previous wars lead to a restructuring of psychiatric priorities. Some "later argued that one of the most important lessons of World War II

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[91] Dean, Eric T. *Shook over Hell*, 40.

[92] Ibid.

was that it required psychiatrists to shift attention from problems of the abnormal mind in normal times to problems of the normal mind in abnormal times."[93] Realizing that even well-adjusted men could break under the stresses of combat forced the psychiatric community to formally acknowledge its impact. This concession was realized in 1952 with the publishing of the first official and standardized diagnostic tool for psychiatric clinicians, the Diagnostic and Statistical Manual of Mental Disorders (DSM).[94] Although years from defining Post Traumatic Stress Disorder as it is known today, the first edition of the DSM included a disorder for which World War II veterans could be diagnosed. Although it was initially titled and defined in vague terms to avoid creating a disorder specifically for combat veterans and to account for the effects of experiencing other types of trauma, combat is clearly identified as a leading trauma that could produce its symptoms.[95]

In the DSM, the initial conceptualization of PTSD was introduced as "Gross Stress Reaction". The definition for the disorder advised that stressful events, such as combat, generated illnesses or symptoms with special frequency. It suggests

> [U]nder conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear… [D]iagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat.[96]

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[93] Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-142. doi:10.2105/ajph.2006.090910.

[94] "History of the DSM." DSM History. Accessed April 05, 2017. https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm.

[95] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV." *Journal of Traumatic Stress J. Traum. Stress* 7, no. 4 (1994): 684.

[96] Ibid.

These established patterns of reaction mimic the symptoms that have been observed for decades in combat veterans such as intrusive imagery, physiological hyperactivity, and the re-living of the event, including flashbacks and nightmares. At the time of its publication, most research on the potential long-term effects or delayed onset of symptoms in World War II veterans had not yet concluded and as such "Gross Stress Reaction" was defined as a treatable disorder and believed to be temporary in nature.[97] Believed to be acute, it was assumed once the trauma disappeared, the symptoms would likely diminish. In fact, if symptoms persisted beyond six months another diagnosis would be needed.[98] Freud suggested this lack improvement to be a reflection of "underlying psychopathology".[99] It would be years before this condition and symptoms were recognized for their stubborn resistance.

The development of the DSM and the inclusion of Gross Stress Reaction took a giant step toward providing veterans with an explanation for their experiences, and more importantly, potential treatments for recovery. Although in its infancy, and flawed, it provided, context for thousands of World War II veterans struggling with debilitating symptoms. Unfortunately, its inclusion was likely the result of timing. In the following edition of the DSM in 1968, perhaps due to a comparatively peaceful era,

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[97] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV", 689.

[98] "PTSD: National Center for PTSD." PTSD History and Overview -. Accessed November 02, 2016. http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.

[99] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV.", 689.

Gross Stress Reaction was omitted and re-classified into another category titled "Adjustment reaction of adult life".[100] This diagnosis failed to truly capture the nature of combat trauma and haphazardly listed it among others. "This diagnosis was limited to three examples of trauma: unwanted pregnancy with suicidal thoughts, fear linked to military combat, and Ganser syndrome (marked by incorrect answers to questions) in prisoners who face a death sentence."[101]

[100] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV.", 690.

[101] "PTSD: National Center for PTSD." PTSD History and Overview -. Accessed November 02, 2016. http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.

CHAPTER FIVE: THE VIETNAM WAR

In the years following World War II, as peace returned, the field of psychiatry experienced a resurgence of prejudice and degradation that was previously aimed at the young science. Many psychiatrist-civilians who volunteered their services during the war returned home to private practice and state hospitals. Quickly, military officials began to overlook the importance of their contribution to the war effort. As often happens, in times of peace, the reality of the war and its struggles are diluted.

The Korean War, which began in 1950, shared many characteristics with previous wars. For instance, the Korean War had alarmingly high psychiatric casualties, estimated at approximately 37 per 1,000 among US troops.[102] In addition, PIE was again utilized in the field to curb combat exhaustion and the intense environmental conditions of the war often intensified its effects. However, something that remained relatively unchanged was the psychiatric interpretation of those reactions. There is ample data and research available on the psychiatric impact on veterans of the Korean War, however there were no major advancements toward the development of an official PTSD diagnosis. This plateauing was likely a result of the lack of attention stress disorders received during the years of relative peace prior to the Korean War. It was not

[102] Jones, Edgar, and Simon Wessely. *Shell shock to PTSD: military psychiatry from 1900 to the Gulf War*. Hove: Psychology Press, 2005, 121.

until the Vietnam War, and particularly the years that following its conclusion, that growth in this area became evident.

By the time the Unites States entered the Vietnam War, the military was far more knowledgeable about the impact of combat on its soldiers. Recognizing the effects of enduring stressful events, tours of duty for infantryman in combat were limited to one year. Many hoped this tactic would help control the impact of war on the psychiatric state of the soldiers. The unique nature of this war, however, eventually lead to a staggering number of affected soldiers and many leading psychiatrists of the day, including Robert Lifton and Chaim Shatan, argued those numbers far surpassed those of World War II.[103] Critics suggest that many characteristics of this war created a breeding ground for psychiatric breakdowns in men at some point during or after their tour of duty.

It can be argued that Vietnam veterans did not witness the gruesomeness of combat to the degree that soldiers in previous wars had. Far fewer soldiers endured relentless, direct combat and were better able to maintain contact with their support systems at home. Data suggests that "the incidence of combat stress was reported to be very low (less than 5% of all medical cases)."[104] However, these soldiers undoubtedly endured a variety of challenges that made them vulnerable to stress. Soldiers were

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[103] Dean, Eric T. *Shook over Hell*, 41.

[104] Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-142. doi:10.2105/ajph.2006.090910.

younger on average than in previous wars and the use of the draft created a military far less resilient. They were unfamiliar with the use of guerilla warfare that the Viet Cong were proficient in creating highly stressful battles when they erupted as well as a near constant state of panic when at rest. The limited tours of duty believed to combat stress disorders actually prevented them from bonding and creating a sense of unity within their platoon which undoubtedly contributed to low morale. The knowledge that their efforts were largely unappreciated, even opposed, back home created further guilt and traumatization.[105] Any of these variables, individually, could wear on one's psychological state, but the combination made the effects of the Vietnam War particularly difficult to combat.

The United States military employed a variety of techniques to prevent the development of severe combat stress casualties, what was then referred to as combat fatigue or combat reaction. On the surface, this approach appeared successful. "Throughout the entire conflict, less than 5% (and nearer to 2%) of casualties were placed in this category."[106] It wasn't until soldiers began returning home that the true nature of Vietnam's effects became evident. Many suggested that the rate of mental breakdowns were significantly higher than initially believed and the unique nature of this war subjected its soldiers to a delayed onset in stress disorders.[107] Some

[105] Dean, Eric T. *Shook over Hell,* 41.

[106] Jones, Edgar, and Simon Wessely. *Shell shock to PTSD*, 128.

[107] Dean, Eric T. *Shook over Hell,* 42.

psychologists estimate the proportion of Vietnam veterans who may have suffered from the symptoms of PTSD as high as one-third of the entire veteran population.[108]

Returning home from a losing war, many with substance abuse dependencies, Vietnam veterans were perceived as a social problem by the generally anti-war population. The problems many veterans faced ranged from difficulty finding and maintaining work to arrests for drug-related and domestic charges, some of which were violent.[109] Popular culture's portrayal of the Vietnam veteran, a man unable to readjust to civilian life after combat, more so than previous wars, helped to push many psychologists to advocate for an official diagnosis.[110] Within the field of psychiatry these men were described as suffering from "post-Vietnam syndrome," but many wanted an official diagnosis to be represented within the DSM.[111]

> Aware that the American Psychiatric Association was preparing a new edition of their diagnostic manual, DSM, Lifton and Shatan formed a working group to collect evidence to support their case of the syndrome's inclusion. . . In January 1978 the working group presented its final report to the Committee, which one month later recommended the inclusion of the classification in DSM-III in the section on anxiety disorders, although their suggested term 'catastrophic stress disorder' and the sub-category 'post-combat stress reaction' did not find favour.[112]

When the DSM-III was published in 1980, Post-traumatic Stress Disorder was listed as

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[108] Dean, Eric T. "We Will All Be Lost And Destroyed", 138.

[109] Schaller, Barry R. *Veterans on Trial*, 104.

[110] Ibid., 91.

[111] Jones, Edgar, and Simon Wessely. *Shell shock to PTSD*, 130.

[112] Ibid.

a distinct and separate diagnostic entity among other anxiety disorders, such as Panic and Phobic Disorders. The development of the title emphasized the necessity of first experiencing a trauma followed by a change in functioning.[113] In its creation, the committee decided against narrowing the trauma specifically to combat, instead allowing for other traumas more likely to be experienced by the general population as well.

> The authors of the DSM decided to write a general definition for the disorder rather than a combat-specific or even Vietnam War-specific diagnosis in order to create a category of broad application. Writing a more general diagnosis was consistent with prior practice and tended to avoid the claim that the disorder category was not organic or that it was the product of political lobbying for a particular group.[114]

The general use of the word trauma allowed for those who had survived natural disasters, sexual assault, witnessing a violent crime, among others, to be labelled with a diagnosis of PTSD and receive treatment for their symptoms. There were twelve diagnostic symptoms for diagnosis, of which a patient would be required to experience at least four for diagnosis.[115] Some of the most commonly experienced symptoms from the diagnostic criteria included cognitively re-experiencing the trauma, numbing and detachment responses, sleep disturbances, and survival guilt.[116] Soldiers returning from Vietnam were not the only population affected. Approximately 80 percent of the

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[113] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria, 692.

[114] Schaller, Barry R. *Veterans on Trial, 80.*

[115] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria, 691.

[116] *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, D.C.: American Psychiatric Association, 2013.

women who served in Vietnam were nurses.[117] "The nurses who returned from Vietnam exhibited the same symptomatology [as combat veterans], demonstrated by persistent avoidance and numbing of general responsiveness, markedly diminished participation in significant activities and sense of a foreshortened future, which are included in PTSD C criteria."[118] The women of the Vietnam War are understudied, but based on research of PTSD, women in general are twice as likely to develop PTSD over men.[119]

By 1987, when the following edition of the DSM was published (DSM-III-R), there had been significant research and clinical work with patients of PTSD that allowed for the diagnostic criteria for PTSD to be revised. Patients would be required to experience six of a list of seventeen symptoms that were not previously experienced prior to their exposure to the trauma.[120] In addition, the revised edition operationalized the symptomatology of PTSD in a way which was not done in previous editions. This included specifying the "trauma" on a severity beyond that of normal, everyday hassles.[121] In addition, the cognitive "reexperiencing of trauma" must differ from a

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[117] Badalucco, Traci. "Vietnam Veterans Still Have PTSD 40 Years After War." *US News & World Report*, December 5, 2015.

[118] Birmes, Philippe, Leah Hatton, Alain Brunet, and Laurent Schmitt. "Early Historical Literature for Post-traumatic Symptomatology." *Stress and Health* 19, no. 1 (2003): 23.

[119] *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*.

[120] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria, 693.

[121] Ibid.

mere memory, such as in the form of a flashback or nightmare.[122] Finally, and importantly, it clarified the impact these symptoms had on the individual's overall functioning, such as distancing, avoidance, and cognitive impairments.[123] Providing an official diagnosis for these millions of sufferers within the psychological community acted to legitimize their experiences and validate their suffering. For Vietnam veterans who were navigating the criminal justice system, the diagnosis provided a basis for their defense that previously would have likely resulted in a conviction.[124] Most importantly, it provided a solid foundation for the necessity of treatment and rehabilitation.

The United States military believed that limiting the average tour of duty would reduce the overall likelihood of psychological breakdowns. The lack of post-combat support provided for these men based on that assumption resulted in a gross underestimation of delayed responses at home.

> A major shift in psychiatric interest in war-related psychiatric disability took place after the Vietnam War. Fifteen years after the United States withdrew from Vietnam, an epidemiological survey concluded that 480,000 (15%) of the 3.15 million Americans who had served in Vietnam were suffering from service-related PTSD. In addition, between one quarter and one third (nearly 1 million ex-service personnel) displayed symptoms of PTSD at one time or another.[125]

The Vietnam War followed the pharmaceutical revolution in psychology. By the 1970s most psychiatric treatments included some form of chemical intervention. Most

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[122] Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria, 693.

[123] Ibid., 695.

[124] Schaller, Barry R. *Veterans on Trial*, 104.

[125] Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-14.

veterans were recommended, based on many research studies, to take antidepressant medication in conjunction with individual and group therapy.[126] Other methods were attempted, such as biofeedback and Eye Movement Desensitization and Reprocessing (EMDR), with lackluster results.[127] Unfortunately, based on the National Vietnam Veterans' Readjustment Study (NVVRS), published in 1990, few were actively seeking treatment. "[The report] confirmed other reports that 'very substantial proportions' of Vietnam veterans with readjustment problems had not used the VA or any other source for their mental health problems especially during the twelve months just prior to the report's publication."[128] Getting "veterans to speak up about their symptoms is one of the biggest challenges in identifying those who need help, mental experts say, because of a fear of showing weakness. This is especially true in the military's 'toughen up' culture."[129] Despite best efforts, many found PTSD particularly difficult to treat among many of these veterans. A longitudinal study conducted by Marmar, Schlenger, and Henn-Haase "determined that even now—40 years after the war ended—about 271,000 Vietnam vets have full war-zone-related PTSD plus war-zone PTSD that meets some

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[126] Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-14.

[127] Silver, Steven M., Alvin Brooks, and Jeanne Obenchain. "Treatment of Vietnam war veterans with PTSD: A comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training." *Journal of Traumatic Stress* 8, no. 2 (1995): 337-42. doi:10.1007/bf02109568.

[128] Schaller, Barry R. *Veterans on Trial*, 109.

[129] Badalucco, Traci. "Vietnam Veterans Still Have PTSD 40 Years After War." *US News & World Report*, December 5, 2015.

diagnostic criteria. More than a third of the veterans who have current war-zone PTSD also have major depressive disorder."[130]

The progress made in the development of the definition of PTSD as a result of the Vietnam War and its veterans was unprecedented. Decades later, as the United States sent soldiers to war in Iraq and Afghanistan, the concept of PTSD was well known and better understood. Although like any war, it was fraught with conditions ripe for the development of PTSD, now it had a uniform understanding of what to expect, how to recognize it, and perhaps better combat it.

[130] Oaklander, Mandy. "More Than 200,000 Vietnam Vets Still Have PTSD." *Time*, July 22, 2015. http://time.com/3967590/vietnam-veterans-ptsd/.

CHAPTER SIX: CONCLUSION

Despite a more scientific definition and better understanding of Posttraumatic Stress Disorder following the Vietnam War, PTSD was not erased from the military landscape. Two and a half million soldiers were deployed during the wars in Iraq and Afghanistan and nearly 1.6 million served in some other conflict as well.[131] A survey commissioned by *The Washington Post* and the Kaiser Family Foundation reported an alarmingly high rate of suicidal ideation among these veterans.[132] A study tracking the vitals of veterans through 2009 found that 21.3 percent of deployed veterans and 19.7 percent of non-deployed veterans serving during the Iraq and Afghanistan wars committed suicide.[133] Equally concerning is the apparent failure to adequately provide treatment for these veterans.

> Recent data show that more than 200,000 Vietnam War veterans still have PTSD, and other research shows that around 13% of Iraq or Afghanistan veterans who experienced combat have PTSD. The numbers continue to climb. As TIME previously reported, PTSD diagnoses among deployed troops grew by

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[131] Chalabi, Mona. "What Percentage Of Americans Have Served In The Military?" FiveThirtyEight. May 25, 2015. Accessed April 07, 2017. https://fivethirtyeight.com/datalab/what-percentage-of-americans-have-served-in-the-military/.

[132] "Majority of veterans say they would join military again, despite scars of war." Interview by Gwen Ifill. PBS NewsHour. March 31, 2014. http://www.pbs.org/newshour/bb/state-veterans/.

[133] "Public Health." Suicide Risk and Risk of Death Among Recent Veterans - Public Health. January 16, 2015. Accessed April 05, 2017. https://www.publichealth.va.gov/epidemiology/studies/suicide-risk-death-risk-recent-veterans.asp.

400% from 2004 to 2012.[134]

As previously discussed, PTSD is commonly treated using an eclectic approach. Prescribed medications in conjunction with various other therapy techniques are typical. In the time of the Iraq and Afghanistan wars, the most common therapeutic approaches for PTSD were cognitive and behavioral therapies such as Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) Therapy. These therapies were originally designed to provide treatment for abuse victims and have recently been applied to the growing veteran PTSD population.[135]

> Prolonged Exposure Therapy forces a patient to vividly remember every detail of a traumatic experience and verbalize the memories . . . Dr. Kevin Reeder is the man behind the VA program. He explains that the idea is to relive the story of the attack at least five times in a single session, and then listen to your voice on tape re-telling the story. The belief is that hearing the traumatic memory repeatedly will neutralize its power from bubbling up from your subconscious memory and catching you off guard.[136]

By verbalizing their experiences continuously therapists hope to reduce the impact of triggers that veterans may encounter in their daily lives which previously may have debilitated them. CPT's group sessions "begins with writing an impact statement, which is shared with the group in which veterans talk about how their lives are still held in the grip of war."[137] The goal of this therapy is to allow veterans to reflect on their

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[134] Sifferlin, Alexandra. "How Effective Are PTSD Treatments for Veterans?" *TIME,* August 4, 2015. http://time.com/3982440/ptsd-veterans/.

[135] Bergland, Christopher. "Two New PTSD Treatments Offer Hope for Veterans." *Psychology Today*, November 26, 2013. https://www.psychologytoday.com/blog/the-athletes-way/201311/two-new-ptsd-treatments-offer-hope-veterans.

[136] Ibid.

[137] Ibid.

feelings, especially those which may be harmful to their well-being, such as guilt and anger, while attempting to restructure their dysfunctional thoughts.[138] These are often discussed in a group setting which many veterans find comforting and familiar following their time in the military. "In the CPT groups, veterans seem to bond and recreate this sense of camaraderie with other soldiers in a safe environment."[139] It can provide a sense of familiarity and stability at a time in their life when things feel new and chaotic.

Unfortunately, new research from the Steven and Alexandra Cohen Veterans Center for Post-Traumatic Stress and Traumatic Brain Injury at NYU Langone Medical Center questions its effectiveness. The study suggests that while approximately 70 percent of the participants utilizing these methods experienced a reduction in their symptoms, nearly 67 percent still met the diagnostic criteria for PTSD following treatment.[140] They believe the chronic and severe nature of combat may create symptoms that are particularly resistant to treatment. Others, such as Dr. Paula Schnurr, the executive director of the National Center for PTSD under the U.S. Department of Veterans Affairs, are hesitant to assume that veterans experience PTSD more severely than civilians, and argue that despite a continued PTSD diagnostic label, any alleviation of symptoms likely creates an improved quality of life for these veterans.[141]

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[138] Sifferlin, Alexandra. "How Effective Are PTSD Treatments for Veterans?"

[139] Bergland, Christopher. "Two New PTSD Treatments Offer Hope for Veterans." *Psychology Today*, November 26, 2013.

[140] Sifferlin, Alexandra. "How Effective Are PTSD Treatments for Veterans?"

[141] Ibid.

As discussed, the diagnosis of PTSD has become more clear and finite, especially following its inclusion in the DSM, but medical professionals are still unable to determine who will fall victim to the disorder.[142] With little ability to predict its victims, the main area of focus remains in attempts to control the symptoms once they appear. Although current treatment methods, when utilized, have proven effective to a great degree in alleviating symptoms, most agree that continued research, new treatment methods and resources should be explored. This is especially important considering their troubles at home following the war continue to mimic those of veterans from previous wars as 55 percent of veteran survey respondents reported "they sometimes or often feel disconnected from civilian life."[143] This is a time in their life when they are particularly vulnerable to their symptoms as the stressors of readjustment emerge.

The question remains, what additional resources could be provided for these men and women? There is ample evidence, as previously discussed, to suggest that exposure to combat in war contributes to the development of PTSD and its symptoms, but there are a variety of experiences prior to and following deployment that may serve as significant stressors as well. Better and more thorough screening processes, especially post-deployment may serve to identify veterans who may be at risk in the future and to provide resources before the symptoms become debilitating. Research has indicated that veterans with mental disorders are more likely to commit suicide than the

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[142] Dean, Eric T. *Shook over Hell*, 44.

[143] Sifferlin, Alexandra. "How Effective Are PTSD Treatments for Veterans?"

general population.[144] In a study of 435 Operation Iraqi Freedom and Operation Enduring Freedom veterans published in the Journal of Traumatic Stress, 3 percent reported attempting suicide in the previous four months.[145] It is imperative that post-deployment screening pay special attention to those who show signs of depression and suicidal ideation to provide immediate assistance and treatment. Finally, reducing drug and alcohol abuse among active and inactive-duty military is necessary in controlling future breakdowns. Thirty-one percent and five percent of the previously mentioned participants screened positive for alcohol and drug dependencies. Addictive disorders comorbid with PTSD can be a deadly combination. "Substance abuse within the military undermines effectiveness, contributes to MST [military sexual trauma] and other violence, and increases the likelihood of mental health problems when veterans reenter civilian society."[146] Providing drug programs in conjunction with continued supervision in vital.

Psychiatric casualties of war are littered throughout American history and a great deal of them can be explained by a lack of understanding of the relationship between combat trauma and mental health. However, these casualties are not limited to

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[144] Jakupcak, Matthew, Jessica Cook, Zac Imel, Alan Fontana, Robert Rosenheck, and Miles Mcfall. "Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan War veterans." *Journal of Traumatic Stress* 22, no. 4 (August 2009): 303-06. doi:10.1002/jts.20423.

[145] Jakupcak, Matthew, Jessica Cook, Zac Imel, Alan Fontana, Robert Rosenheck, and Miles Mcfall. "Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan War veterans." *Journal of Traumatic Stress* 22, no. 4 (August 2009): 303-06. doi:10.1002/jts.20423.

[146] Schaller, Barry R. *Veterans on Trial: The Coming Court Battles over PTSD*, 199.

the battlefield and often return home with veterans which significantly impact their lives as well as the lives of those around them. It is imperative that the knowledge acquired about PTSD from past survivors be utilized to its fullest extent to minimize the impact on our future.

REFERENCES

Badalucco, Traci. "Vietnam Veterans Still Have PTSD 40 Years After War." *US News & World Report*, December 5, 2015. https://www.usnews.com/news/articles/2015/12/05/vietnam-veterans-still-have-ptsd-40-years-after-war.

Bergland, Christopher. "Two New PTSD Treatments Offer Hope for Veterans." *Psychology Today*, November 26, 2013. https://www.psychologytoday.com/blog/the-athletes-way/201311/two-new-ptsd-treatments-offer-hope-veterans.

Boone, Katherine N., and Frank C. Richardson. "War Neurosis: A Cultural Historical and Theoretical Inquiry." *Journal of Theoretical and Philosophical Psychology* 30, no. 2 (2010): 109-21. doi:10.1037/a0021569.

Birmes, Philippe, Leah Hatton, Alain Brunet, and Laurent Schmitt. "Early Historical Literature for Post-traumatic Symptomatology." *Stress and Health* 19, no. 1 (2003): 17-26. doi:10.1002/smi.952.

Blank, Arthur S., Jr. "Clinical Detection, Diagnosis, and Differential Diagnosis of Post-Traumatic Stress Disorder." *Psychiatric Clinics of North America* 17, no. 2 (June 1994): 351-83.

Brokaw, Tom. *The greatest generation*. New York: Random House, Paw Prints (imprint of Baker & Taylor Books), 2010.

Chalabi, Mona. "What Percentage Of Americans Have Served In The Military?" FiveThirtyEight. May 25, 2015. Accessed April 07, 2017. https://fivethirtyeight.com/datalab/what-percentage-of-americans-have-served-in-the-military/.

Dean, Eric T. *Shook over Hell: Post-traumatic Stress, Vietnam, and the Civil War*. Cambridge, MA: Harvard University Press, 1997.

Dean, Eric T. "We Will All Be Lost And Destroyed": Post-Traumatic Stress Disorder and the Civil War." *Civil War History* 37, no. 2 (1991): 138-53. doi:10.1353/cwh.1991.0078.

Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Washington, D.C.: American Psychiatric Association, 2013.

"FAQ about the American Revolutionary War." Campaign 1776, 2014, Accessed November 04, 2016, http://www.campaign1776.org/revolutionary-war/facts-of-the-american.html?referrer=https://www.google.com/.

Grossman, David. On killing: the psychological cost of learning to kill in war and society. Boston: Little, Brown, 1996.

Hanson Frederick, ed., *Combat Psychiatry: Experiences in the North African and Mediterranean Theaters of Operation, American Ground Forces, World War II*, vol 9 supplement, *Bulletin of the US Army Medical Department* (Washington, DC, 1949).

"History of the DSM." DSM History. Accessed April 05, 2017. https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm.

Hess, Earl J. *The Union Soldier in Battle: Enduring the Ordeal of Combat*. Lawrence, KS: University Press of Kansas, 1997.

Horowitz, Tony. "Did Civil War Soldiers Have PTSD?" Smithsonian Magazine. January 2015. Accessed October 2016. http://www.smithsonianmag.com/history/ptsd-civil-wars-hidden-legacy-180953652/.

Jakupcak, Matthew, Jessica Cook, Zac Imel, Alan Fontana, Robert Rosenheck, and Miles Mcfall. "Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan War veterans." *Journal of Traumatic Stress* 22, no. 4 (August 2009): 303-06. doi:10.1002/jts.20423.

Jones, Edgar, and Simon Wessely. "Battle for the Mind: World War 1 and the Birth of Military Psychiatry." *The Lancet* 384 (2014): 1708-714.

Jones, Edgar, and Simon Wessely. "“Forward Psychiatry” in the Military: Its Origins and Effectiveness." *Journal of Traumatic Stress J. Trauma. Stress* 16, no. 4 (2004): 411-419.

Jones, Edgar, and Simon Wessely. *Shell shock to PTSD: military psychiatry from 1900 to the Gulf War*. Hove: Psychology Press, 2005.

Loughran, Tracey. "A Crisis of Masculinity? Re-writing the History of Shell-shock and Gender in First World War Britain." *History Compass* 11, no. 9 (2013): 727-38.

"Majority of veterans say they would join military again, despite scars of war." Interview by Gwen Ifill. PBS NewsHour. March 31, 2014. http://www.pbs.org/newshour/bb/state-veterans/.

Oaklander, Mandy. "More Than 200,000 Vietnam Vets Still Have PTSD." *Time*, July 22, 2015. http://time.com/3967590/vietnam-veterans-ptsd/.

Palmer, Greg. "The Perilous Fight - The Mental Toll." PBS. 2003. http://www.pbs.org/perilousfight/psychology/the_mental_toll/.

Pols, Hans, and Stephanie Oak. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (December 2007): 2132-142. doi:10.2105/ajph.2006.090910.

"PTSD: National Center for PTSD." How Common Is PTSD? -. Accessed November 02, 2016. http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp.

"PTSD: National Center for PTSD." PTSD History and Overview -. Accessed November 02, 2016. http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.

"Public Health." Suicide Risk and Risk of Death Among Recent Veterans - Public Health. January 16, 2015. Accessed April 05, 2017. https://www.publichealth.va.gov/epidemiology/studies/suicide-risk-death-risk-recent-veterans.asp.

Purtle, Jonathon . "'Railway spine'? 'Soldier's heart'? Try 'PTSD.'." *The Inquirer Daily News*. http://www.philly.com/philly/blogs/public_health/Railway-spine-Soldiers-heart-Try-PTSD.html.

Reid, Fiona. "'His Nerves Gave Way': Shell Shock, History and the Memory of the First World War in Britain." *Endeavour* 38, no. 2 (2014): 91-100.

Schaller, Barry R. *Veterans on Trial: The Coming Court Battles over PTSD*. Washington, D.C.: Potomac Books, 2012.

Sifferlin, Alexandra. "How Effective Are PTSD Treatments for Veterans?" *TIME*, August 4, 2015. http://time.com/3982440/ptsd-veterans/.

Silver, Steven M., Alvin Brooks, and Jeanne Obenchain. "Treatment of vietnam war veterans with PTSD: A comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training." *Journal of Traumatic Stress* 8, no. 2 (1995): 337-42. doi:10.1007/bf02109568.

Stiles, Anne. "Go Rest, Young Man." *APA Monitor*, December 2012, 32.

Webb, T. E F. "'Dottyville'--Craiglockhart War Hospital and Shell-shock Treatment in the First World War." *Journal of the Royal Society of Medicine* 99 (2006): 342-46.

"What is Cognitive Behavior Therapy | Beck Institute." Beck Institute for Cognitive Behavior Therapy. Accessed March 21, 2017. https://www.beckinstitute.org/get-informed/what-is-cognitive-therapy/.

Wilcox, Vanda. "Combat and the Soldier's Experience in World War One." The British Library. 2014. Accessed November 09, 2016. https://www.bl.uk/world-war-one/articles/combat-and-soldiers-experiences.

Wilson, John P. "The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV." *Journal of Traumatic Stress J. Traum. Stress* 7, no. 4 (1994): 681-98. doi:10.1002/jts.2490070413.

Madison, New Jersey

May 2017

VITA

Full name: Laura Ann Rieder

Place and date of birth: Edison, New Jersey June 16, 1984

Parents Name: Gary and Eva Dengelegi

Educational Institutions:

School	Place	Degree	Date
Secondary: Bishop Ahr High School, Edison NJ		High School	June 2002
Collegiate: University of Delaware, Newark DE		BA	May 2006
Graduate: Drew University, Madison NJ		MLitt	May 2017