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Are We In the Clear? : A History of Military Treatment of Post-Traumatic Stress Disorder from the Civil War until the Wars on Terror

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To the Dean of the Graduate School:

We are submitting a thesis written by Susanna Ola Lee entitled, “Are We In the Clear? A History of Military Treatment of Post-Traumatic Stress Disorder from the Civil War until the Wars on Terror.” We recommend acceptance in partial fulfillment of the requirements for the degree of Master of Arts in History.

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ARE WE IN THE CLEAR?

A HISTORY OF MILITARY TREATMENT OF POST-TRAUMATIC STRESS DISORDER FROM THE CIVIL WAR UNTIL THE WARS ON TERROR

A Thesis

Presented to the Faculty

Of the

College of Arts and Sciences

In Partial Fulfillment

Of the

Requirements for the Degree

Of

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In History

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By

Susanna O. Lee

Abstract

Post-traumatic stress disorder is known as a common element of warfare. However, it has only gained significance during the last century. The Civil War was the first time that the military began to record soldiers who were diagnosed with “nostalgia.” With every conflict that followed, the name of the disorder changed. Along with changing the name, new treatments were implemented.

The goals of the paper are to show depictions of the treatment of post-traumatic stress disorder beginning with the Civil War until the present Afghan/Iraqi conflicts and how it was dealt with by military organizations. This paper will also cover how changes in society and advancements in fighting techniques have affected post-traumatic stress disorder.

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Introduction

War is not an ordinary or normal state of being for humans. Warfare over time has evolved from the single stage of defending one's family or homeland against invaders to foreign excursions away from the warriors' homes. Often, these operations lasted for extended periods of time. This caused soldiers to develop homesickness and depression. When soldiers are in situations where they have to physically and mentally defend themselves almost continuously, emotional trauma can be caused.

War began with hand-to-hand combat. It meant that soldiers were face-to-face with their enemy. Following the introduction of gunpowder to the battlefield, the space between combatants began to expand. Until World War I, soldiers charged into battle in a similar fashion as they had for centuries. Hand to hand combat still exists today, but it is only used in extreme circumstances. The innovations that were introduced during World War I caused the battlefield to change drastically.

When war was fought with swords, shields, bows and arrows, death to one's comrades and enemies was more visible. This did not just apply to the battlefield where death was expected, but it was also more visible in everyday life. People had shorter life expectancies than they have today. More people died suddenly from accidents, or people also died from things for which time

has found cures. Violent death was more frequent and more visible. It could be said that it was more common, and people were more used to death.

Post-traumatic stress disorder occurs when a person experiences a traumatic event. Battle and war are considered traumatic events. The recorded history of post-traumatic stress disorder begins in the seventeenth century, the Swiss and Spanish recorded a phenomenon termed nostalgia, where soldiers sent to foreign fronts felt deep despair. Many of these soldiers were mercenaries who had left their homes in Switzerland. They were thought to suffer from this condition because they had been forced to leave their homes and fight. Nostalgia was also recorded by the French and the Germans in the eighteenth century. By this time it had become known to not just affect Swiss mercenaries but any soldier who was displaced from his home.

The term nostalgia was created by the Swiss doctor Hofer to describe soldiers who had been diagnosed as suffering from “Das Heimweh” also known as homesickness. In 1761, Leopold Auenbrugger wrote in his book *Inventum Novum* the following about nostalgia:

> When young men forced to enter military service and thus lose all hope of returning safe and sound to their beloved homeland, they become sad, taciturn, listless, solitary, musing, full of sighs and moans. They cease to pay attention and become indifferent to everything which the maintenance of life requires of them. This is bad nostalgia. Neither medicaments, nor arguments, nor

> promises nor threats of punishment is able to produce any improvement.[1]

Auenbrugger's work also states that nostalgia was commonly called "Heimweh." It was noted by Baron Van Swieten, in one of the few medical manuals used during the American Revolution that once a man is removed from his home and village melancholy appears. After a time, the soldier will become used to military life but at first, he must be kept distracted.[2]

The idea that keeping a soldier busy would keep him from developing melancholia persisted through the 18th and into the 19th century. In the Napoleonic Wars, cases of cerebro-spinal shock were experienced by soldiers who had been near an explosion or who had been closely missed by a projectile but not wounded. They displayed symptoms such as "tingling, twitching, and at time partials paralysis."[3] These cases, however, were met with doubt by military doctors due to the fact that the soldier lacked any visible wounds. Nostalgia was a term that was frequently used up to the American Civil War by medical officials to cover a wide range of mental disorders.[4]

During the time that elapsed between the American Civil War and the Boer War in South Africa, the terminology changed. In the Crimea and the

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[1] Leopold Auenbrugger, *Inventum Novum Ex Percussione Thoracis Humani Ut Signo Abstrusos Interni Pectoris Morbos Detegendi* (Vindobonae: Typis Joannis Thomae Trattner, 1761), 44.

[2] Gerard Van Swieten, William Northcote, and John Ranby, *The Diseases Incident to Armies. With the Method of Cure* (Boston: Philadelphia, 1777), 7.

[3] Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove: Psychology Press, 2005), 2.

[4] Jones and Wessely, *Shell Shock to PTSD,* 2-3.

American Civil War, physicians diagnosed service men who presented with symptoms such as unexplained palpitations, exhaustion, and tremors with “irritable” or "soldier's heart" but more commonly diagnosed as nostalgia.

In 1871, J.M Da Costa published a paper in the *American Journal of Medical Science* detailing cases he had encountered as a visiting physician during the American Civil War. Da Costa would be known as the doctor who did in-depth studies of "soldier’s heart." In his 1871 paper he would make this bold statement:

> It cannot be said that ours was the first war in which it was noticed; for we find in the British Blue Book of the Crimean war … and I have seen here and there short statements which make it likely that the same affliction was noticed in India … Nor can I believe that it has not always existed.[5]

By the time the British began fighting Boer War, the terminology had changed from "soldier's heart" to “disorder action of the heart” (DAH) along with nostalgia.[6] Boer War physician Anthony Bowlby summed up the view of the Victorian doctors on “shell shock” when he wrote:

> The frequent poor state of general nutrition, the excitement of battle often following prolonged mental strain and bodily fatigue, must all combine to favours[sic] the appearance of functional nervous symptoms.[7]

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[5] J. M. Da Costa, "Art. I.On Irritable Heart; a Clinical Study of a Form of Functional Cardiac Disorder and Its Consequences." *The American Journal of the Medical Sciences* 121, no. 1 (1871), 17.

[6] Jones and Wessely, *Shell Shock to PTSD*, 5.

[7] Anthony A Bowlby, *A Civilian War Hospital. Being an Account of the Work of the Portland Hospital, and of Experience of Wounds and Sickness in South Africa, 1900, with a*

It is interesting to note that Bowlby also pointed out that many of the men who displayed neurasthenia during the Boer War had many of the same symptoms which would later be associated with men diagnosed with “shell shock.”

During World War I, this disorder was known as "shell shock." This was the first war where the American and British militaries had military psychiatrists in their medical units. Shortly after the start of the war, the British Army began to see large numbers of "war neurosis" and "hysteria." They developed ways to treat soldiers with this disorder and in 1917, the United States sent doctors over to learn their practices.

When World War II began (1939 for Britain and 1941 for the United States), both militaries had forgotten any lessons that they had gleaned from World War I. The terminology changed once again, and the disorder was known as "combat exhaustion." This name would last through the Korean War where the name would become interchangeable with “combat fatigue.” By the civilian world, the disorder would be known as a gross stress reaction.[8]

The Vietnam War is the point where the history of this disorder changed. This war is the war where the public became very aware of the existence of this disorder. The Vietnam War is also the first war that was broadcasted on the evening news. The name was finally changed to post-

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Description of the Equipment, Cost, and Management of a Civilian Base Hospital in Time of War (New York: Longmans, Green &; London, J. Murray, 1901), 129.

[8] Jones and Wessely, *Shell Shock to PTSD,* 67.

traumatic stress disorder in 1980. At this point the medical community begins to recognize it as an actual disorder.[9]

Following the Vietnam War, the United States was not involved in long drawn out engagements. The Gulf War from 1990 to 1991 was limited in combat but led to the term “Gulf War syndrome.” “Gulf War syndrome” covered a number of symptoms that included those related to post-traumatic stress disorder. Between the Gulf War and the present wars in Iraq and Afghanistan, the United States was involved in a number of “humanitarian” efforts. These were not long drawn out engagements like the Vietnam War, but some did involve combat.

The current engagements in Iraq and Afghanistan have brought Post-Traumatic Stress Disorder back into the forefront. Unfortunately, the reason for it being in the forefront is not due to a new form of treatment but a large number of soldier suicides. There are many reasons for suicide, but many of recent soldier suicides have been blamed on their involvement in the Iraq and Afghanistan.

Post-traumatic stress disorder has become recognized as a common element of warfare. However, it has only gained significance during the last century. The goals of this paper are to show depictions of post-traumatic stress disorder beginning with the Civil War until the present Afghan/Iraqi

[9] Ibid, 131.

conflicts and how it has been dealt with by military organizations. This work will also cover how advancements in fighting techniques have influenced the treatment of post-traumatic stress disorder.

While this work will mainly focus on the American military, it is important to note that other militaries have been influential in the treatment of post-traumatic stress disorder. The British Army became the model for the United States during World War I. It was through the partnership with the British that the United States was able to be prepared for the casualties during the war. Other militaries, like the Russians and Italians, also made advancements in the field of post-traumatic stress disorder. Their advancements will be addressed along with the British and American.

It is also important to note that when looking at a disorder such as post-traumatic stress disorder throughout the span of 150 years, the definition changes. Starting with "Nostalgia" and "Soldier's Heart" in the 1860's the definition is broad and covers a number of ailments. The nineteenth century was a time when the idea of mental illness was changing, and there was momentum for better treatment of the mentally ill. As time passed and more research was done on the disorder, the definition was narrowed.

In 1980, post-traumatic stress disorder was recognized as an official disorder by the American Psychiatric Association. At this time, there was still a belief that traumatic events were rare. In the past few years, there has been a

debate between military officials and civilian psychiatrists to change the name of post-traumatic stress disorder to post-traumatic stress injury. The military argument is to change the name because they believe that the current name is a deterrent for soldiers to get treatment. The civilian argument is that the name is not the problem, but the military environment is the problem.[10]

Currently, the Mayo Clinic defines post-traumatic stress disorder as:

> Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event — either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.[11]

There is still a stigma associated with Post-Traumatic Stress Disorder and any mental illness. Treatment has progressed from electroshock and lobotomies to psychotherapy and group therapy.

The purpose of this work is to show that, over time, technology has expanded the battlefield so that the soldier at times does not even see his enemy. Now society has advanced so much that death has become a more private matter. These things have caused combat to be a more traumatic experience.

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[10] American Psychiatric Association, "American Psychiatric Association DSM-5 Development," DSM-5 Development, 2013, accessed February 03, 2016, http://www.dsm5.org/Pages/Default.aspx.

[11] Mayo Clinic Staff, "Post-traumatic Stress Disorder (PTSD)," Mayo Clinic, accessed January 28, 2016, http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/definition/con-20022540.

Chapter One

When these Splendid Little Wars are Over

The extreme nature of war causes a psychological impact on those who are called or forced to participate. Even when the battle has ceased, those involved re-live the memories. The Civil War was a unique event in American history where both sides' medical staff were very similar in training, but due to different circumstances relating to supplies and manpower, the sides had to react differently.

The middle and late 19th century is classified as the Victorian era due to the British monarch at the time Queen Victoria. During this time, the average life expectancy was about 40 years old, although some people lived longer. Diseases such as typhoid, cholera, tuberculosis, and scarlet fever were common causes of death.[12] Seeing death was not an uncommon event in a person's life. Pubic hangings were also a common form of entertainment. The process of dying and grief were public affairs. The ritual of mourning was extensive at this time. Of course, this was mainly observed by the upper classes of society. The ritual of mourning varied by class and by gender, with women's periods of mourning being longer than men's. This ritual regulated the daily rituals and clothing of the mourner. While seeing death was not an

[12] Legacy.com, "1850-1900," Vaccines Extend Life!, accessed January 30, 2016, http://www.legacy.com/life-and-death/the-vaccination-era.html.

uncommon occurrence, violent death was not something a person witnessed every day.

The Civil War hosted some of the bloodiest battles that have ever been fought. While there had been advancements in weapons, the strategy had not changed greatly since the revolution. This involved the soldiers marching in formation on the battlefield and then firing and at times charging directly at each other. Hand-to-hand combat was not an unusual event. The violence of the Civil War battlefield was not uncommon for 19th-century warfare; it was, however, uncommon for those involved.

The first three years of the Civil War were fought in the same tactical style that had been used for the previous 150 years. The technology had advanced to where troops were using rifled muskets, repeating guns, breach loading rifles and new rifled artillery. These new rifles and muskets would shoot conical shaped bullets.[13]

These advancements in firepower would expand the battle field. With the new rifled gun, a skilled shooter could hit a target at 500 yards. The large majority of soldiers, however, were killed within 100 yards or less of each other.[14]

[13] Michael Stephenson, *The Last Full Measure: How Soldiers Die in Battle* (New York: Crown Publishers, 2012), 121.

[14] Ibid, 131-132.

Soldiers' marching in a column is a tactic that has existed for centuries. It limits soldiers from making individual decisions and puts their lives in the hands of their commanders. Due to the advancements in firepower, military tacticians were beginning to dislike the use of the column formation. Marching in battle this way presented the soldiers as more of a target than a useful form of attack. Most men were unable to fire while in formation due to being boxed in by other soldiers.[15]

While the majority of both sides' artillery was still non-rifled, known as smoothbore, the Union did outnumber the Confederacy in rifled artillery. For advancing infantry, the chance of being killed by artillery fire began at 1,500 yards. Artillery would then be effective in killing at 300 to 100 yards. Most soldiers who were killed by artillery fire were killed at the 300 to 100 yard range.[16]

During the Civil War, many doctors were not required to have a formal medical education. Most earned the title of surgeon because they had apprenticed under another surgeon. Germ theory was a new idea, and the idea of cleaning and sterilizing medical equipment was non-existent. Many doctors thought that pus on a wound was a sign of healing.[17]

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[15] Ibid, 137.
[16] Ibid, 145-146.
[17] Dennis W Brandt, *Pathway to Hell: A Tragedy of the American Civil War* (Bethlehem: Lehigh University Press, 2008),174.

What today is called post-traumatic stress disorder was called by a variety of names during the Civil War. The most common term was “nostalgia” but “soldier’s heart” and “DaCosta’s Syndrome” were used as well. While it had been understood during the American Revolution that soldiers could become depressed, the correlation between melancholy and the battle was unknown. The most common treatment for a soldier displaying symptoms of “nostalgia” was to send them back into battle. If doctors determined that a soldier was unfit to continue with his military service and declared insane, he was sent to a government hospital for the insane or just turned out to wander among the general public.[18]

Many Civil War doctors believed in dualism. Physical and mental ailments developed separately of each other. Mental ailments were considered problems of the soul and were left to be treated by those outside of the medical field. Nostalgia was a disorder that fell somewhere between a real disease and malingering.[19]

While the idea of insanity was changing during the nineteenth century, the ancient Greek system of diagnosing mental ailments was still used. A person who displayed symptoms of agitation or anxiety, was diagnosed with

[18] Eric T. Dean, Jr., *Shook Over Hell. Post-Traumatic Stress. Vietnam, and the Civil War* (Cambridge, Massachusetts/London, England: Harvard University Press, 1997), 114.

[19] R. Gregory Lande, *Madness, Malingering, and Malfeasance: The Transformation of Psychiatry and the Law in the Civil War Era* (Washington, D.C.: Brassey's, 2003),172-173.

mania. Soldiers were diagnosed with melancholy if they were depressed and if their mental state was disordered, then they were diagnosed with dementia.[20]

In 1840, the Deputy Inspector General of Army Hospitals, Henry Marshall, published a book entitled *On the Enlisting, Discharging and Pensioning of Soldiers.* There was a short section about "Mental Alienation." In this section, there are examples of soldiers who displayed varying types of mental ailments. Marshall describes an occurrence where sometimes mental alienation was mistaken for a made up disease.[21] One such example used by Marshall is the story of Joseph Godfry. Soldier Joseph Godfrey served in the Army for eleven years. During different periods of time throughout his enlistment, he displayed symptoms of being deranged. He was court martial five times for pretending to be insane. Each time he was found guilty and sentenced to be flogged. After he was discharged from the army, his mental state did not improve, and he later committed suicide by drinking sulfuric acid.[22] While this event happened three decades before the Civil War, it does set the tone for how insanity and mental diseases were treated with in the 19th century.

Shortly after the start of the Civil War, Jacob Mendez Da Costa was a visiting doctor with the Union Army in Philadelphia. He began to notice soldiers being admitted with a particular type of heart problem that he began to label as

[20] Dean, *Shook Over Hell,* 116.

[21] Henry Marshall, *On the Enlisting, Discharging, and Pensioning of Soldiers: With the Official Documents on These Branches of Military Duty* (Philadelphia: Published by A. Waldie, 1840), 182.

[22] "Coroner's Inquest." *The Times* (London), February 22, 1826.

"irritable heart."[23] At this point, he began to study those soldiers who had been admitted with this disorder. In 1864, Da Costa first published some ideas about what caused "irritable heart." It was not until 1871 that he was able to publish an article in the *American Journal of Medical Science* that was more detailed. In this article, Da Costa presented some cases he had encountered that he had diagnosed with "irritable heart." [24]

The story of John Hildt is similar to the story of many Civil War soldiers. John Hildt was a 25-year-old corporal, was shot in the right arm during the Seven Days Battle in Virginia. His arm was amputated, a procedure that almost cost him his life. After this, he was sent to the Government Hospital for the Insane in Washington D.C., diagnosed with acute mania. Before the war, he had been of a sound mental state, but months and years passed and his mental state did not improve. He was withdrawn most of the time, but could become so excited that he hit other patients. He died in the hospital in 1911.[25]

There were many occurrences where a soldier's mental state was compromised before being involved in the fighting. This was due to some things like a prior nervous condition, the anticipation of battle and even the living conditions that accompanied military enlistment. Soldiers were required to march vast distances carrying heavy knapsacks. Soldiers soon learned that they needed to get rid of all things that were not necessary, like winter clothing

[23] Da Costa, On Irritable Heart, 2-52.
[24] Ibid, 30.
[25] Tony Horwitz, "Did Civil War Soldiers Have PTSD?," *Smithsonian Magazine*, accessed January 3, 2016, http://www.smithsonianmag.com/history/ptsd-civil-wars-hidden-legacy.

that was missed when the seasons changed. Marching for such long periods of time without rest caused many of the soldiers to develop heat stroke, migraines, and persistent nausea. Conditions were even harsher for the Confederate troops.[26]

The large majority of men who fought in the Civil War were farmers. This gave them a level of independence while still being able to spend time with their families. Once they entered the military, their independence and the ability to communicate with their families changed. These men were taken away from their homes and were at times subjected to discipline that they considered pointless. This, in time, led to depression and even suicide.[27]

The simple act of marching from place to place could even become a traumatic event in a soldier's life. The importance of being hydrated during physical activity was not completely recognized by the medical community. There were many cases where soldiers would collapse from heatstroke. In serious cases, the heat-stroked soldier would go into a fit and die. Since most units at this time were made up of people from the same town or county, the soldier most likely died in front of family and longtime friends.[28]

The experience of battle was much more than many had expected. When the troops began to move to the front, anxiety and fear started to rise,

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[26] Ibid.

[27] R. Gregory Lande, "Felo De Se: Soldier Suicides in America's Civil War." *Military Medicine* 176, no. 5 (2011), 531-36.

[28] Daniel Clark, "Post-Traumatic Stress Disorder and the American Civil War: A Reappraisal," Post-Traumatic Stress Disorder and the American Civil War: A Reappraisal, accessed January 26, 2016, http://www.academia.edu/5812575/Post-traumatic_Stress_Disorder_and_the_American_Civil_War_A_Reappraisal.

especially among the newer recruits. At times, men were so afraid that they fell to the ground unable to move. For many, this fear subsided after they had experienced their first battle. They were able to move and complete the task at hand. Eventually, for some, the constant involvement in war took its toll. Some soldiers began to develop a recklessness and emotional detachment from the world. Battle and dying became a regular event.[29]

While manuals for the surgeons in the Union Army briefly covered the topic of nostalgia, the manuals for the surgeons in the Confederate Army were a bit different. Nostalgia was not mentioned directly, but things like “nervous shock” and “nervous exhaustion” were mentioned. “Nervous shock” was said to accompany not only serious wounds but also could be found with "trivial injuries." The soldiers suffering from nervous shock would become "cold, faint and pale." They would also break out in cold sweats; their pulse rate would drop, and they would become depressed. Also at times, they could have trouble speaking. The remedy was a drink of water and a few encouraging words.[30] Later in the war, it was advised that if the depression was deeper or connected with a serious injury, morphine and a drink of brandy were to be administered if available.[31]

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[29] Ibid.

[30] Julian John Chisolm, *A Manual of Military Surgery for the Use of Surgeons in the Confederate Army with an Appendix of the Rules and Regulations of the Medical Department of the Confederate Army*, (Charleston: Evans & Cogswell, 1861), 127-128.

[31] Julian John Chisolm, *A Manual of Military Surgery for the Use of Surgeons in the Confederate Army with an Appendix of the Rules and Regulations of the Medical Department of the Confederate Army*, (Charleston: Evans & Cogswell, 1864), 166.

In 1862, while Union soldier Albert Frank was sitting in a trench outside of Richmond, Virginia, he offered the man next to him a drink from his canteen. The canteen was on a strap around Frank's neck. At the moment Frank extended the bottle to his fellow soldier, the soldier was decapitated by a shell. Frank was not hurt by the shell. Albert Frank began to act abnormally later in the day. It was suggested that he take shelter in a bomb shelter. Once inside the shelter, Albert Frank started screaming and then bolted out the door, over the top of the trench and straight toward the enemy. When he was being brought back to the Union lines, he again began to act erratically, dropping his gun and repeating the phrase “Frank is killed.” Due to his behavior, he was restrained and taken to a doctor the following day. At that point, he was formally declared insane and sent to the Government Hospital for the Insane in Washington, D.C. [32]

Large cases of nostalgia were first recognized during the Civil War. For every 1,000 troops, there were three cases of nostalgia diagnosed each year of the war. This was often reported among the teenage draftees in the Union army.[33] During the war, there were 2,600 cases of insanity and 5,200 of nostalgia in the Union Army that required hospitalization.[34] When the war began in 1861 the Union troops recorded 57 cases of nostalgia. [35] Between

[32] Dean, *Shook Over Hell*, 66.
[33] *War Psychiatry*, 7.
[34] *War Psychiatry*, 8.
[35] Joseph K Barnes, Joseph Janvier Woodward, Charles Smart, George A. Otis, and D. L. Huntington, *The Medical and Surgical History of the War of the Rebellion (1861-65)* (Washington: Government Printing Office, 1875), 8.

the months of July and December of that year, the number of nostalgia cases averaged 11.4[36] with the highest month being November with 22 cases.[37] For the same period in 1862, the average number of cases was 120 cases again with November having the highest number with 211 cases.[38] There were also two deaths from nostalgia that year. In 1863, there was an average of 99.2 cases. July had the highest number of cases with 113. There were six deaths from nostalgia in 1863 with four of them being in November.[39] The highest average number of cases were diagnosed in 1864 with107.6. There were ten deaths that year with the most being in September.[40] By the end of the war there were 31 soldiers discharged with the disability of nostalgia.[41]

These numbers did not include African American troops. The rates of nostalgia among African American troops were slightly larger. These troops were not used in the Union army until 1863, so the majority of their medical data is from 1864. In 1864, there were 146 cases and nine deaths related to nostalgia among African American troops.[42]

To prevent cases of nostalgia, the Surgeon General in 1862 recommended that the minimum age for recruits be set at 20. This change did not affect the amount of soldiers diagnosed with nostalgia. It was believed at

[36] Ibid, 32.
[37] Ibid, 148.
[38] Ibid, 298.
[39] Ibid, 454.
[40] Ibid, 606.
[41] Ibid, 646.
[42] Ibid, 711.

the time, and going back to the American Revolution, that the best way to prevent nostalgia was to keep both the mind and body occupied.[43] Popular army surgeon, J.T. Calhoun, felt that nostalgia was caused by recruiting unmotivated soldiers who had unrealistic ideas about war. He felt that this would be offset by a providing a generous furlough system. Under the current system, leave was only granted as reward for re-enlisting or to deal with emergencies at home.[44]

During the Civil War, the rules of war were vastly different from what is practiced today. Occurrences of killing prisoners and rape were not uncommon events on either side. Those who witnessed, and even took part in these events carried the memories for many years. In 1864 at Fort Pillow, Confederate troops killed the Union soldiers who had surrendered to them. In another battle following this event, some Confederate soldiers were taken prisoner. When the Union soldiers noticed that a Confederate soldier had a tattoo celebrating the event at Fort Pillow, they stabbed him with their bayonets. The memories of what one Union soldier did to enemy prisoners haunted him so that he believed that Confederate spies had been sent to kill him. At times, he would take a blanket and his gun into the woods to hide from them.[45]

[43] *War Psychiatry* , 7.
[44] Jones and Wessely, *Shell Shock to PTSD, 5.*
[45] Dean, *Shook Over Hell*, 61-62.

By the end of the war, many of the men lacked shoes and many tied rags around their feet for protection. Once a soldier reached where he was going his hardships did not end. Soldiers were always exposed to the elements. They slept in the cold on the ground and marched in the heat of summer. After the war, pension applications frequently mentioned exposure in the Army as the claim to compensation.[46]

The goal of the army was to keep the soldiers fighting, regardless of the cost. A soldier who claimed to have psychological problems was labeled a coward or thought to be faking. Should the soldier legitimately be insane he would be kept on the sick roll until he could be given a medical discharge. One of the common ways to help a soldier get over his fear of battle was to tie him up during another fight. This action often had an opposite effect than intended.[47]

The soldiers who were declared insane they were sent temporarily to an asylum, and then they were released to relatives. The asylums only kept those who deemed chronically insane. Asylums had advanced by the time of the Civil War. They had supportive regiments that included steady work, rest, and social activities. Soldiers who were placed in these asylums had a 90 percent cure rate. If the asylums were full or the soldiers' relatives could not care for them, they were sent to a local jail to be housed.[48]

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[46] Ibid, 61-62.
[47] Ibid, 61-61.
[48] Dean, *Shook Over Hell*, 122.

The state of prisoner of war camps during the Civil War has been discussed over time. Those soldiers who were kept prisoner tried to occupy their minds by telling stories and re-reading letters and newspaper clippings they had received before being captured. Yet, some did go insane while in the prisons.[49] A third of the prisoners at Andersonville died from disease and starvation. Those soldiers who made it out of the prisons alive had multiple heath problems. Men who returned from these prisons were numb emotionally and were frequently abusive to their families. Those who did not die from health problems shortly after the war were either committed to asylums or committed suicide.[50]

During the 19th century and well into the 20th century, the concept was that cowardice came from a moral weakness. For a soldier to run away from a battle, there had to be some extreme circumstance behind that action. Fear was not a legitimate or reasonable answer. The only reason a man should not be able to be in battle was if he had some physical ailment that prevented him from being in combat.

When a soldier was court-martialed, it was important to determine his mental state. Much like today, it was important that the accused soldier be able to understand the charges that were being brought against him and have the mental ability to provide a defense for himself. If evidence could be given by other soldiers or a doctor that the soldier was somehow mentally impaired

[49] Ibid, 83-85.
[50] Horwitz, "Did Civil War Soldiers Have PTSD?"

at the time his crimes were committed, the charges would be dropped and he would be released from military service. Nonetheless, proper procedures were not always followed by many court-martials due to their quick organization.[51]

Following the Civil War, the federal government provided pensions for the soldiers. When pensions had been established after the Revolution, they were meant to support those who had suffered a physical injury. This was later expanded to help those who had suffered a mental trauma. To get this pension, family and former comrades of the affected veteran had to sign affidavits stating how ill the veteran had become. These affidavits were then presented to a panel of three doctors who then interviewed the veteran and his supporters. After this, the panel would set the per month amount pension a veteran could receive. The highest pension awarded was $72 a month. In 1861, there were about 4,300 veterans who were receiving pensions. By 1902, this number had risen to one million.[52]

The story was different for Confederate veterans. They were not entitled to federal pensions since they had actively fought against the federal government. They, or their widows, could apply for state pensions, but these were only for soldiers who had lost limbs. A veteran could be placed in a Soldier's Home that was operated by the state. To be able to be admitted to

[51] R. Gregory Lande*, Madness, Malingering & Malfeasance: The Transformation of Psychiatry and the Law in the Civil War Era* (Brassey's Inc., Washington D.C., 2003), 157-163.

[52] Dean, *Shook Over Hell*, 143.

these homes, the veteran had to prove that he could not work to support himself, the family could not provide shelter for him, or that he had no family. If he was not able to obtain admission with these factors, he was left to his own devices to find support. [53]

In Britain during this time, the diagnosis of nostalgia was not used very often by the military. Their preferred diagnosis was melancholy. This still was a very unused diagnosis. In 1880, Britain was involved in fighting the Dutch in South Africa known as the Boer War. Since the British did not like to classify soldiers with having nostalgia, the common terminology at this time was "disordered action of the heart" or DAH. Out of the 6,200 pension cases from that war, 37 were diagnosed with melancholia.[54]

Many doctors during the Boer war encountered cases of melancholia, but they attributed the cases to the harshness of army life. The most common treatment was to put the soldiers in hospitals where they would receive showers, new linens, and a better assortment of food than they received in the field. They would be kept here for a couple of days and then sent back out to the field.[55]

During the Boer War, there were about 6,276 soldiers who were diagnosed with psychological disorders. Most of those diagnosed displayed

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[53] Ibid, 232-235.

[54] Edgar Jones, "Post-combat Syndromes from the Boer War to the Gulf War: A Cluster Analysis of Their Nature and Attribution." *Bmj* 324 (November 09, 2002): 321-28.

[55] J.C., De Villiers, *Healers, Helpers and Hospitals*. Vol. II.(Pretoria: Protea Book House, 2008), 182.

depressive and delusional disorders.[56] In 1912, Lt. Colonel A.G Kay made the observation that war increases the rate of insanity and that it was usually in the depressive and delusional type.[57]

Another common theory about nostalgia was the further away from home the soldier was, the more susceptible he was to developing the condition. The further a soldier was from home the harder it was for him to get mail and information about his family. Medical professionals noted that this had a big effect on soldiers who were sick or wounded. This became evident during the Spanish-American War, where soldiers were sent away from the continental United States to Porto Rico and Cuba to fight. During this conflict, nostalgia was also thought to spread among the soldiers by suggestion.[58]

Russian psychiatrists were the first to relate symptoms of nostalgia, DAH, and “soldier’s heart’ to combat during the Russo-Japanese War that occurred from 1904 to 1905. They were able to view the symptoms of soldiers from this war and were able to interview returning soldiers about how they experienced fear.[59] From this survey, it was summarized that “when cannon and, most important, rifle shots can be heard, the anxiety [. . .] and fear of the unknown, the consciousness of a possible close death or injury, becomes

[56] Jones and Wessley, Shell Shock to PTSD, 13.

[57] A. G Kay, "Insanity in the Army during Peace and War and Its Treatment." *Journal of the Royal Army Medical Corps* 18 (1912): 146-58.

[58] Nicholas Senn, *War Correspondence (Hispano-American War) Letters from Dr. Nicholas Senn .* (Chicago: American Medical Association Press, 1899), 123.

[59] Jan Plamper, "Fear: Soldiers and Emotion in Early Twentieth-Century Russian Military Psychology," *Slavic Review* 68, no. 2 (2009): 275.

maddeningly palpable in soldiers who are not being shot at."[60] They believed that there appeared to be a learning curve associated with battle. This fear was only felt during the first battle and in subsequent battles, the soldiers felt calmer. [61]

The belief that fear was the strongest during the first battle that a soldier experienced existed through World War I. Russia was the first nation to put psychiatrists on the front line, and they were one of the first nations to write about fear and war. In this aspect, before the revolution Russia was fairly progressive and modern in their treatment of war neurosis.[62]

The problems of malingering and self-inflicted wounds are issues that come along with war. Nostalgia could often be confused with malingering since it frequently did not display any physical symptoms. Soldiers often would inflict wounds upon themselves as a means of escaping the war. The problem with this was that soldiers did not realize the damage that could be caused by these types of wounds. Also, doctors became wise to the fact that soldiers would injure themselves and not send them home.[63]

Psychology and psychiatry were subsets of neurology during the 19th century. Military psychiatry was non-existent. Doctors in these fields dealt with

[60] Ibid,276.
[61] Ibid,276.
[62] Ibid, 263.
[63] De Villers *Healers, Helpers, and Hospitals,* 187-188.

a wide range of nervous disorders. The overall belief throughout the century was that melancholia and hysteria came from a lack of moral fiber and were part of heredity disorder. Near the end of the century, as many modern inventions were being produced, the medical community began to discuss the nature of nervous disorders.[64]

Nostalgia was a recognized mental illness by the government and the military following the Civil War. Cases of it were most likely under-reported in official reports, but it was still reported as an illness. Fortunately, there were those who saw nostalgia as an illness and campaigned for better treatment. Those like, Dorothea Dix, worked for the advancement in the treatment of all mental illnesses. There were those who believed that nostalgia was caused by a weak moral fiber. This belief would last throughout the end of the 19th century and well into the 20th century.

[64] De Villers, *Healers, Helpers, and Hospitals*, 176-177.

Chapter Two

We're Here Because We're Here

World War I has historically been the starting point from which modern warfare originates. It saw the first use of the tank, the widespread use of the machine gun, the start of chemical warfare, and the efficient use of airpower. While all of these are things that are tangible and were used to great advantage by both the Allied and Central powers, there was something that emerged from this conflict that was intangible; something neither side had dealt with in such large numbers before. After the horrendous battles and new forms of warfare originating from World War I, many soldiers who had been traumatized by what they had experienced, began to exhibit similar symptoms. These soldiers were often diagnosed with maladies that went by names such as "traumatic hysteria," "irritable heart", or "war exhaustion." The most common label that was used for this disorder was "shell shock." This label made it appear that the sufferer had some physical injury caused by exploding "shells" from bombardment.

By using this term to describe the symptoms soldiers were suffering, the term's use implied that what they were suffering from was less of a mental disorder therefore, making it more acceptable to military organizations. Unfortunately, this label hid the real psychological nature of the affliction. Each military involved in the war had its way of dealing with "shell shock."

They entered the war with their beliefs about what caused “shell shock”, and this belief dictated how their medical teams would deal with those who were suffering from this malady. British Private Walter Grover described how the war affected people differently:

> You can understand some chaps, they’re not all built the same and some couldn’t stand it…Then they called it cowardice but it wasn’t that at all it was just the way he was made. I was afraid…But what I didn’t want to see other people to see I was afraid, that was the thing. Everybody was afraid, but you didn’t want your pal to see it.[65]

Throughout World War I, “shell shock” went by several different names. “Shell shock” was the most popular term, but that term did not appear until 1916.[66] Before and after the war names such as "war neurosis" and "hysteria" were used to describe this illness. Those suffering from “shell shock” also fell into a new classification of mental disorders. The treatment of the victims also varied from country to country as did the terminology. While soldiers had experienced “shell shock” before World War I, it was not something that was widely talked about, especially in the military. It was a widespread belief that if a soldier "lost control" or "showed the signs of cowardice,"[67] he would be dealt with according to military procedure.

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[65] Kate Clements,"Podcast 33: Shell Shock,” *Imperial War Museum* (audio blog), accessed December 9, 2015, http://www.iwm.org.uk/history/podcasts/voices-of-the-first-world-war/podcast-33-shell-shock.

[66] Jones and Wessely, *Shell Shock to PTSD,* 14.

[67] Report of the War Office Committee of Enquiry into "Shell-shock." London: His Majesty's Stationery Office, 1922.

While military psychiatry was either in its infancy or simply did not exist prior to World War I, physicians tried to treat servicemen who were suffering from a “range of unexplained, somatic disorders, including disorder action of the heart (DAH) and psychogenic rheumatism.” Some of the cases that they encountered also showed symptoms that could be neurological.[68]

When treating soldiers on the battlefield, physicians had a problem diagnosing “shell shock” because in each patient it could present with a variety of symptoms. These symptoms included such things as speech impediments, vision impairments, walking disorders, convulsive vomiting, and severe cramps. Along with these symptoms, some men also experienced insomnia, violent nightmares, and flashbacks.[69]

After the Battle of the Somme in 1916, the British forces suffered a huge influx of “shell shock” cases. This was due to a large number of British forces that were used in the Battle of the Somme. The British military put measures in place to treat the cases they had already experienced and to attempt to prevent any future cases. They developed something called, "forward psychiatry.” This treatment involved the setting up of special units ten miles from the trenches. Having these units close to the battlefield would allow an immediate response and hopefully a quick recovery.[70]

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[68] Jones and Wessely, Shell Shock to PTSD, 1.
[69] Jones, and Wessely, *Shell Shock to PTSD, 5.*
[70] Jones and Wessely, *Shell Shock to PTSD,* 21.

These special units were set up by Charles Samuel Myers, the physician who had first used the term “shell shock” in a medical article in December 1916. These specialized units were called, "NYDN" units or "not yet diagnosed nervous”.[71] By June 1917, these NYDN units had been established in each army area.[72] These stations were designed to give soldiers who had just been taken from the front a short rest. During this rest, the soldiers would gradually be put on an exercise program that built their strength back up. The majority of physicians at this time believed that “shell shock” could be cured with “rest, good food and encouragement.”[73] This had been the traditional treatment for a nervous breakdown.

Going hand-in-hand with this thinking, the War Office Committee dealing with this problem made it clear in a report on “shell shock” in 1922 that "soldiers should not be allowed to think that loss of nervous or mental control provides an honorable avenue of escape from the battlefield."[74] Physicians in these areas were urged to keep cases from leaving the battalion or division and limit treatment to rest and comfort. All efforts were to be made to urge these soldiers to return to combat.[75] When soldiers were sent to the special NYDN units, the War Office Committee did not want them to be labeled as having a nervous breakdown because they believed that this thought might

[71] Jones and Wessely, *Shell Shock to PTSD*, 26.
[72] *Report of the War Office Committee of Enquiry into "Shell-shock*.", 119.
[73] Jones and Wessely*, Shell Shock to PTSD,* 27.
[74] *Report of the War Office Committee of Enquiry into "Shell-shock,"*,191.
[75] *Report of the War Office Committee of Enquiry into "Shell-shock,",* 191.

become lodged in their minds and they would not work toward getting better. Should these patients need to be moved to a base hospital, they were to be kept either in a separate hospital or a special unit. Only if these men were truly unfit for service were they to be sent back to the United Kingdom.[76]

A key feature of the World War I battlefield was trench warfare. Military units would be stuck in man-made trenches in the same location for weeks at a time. Living in cramped quarters, under constant and intense enemy attack and bombardment, these soldiers would then be ordered to charge over the tops of their trenches into a wall of machine gun and other weapons fire. It is small wonder that these soldiers began to live in a constant state of anticipatory fear, not knowing from day to day how much longer they were going to be alive.[77] In previous wars, the open battlefield had given the soldier the freedom of retreat and escape. Being in the trenches did not allow for a full retreat. It could leave a soldier feeling trapped.

Physicians knew that these stressful conditions of war could cause a soldier to develop “shell shock.” The prolonged exposure could cause even those of a sound mental state to break down. In a report by the War Office Committee, there were some things that were found to be contributory factors to a soldier developing “shell shock.”

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[76] Report of the War Office Committee of Enquiry into "Shell-shock." ,191-192.

[77] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century (* Cambridge, Mass. Harvard University Press, 2001), 200.

One of the first factors was responsibility. If a man had been elevated to a rank that was beyond his capacity to deal with the problems he was expected to face, or if a soldier was responsible for too much for too long a period, then he was more susceptible to being affected. Married men were also more susceptible because they worried too much about what was going on at home. The second factor was inaction under fire, meaning, in this case, being trapped in the trenches and unable to go forward or retreat and being fired upon continuously. Being stuck like this would cause some men to break down.

The third factor was physical exhaustion. It was not physical exhaustion alone that made a soldier break down, but when it was combined with nervous exhaustion, it could lead to mild cases of “shell shock.” The fourth factor was the enemy's use of poisonous gas. The fear of attack and the actual harm that might result were contributing factors.

Factor number five was alcohol. It was not considered a major factor, but it did appear in some cases. [78] These factors were some of the different reasons that the government committee found could be contributing factors to a soldier being affected by “shell shock.” The committee also noted that the

[78] Report of the War Office Committee of Enquiry into "Shell-shock”, 100.

term “shell shock” should not be used in official publications beyond that point.[79]

There were many problems physicians encountered when trying to treat cases of “shell shock.” When World War I began, there was a flood of civilian physicians recruited and conscripted into the medical corps. These civilian doctors had to adapt quickly to the way that the military medical services were run, which, in most cases, was vastly different than in the civilian world. For most cases, the prescribed treatment was good food and rest. In his book *Shell Shock and Its Lessons,* Sir Grafton Elliot Smith suggested that patients should also be removed from seeing any other wounded soldiers because it could cause "vivid memories."[80] For mild cases of “shell shock”, a period of rest did help the patient improve, sometimes even appearing to cure the patient. These men would then be sent back out to the front to fight again. The data varies on whether or not there were relapse cases.

There were diverse treatments for this disorder if rest did not work. The most common therapy employed was electroshock to what were thought to be the affected areas of the brain. Soldiers were also sent to convalescent homes in the English countryside. In these homes, they were engaged in various

[79] Ibid,190.
[80] Elliot Smith Grafton and Tom Hatherley Pear, *Shell Shock and Its Lessons* (Manchester: University Press; London Green &Longmans,1917). 27.

things like painting and light exercise. After the war, private hospitals and hostels opened up to specifically take care of men suffering from shell-shock.[81]

At the beginning of the twentieth century, the popular perception of the shell-shocked soldier from World War I was that of a wide-eyed male on the verge of insanity. Movies and literature show these men residing in insane asylums and being regarded as lunatics. The truth is that there were movements by political leaders and medical professionals to prevent soldiers suffering from “shell shock” from being classified as lunatics.[82]

Psychiatrists who volunteered for the Royal Army Medical Corps were sometimes more qualified than the men they had to serve under. Even so, they were still able to make big advancements in the diagnoses and treatment of psychological problems. While they were able to make advancements in treatment, the doctors still faced one common problem. This was the problem of removing the soldiers from active service who would break down in the trenches without severely depleting the fighting force.[83]

The United States did not enter World War I until April 1917 and troops did not arrive in Europe in large numbers until 1918. Due to its late entry into

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[81] Caroline Alexander, "History, Travel, Arts, Science, People, Places | Smithsonian." *History, Travel, Arts, Science, People, Places | Smithsonian*, 2010. Web. 29 Apr. 2015.
[82] *Report of the War Office Committee of Enquiry into "Shell-shock",*100.
[83] Jones and Wessley, *Shell Shock to PTSD,* 47.

the war, the United States was able to prepare its medical services somewhat beforehand for what they would encounter. A key player in preparing the United States was Dr. Thomas William Salmon.

In early 1917, Dr. Salmon traveled to England to study soldiers who were suffering from "shell shock." When he returned, he published a report titled *The Care and Treatment of Mental Disorders and War Neuroses "Shell Shock" in the British Army.* In this report, he sets out the basis for how the United States should model its psychiatric hospitals when it entered the war.[84] Dr. Salmon broke his suggestions for treatment into two different categories: overseas treatment and treatment for soldiers sent back to the United States. For overseas treatment, he first recommended that a special base hospital for neuro-psychiatric cases be set up at each base. This hospital would have 500 beds and would specifically hold those who were thought to be able to return to active duty in a six-month time frame. In addition, there would be special neuro-psychiatric wards in the regular base hospitals that had 30 beds. These wards would be run by three psychiatrists. The primary use of these wards would be the observation of patients and emergency neurological cases. He also recommended that psychiatrists attached to the neuro-psychiatric wards could be sent to evacuation hospitals and aid stations.[85]

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[84] Thomas W. Salmon, MD., *The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in The British Army* (New York City: War Work Committee, 1917). 30.

[85] Salmon, *Care and Treatment of Mental Diseases and War Neuroses*, 48.

For soldiers sent to the United States for treatment, Dr. Salmon began his treatment process by first breaking down neuropsychiatric cases into two categories. The first category was those suffering from mental diseases or "insane." He suggested that there be one or more Clearing Hospitals set up to receive and sort enlisted men. Another Clearing Ward that was connected to an officer hospital or private institution should be set up to take care of officers.[86] Dr. Salmon also proposed that there be legislation passed to allow the Surgeon General to make contracts with non-military run hospitals that could maintain satisfactory standards to treat soldiers until they could be recommended for retirement or discharge. These hospitals would be supervised by a special board of medical officers. These offices would be in charge of discharging and retiring soldiers who were not likely to recover.[87]

Dr. Salmon's second classification was soldiers diagnosed as suffering from War Neurosis. He proposed special treatment and re-education centers for soldiers. These soldiers would be sent to special convalescent wards where they would be away from normal hospital life. These wards and centers would be supervised by the special medical board that oversaw the hospitals for the insane. They would also determine if a soldier was able to be retired or discharged.[88]

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[86] Ibid, 49.
[87] Salmon, Care and Treatment of Mental Diseases and War Neuroses, 49.
[88] Ibid, 49.

Prior to World War I, there were no more than 200 hundred beds allotted for those deemed “insane” by the United States Army Medical Corps. As long as the soldiers were not going to harm anyone, they could stay in a local hospital until a bed in a military hospital opened up. But more often than not, they were kept in prison wards. If the soldier was considered dangerous, sometimes they were even kept in portable steel cages.[89]

When dealing with soldiers coming in from the front lines, nurses and doctors were told what the symptoms of shell-shock were, and nurses were warned that some were terrifying to witness. The nurses were told what medicines might be administered, and that these soldiers were going to be removed from the front line as soon it could be arraigned. They were also told that there were new hospitals and homes for soldiers who were suffering from this condition to be sent.[90] It was in the military hospitals away from the front where the nurses dealt with “shell shock” the most.

Nurses and other women involved in the war effort were not immune to “shell shock.” During the war “shell shock” was purely seen as a male condition. This was due to the wide belief that to suffer from the condition one must be in proximity to an exploding shell or involved in combat. Women were not considered combatants, even though, primarily those serving from the

[89] Charles Lynch, *The Medical Department of the United States Army in the World War* (Washington: United States Government Printing. Office, 1921), 39.

[90] Violetta Thurstan, *A Text Book of War Nursing* (London and New York: G. P. Putnam's Sons, 1917), 138-139.

British Empire, served as nurses in front line hospitals and worked as ambulance drivers. Many of the women's symptoms were recorded as exhaustion due to overwork. Like many of the men during World War I, women who served were not affected by "shell shock" during the war, but it affected them once they were away from combat.

For example, the case of Nurse Isma Brown is one of the many cases that came before the pension board. Nurse Brown served as a trained nurse for almost four years in England and then on a hospital ship in Egypt and Mesopotamia. She was diagnosed with "Exhaustion Psychosis" in 1918. Her doctor stated that her "nervous breakdown" was due to her "military service" in Gallipoli, Mesopotamia, France, and India. Although, in her records her condition is attributed more to the heat and her age, and not to being near combat. Following the war, she spent some time in an asylum but did appear to recover to an extent. But like many of her male counterparts, when she applied for a pension she was denied based on the fact her illness was not caused by her war service.[91]

The United States military realized that once it entered the war, it would have to expand the care for the "insane." The Army also realized that

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[91] War Office: Directorate of Army Medical Services and Territorial Force: Nursing Service Records, First World War. WO 399/1008, Isma Brown, Queen Alexandra's Imperial Military Nursing Service. Armed Forces Service Records 1914-1920; The National Archives, Kew England.

the regular methods used in military hospitals, especially those that dealt with the "insane," needed to be changed.[92] Like the British, the United States Army established neuropsychiatric wards at all camp, division, and base hospitals. However, unlike the British, the United States military assigned a psychiatrist at the division level. The Army did not use electroshock therapy except on the most severe cases.[93] These units were at first called isolation-insane units and later the designation was switched to Psychiatric wards. The Army says that the name was switched because the term "isolation-insane" gave the connotation of "misunderstanding and professional discouragement and indifference,"[94] while "psychiatric ward" gave off the connotation of "understanding and professional hope and activity."[95] The purpose of these wards was the temporary care of the "insane" and that the "insane" would be discharged from the army as soon as possible.

Also, like the British, the United States tried to find a reason as to what caused the mental breakdown of the soldiers. The United States, like the British, took detailed histories of their patients. The United States Army compiled a number of statistics on education, marital status, alcohol use, and how these things played into the neuropsychology of the soldiers.[96] There

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[92] Charles Lynch, *The Medical Department of the United States Army in the World War*, 39.

[93] Jones and Wessely, *Shell Shock to PTSD,* 40.

[94] Charles Lynch, *The Medical Department of the United States Army in the World War*, 40.

[95] Ibid,40.

[96] Ibid, 220.

were efforts made to eliminate soldiers who had volunteered for service who might be unfit for duty before they reached Europe.[97] In the study produced by the Army that discussed procedure and statistics for neuropsychiatric cases during World War I, the Army went into extreme detail on how each soldier was to be screened before entering service for neurological problems and how they were to be screened during combat.[98] The procedure of screening soldiers before they entered the Army was suggested by Dr. Salmon in his report. Dr. Salmon also suggested in his report that recruits be screened to eliminate those who were “insane, feeble-minded, psychopathic, and neuropathic individuals.”[99]About 2 percent of all inductees were screened out of the Army using these criteria.

Many of the advancements made by the United States Army Medical Corps before the United States entry into the war were enabled by doctors being sent to Canada and England to observe how those countries were dealing with the war. The method of excluding those who were mentally unstable before they got to the battlefield was something that had been stressed again and again by psychiatrists in England.[100]

Following the war, the Army made provisions for the care of the "insane." The decision to discharge the soldier was made by the War

[97] Ibid, 44.
[98] Ibid,10-20.
[99] Ibid,47.
[100] Charles Lynch, *The Medical Department of the United States Army in the World War*, 7.

Department on a case by case basis. The majority of cases had first to go to St. Elizabeth's Hospital in Washington, D.C. before they could be discharged.[101] Even individual states set up a contact person who would be in charge of the “insane.”[102] After the Civil War, individual states set up veteran's homes to take care of disabled soldiers. By 1917, there were three different agencies that dealt with veterans affairs and in 1921, they were combined to make the current Veterans Affairs administration. Under this new administration, new hospitals for soldiers with mental issues were built.[103] The only problem with treatment was that the soldier’s psychological problem had to be service connected to get treatment. Most of the time, this meant the mental issue had to originate while the soldier was enlisted.[104]

When World War I began, the field of psychiatry was a newly developing field of medicine. Most doctors had realized before World War I that the strain of battle could cause soldiers to breakdown. Problems arose when trying to treat soldiers with mental neurosis. One of the first problems was trying to figure out if the soldier was suffering the effects of trauma or was the soldier just faking the injuries so he did not have to continue fighting. In the United States, there was some effort to eliminate soldiers who might be susceptible to mental problems before they reached the battlefield. The goal

[101] Ibid,67.
[102] Ibid, 200.
[103] U.S. Department of Veterans Affairs, "About VA,” History, accessed April 29, 2015, http://www.va.gov/about_va/vahistory.asp.
[104] Charles Lynch, *The Medical Department of the United States Army in the World War*, 30.

of every military, whether it be Allied or Central Powers, was to rehabilitate wounded soldiers and get them back to the front line as soon as possible, but “shell shock” was not like a bullet wound. For the militaries, excluding the United States, men were needed at the front. If these soldiers could be quickly healed and sent back to the front to fight, there would be no long-term loss to their forces; but if the soldier had to be sent home or to a hospital to receive care, then he would have to be replaced. At this point in time, saying that it was a "mental" problem would have suggested insanity or even a moral weakness.[105] In the United Kingdom and the United States, there was an effort to try and find a root of what caused these soldiers to be affected.

War is a traumatic event, and every soldier who participates in it will be affected. Some soldiers are affected more than others. No one can predict how a soldier will react during a war. Even with all the screening that the United States did of its recruits there were still high numbers of cases of shell-shock. Due to the large numbers of soldiers that fought in World War I, “shell shock” became a much more public issue during and after the war than it had in previous wars. Non-medical officers had very little to no training on how to deal with shell-shock. In the heat of battle, it was hard to distinguish whether a soldier was suffering from mental collapse or if he was just unwilling to fight.

[105] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century,* 200.

It is a sad fact that many men who were charged with cowardice were, in fact, suffering from “shell shock.” Arthur Guy Empey recalled that once at 2:00 am he was woken up by a sergeant major and taken to a barn with other soldiers. They were told that they had been selected for the firing squad for the execution of a soldier. He and the other eleven men were never told what grievous offence the man had committed. [106] In 2006, the British Government began to apologize to the descendents of the men who had been accused of cowardice.

Since the United States did not join the war until 1917, they were able to observe what the United Kingdom and France were doing wrong and make improvements to its system. Efforts were made in the United Kingdom and the United States to help soldiers diagnosed with “shell shock” after the war. Sadly, this only applied to soldiers who had been diagnosed while in the service. Many soldiers in other countries were denied pensions if they had been diagnosed with war neurosis. If they developed the disease after they had been discharged, there was little to be done beyond being sent to an asylum for treatment.

Many military psychiatrists did not go into combat. Some of them felt very guilty about this lack of experience, and this resulted in their writing about

[106] Richard Rubin, *The Last of the Doughboys: The Forgotten Generation and Their Forgotten World War* (Boston : Houghton Mifflin Harcourt, 2013), 39.

what they had learned from the war. Many civilian psychiatrists did not incorporate these writings into their practices and treatments. This led to the issue being overlooked, ignored, and misdiagnosed. The burden of caring for these men fell on their families, friends, and other caring individuals.[107]

Soldier Thomas Olive explained how his experiences effected his civilian life after the war:

> I used to have little breakdowns now and then, and my wife used to be very frightened. It more or less used to happen at night, when I was in bed. I used to spring up off the bed, you know; it used to frighten her…Well I had shell shock, you see. I got blown up, you see, and it affected my whole system. I got a pension for about oh, what was it, about 9 shillings a week.[108]

While World War I ended on November 11, 1918, for those suffering from "shell shock" the war never ended. Poet Wilfred Owen, one of Britain's famous war poets, was diagnosed with "shell shock" in 1917 and sent to Craiglockheart War Hospital in Scotland. He was able to rejoin his unit in June of 1918 but was killed in action on November 4, 1918. While he has been recognized for his poem *Dulce et Decorum Est.* Shortly before he died, and while he was still recuperating in Scotland he sent his mother a poem entitled *The Deranged.* It would later be titled *Mental Cases.* The second stanza sums up "shell shock."

These are men whose minds the Dead have ravished.

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[107] Jones and Wessely, *Shell Shock to PTSD,* 40.
[108] Clements, *Podcast 33: Shell Shock*.

Memory fingers in their hair of murders,
Multitudinous murders they once witnessed.
Wading sloughs of flesh these helpless wander,
Treading blood from lungs that had loved laughter.
Always they must see these things and hear them,
Batter of guns and shatter of flying muscles,
Carnage incomparable and human squander
Rucked too thick for these men's extrication[109]

World War I brought a number of advancements to the battlefield. There were huge advancements to firepower and air warfare, but it was still fought as a conventional war. What became the main characteristic of World War I warfare were the trenches. While trenches had been a part of warfare for centuries, World War I was the first time that it had been used in combination with such heavy artillery. This bogged down troops in a confined space for a long period of time. Conditions in the trenches were far from ideal and contributed to many health conditions suffered by the soldiers.

As with previous wars, the saying at the beginning of World War I was, “It will be over by Christmas.” At first, this is an encouraging statement, but when the war does not end, it can be demoralizing. Being stuck in the trenches, under heavy bombardment, believing that the war should have ended months ago weighed heavily on soldiers. There is no way to tell what will cause a man to break. Seeing one's friends and comrades blown to pieces and feeling like death was imminent, certainly could cause a soldier to break.

[109] Wilfred Owen, C. Day Lewis, and Edmund Blunden, *The Collected Poems of Wilfred Owen* (New York: New Directions Publishing,1965), 69-70.

It is now known that “war neurosis” symptoms can occur months and years after the war has ended. Psychologists and psychiatrists following World War I had a hard time explaining why former soldiers would have symptoms after being away from the war. This created problems for them well into World War II, the Korean War, and the Vietnam War.

The United States attempted to build a number of new psychiatric hospitals just for veterans following World War I but due to the poor leadership of the Veterans Administration at the time, these hospitals were underfunded and ill-equipped. In 1921, a number of veterans services were consolidated into the Veteran’s Bureau. This agency was rife with corruption it was reorganized in 1923.[110]

“Shell shock” has been portrayed many ways over the past century. It was something that, before World War I, had not been dealt with in such large numbers and certainly not treated very often by civilian psychiatrists and doctors. Those who suffered from “shell shock” either were unable to talk about it or did not talk about it until later in life. While some believed that “shell shock” did not exist, many did believe in its existence.

There were many lessons learned during World War I about treating “shell shock.” These lessons laid the foundation for treating “combat fatigue”

[110] United States Department of Veterans Affairs, “Veterans Administration,” Veterans Administration, accessed October 10, 2015, http://www.va.gov/opa/fact/

during World War II, but what remained unchanged was the stigma associated with the disorder.

Chapter Three

Praise the Lord and Pass the Ammunition

A little more than twenty years after World War I, Europe was sent back into turmoil. In 1941, the United States was pulled into the conflict. World War I had not only brought about great technological changes, but it had also brought about many changes in medical treatment. World War I was also the first time that officially British and American militaries determined that war could cause mental trauma.

By the time World War II started, death and mourning had become a private matter. The average lifespan had increased to 68 years. This was due to advancements in healthcare and living conditions. The discovery of antibiotics and penicillin were tremendous in curing diseases that had previously been fatal. The majority of soldiers came from urban areas. Executions were no longer public forms of entertainment and by the Korean War, efforts were being made to end them.

The major difference between World War I and World War II is that in World War II there are two different arenas of battle. Battles in the European arena were fought with a distinct conventional war tactics. Battles fought in the Asian arena were vastly different in tactics and methods of warfare than those in Europe. The United States had only been involved in Asian warfare during the Philippine Insurrection of 1901.

As with many other major conflicts, the military had downsized after World War I, which required the United States to recruit and train soldiers quickly. Age was a factor in the long-term psychological effects of combat. Soldiers went from being high school students one day, looking forward to the big game that Friday, to instruments of war the next

A U.S infantryman was less likely to die in battle in the Pacific than in Europe in World War II. But a wounded soldier in the Pacific was more likely to die of his wounds than a soldier in Europe. Soldiers in the Pacific were also more likely to die from small arms fire while those in Europe were more likely to die by artillery fire. [111]

Gordon Larsen quit high school at 17, joined the Marines, and was sent to the South Pacific. This is where he saw his older brother shot by enemy fire. Gordon had to wait for nightfall so he and others could try to give aid to his brother. By then enemy snipers had his brother in their sights. There was too much damage done, and his brother died two weeks later.[112] For many soldiers, the only way for them to deal with what they had experienced during combat was to move on and try to forget.

During World War II, the terminology changed from “shell shock” and “war neurosis” to “combat exhaustion” or “combat fatigue.” These conditions

[111] Stephenson, The *Last Full Measure,* 261.

[112] Tom Brokaw, *The Greatest Generation* (New York, Random House 1998), 69-72.

were defined as forces from the stress of war that affected a normal person, so they became ineffective as a soldier. Psychiatrists and doctors looked more into the background of the soldier and how that was affected by the soldier's current environment. During the war, it was found that combat fatigue happened during two specific periods. The first period occurred during the first two weeks when new troops were sent to the combat zone were more likely to suffer from combat fatigue. These soldiers had not had the time to be fully accepted into their units.

The second time that "battle fatigue" was most likely to occur was when a soldier had been exposed to long periods of constant combat. The first sign was irritability combined with decreased efficiency and carelessness to his personal safety.[113] The longer a soldier was involved in combat, the less likely he was to be affected by combat fatigue. If he did develop combat fatigue, the less likely he could be restored to health and returned to combat.

Soldiers who had been wounded in combat and were able to return were more likely to suffer from combat fatigue. Those soldiers who had been in the first part of the D-Day landings were more susceptible to suffering from combat fatigue. This was due to the soldiers continued fighting with little or no results.

[113] "Combat Exhaustion" *U.S. Army forces in the European Theater*, General Board. Study Number. 91.

As the Allied Forces began to make their way through France and to the German border, morale within the forces began to drop. Forces also began to encounter intense fighting and winter weather began to occur. The medical units realized that the combination of these two things would cause the cases of combat fatigue to rise. It was hard for medical professionals to determine if a soldier was suffering from a mild case of combat exhaustion or if they were malingering. It was common belief that soldiers would use the excuse of combat fatigue to get away from the front.

There was only one soldier executed for desertion during World War II. While there were some soldiers charged with desertion, they were usually just put in prison until the end of the war. Private Edward Slovik was the only soldier who was executed for desertion.[114]

It began to be stressed by commanders that the prevention of combat fatigue was the function of command. Division commanders established training centers in the rear areas of the front. In these centers replacements were properly trained for the tasks they would be required to perform, and they formed more unit cohesion. Since the front covered by the United States was so wide, there was no plan for rotating the soldiers who were experiencing the most fighting.

[114] History.com Staff, "The Execution of Eddie Slovik Is Authorized," History.com, accessed January 31, 2016, http://www.history.com/this-day-in-history/the-execution-of-eddie-slovik-is-authorized.

It was realized by the medical department that combat exhaustion could be prevented. They realized that it was easier to work at preventing it than it was to treat combat fatigue after a soldier was diagnosed. There were several principles that were stressed to help prevent combat exhaustion. Good leadership was the first principle that was stressed. It was shown that having good leadership was the best method for preventing combat fatigue.

The second principle was unit spirit. If soldiers felt like they belonged to a unit, then they felt like they mattered. The third principle that was stressed was allowing short Rest and Relaxation breaks away from intense fighting. This allowed for mental and physical rest but gave the sense that those in command cared for their well being.[115]

The fourth principle was to allow a rotation of units involved in constant combat every 90 to 120 days. The fifth principle that was stressed was more screening. It was stressed that more effort was needed to sort out those who might be physically and emotionally unable to withstand combat.[116]

The treatment for soldiers showing symptoms of combat exhaustion was much like that in previous wars. The best treatment was thought to be done at the front, and those who could not be cured quickly were sent to the rear for more treatment. Those soldiers who were deemed cured were sent

[115] "Method of Handling Neuropsychiatric Casualties in Theaters of Operation (Proposed 1949)." In *The BULLETIN of the U. S. Army Medical Department Combat Psychiatry*, edited by Wayne G. Brandstadt, (Washington, D.C.: Government Printing Office, 1949). 206.

[116] Ibid,206.

back out into the combat zone. The first course of treatment at the front was usually a drink of whiskey, a warm drink and food, and a mild sedative. This was followed by a few hours of sleep near the aid station. The battalion surgeon would be the one who determined if the soldier was suffering from combat fatigue or if they were malingering.

If the strong drink and few hours of sleep away from the front did not work, the soldier would be evacuated to the Regimental Aid Station and division aid station. As with World War I, soldiers who were suffering from combat exhaustion were segregated from the regular hospital.[117]

In 1949, an operational plan for the treatment of combat psychiatric casualties was proposed by the Army medical department. Treatment should be begun as near the front as possible. Those who had received the forward psychiatric treatment invented by Dr. Salmon in World War I had the best chance of recovery. The plan called for screening, treatment and evacuation of psychiatric cases should be centralized. The next part of the plan called for neuropsychiatric cases not to be kept in a hospital atmosphere. It was felt that while neuropsychiatric disorders were a real sickness, it did more harm to keep a person in a hospital atmosphere. The plan then set out how neuropsychiatric cases would be evacuated and returned. It then laid out how the units for the neuropsychiatric patients would be function.[118]

[117] Ibid, 206.
[118] Ibid, 206.

There were three different levels set up to deal with the neuropsychiatric cases. The first level was the Division level, and it was broken down into four different sections. The battalion aid station would be the first place to receive the patients. Here they would receive 24 hours rest and be evaluated by a battalion surgeon. They would either be returned to battle or evacuated to the Regimental collecting stations. They would not receive treatment here unless they needed to be sedated. They would only be evaluated here if they had not been evaluated previously. [119]

Next they would be sent to clearing stations and would be sorted into two groups. These two groups were those who needed longer treatment and those who could be returned to duty shortly. If it was determined that the patient could be returned to the front within a few days but needed more combat training before going back, he would then be sent to the division replacement company.[120]

At the Army level, the plan would set out different levels of hospitals to deal with neuropsychiatric cases. The first would be a neuropsychiatric treatment center. Here they would be evaluated but not kept longer than eight days.[121] Patients would not be sent to an evacuation hospital unless they needed medical or surgical care outside of their psychiatric treatment. Patients would only be sent to a Convalescent hospital if they could be recuperated for

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[119] Ibid, 206.
[120] Ibid, 207.
[121] Ibid, 208.

combat or noncombatant duty. These were patients who would need longer care than provided at treatment centers.[122] The plan then went on to detail how neuropsychiatric cases would be dealt with outside of the Army level.

Military leaders wanted to reduce the number of psychiatric casualties from the number that had occurred during World War I.[123] The military believed that screening soldiers when they enlisted would be the best way to solve the problem of psychiatric casualties.[124] Screening at enlistment was seen as a two-part way to success. First, the screening would be a way of eliminating unfit soldiers for combat. This, in turn, would limit the costs of caring for large numbers of psychiatric casualties after the war.[125]

At first, the screening system worked wonderfully. Those trying to enlist were rejected due to prior anxiety disorders, educational failings, and neurotic personalities.[126] With all of the screening about 1.6 million men were rejected from military service due to some kind of psychological problem.[127]

The effectiveness of the screening system was questioned after the first combat experiences of the war. During the Battle of Guadalcanal that lasted from August to November of 1942, marines had to deal with poor living and

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[122] Ibid, 208.
[123] Shephard,*War of Nerves,* 54.
[124] D.H Marlow, “Delayed and Immediate Onset of Post Traumatic Stress Disorder.” Social Psychiatry and Psychiatric Epidemiology (1991): 1-7.
[125] Harry S. Sullivan, "Psychiatry and the National Defense," in Harry S. Sullivan, *The Fusion of Psychiatry and Social Science* (New York: Norton, 1964): 2.
[126] A.J. Glass and R.J. Bernucci, eds., *The History of Neuropsychiatry in World War II, Vol. 1, Zone of Interior* (Washington, DC: Government Printing Office, 1966): 735-760.
[127] Glass, *History of Neuropsychiatry in World War II,* 735-737.

nutritional conditions and unrelenting attacks from the enemy.[128] In previous wars, these things had been proven to cause high cases of war neurosis. Again, hospitals were flooded with psychiatric cases.

On the European front, the story was very similar. The problem of psychiatric cases concerned General Omar Bradley so that he asked for assistance from civilian experts. Dr. Frederick Hanson and Dr. Louis Tureen were two who volunteered. When they arrived they pushed to again implement the forward based treatment facilities that had been started during World War I. Using some of the same methods that had been used during World War I, Dr. Hanson and Dr. Tureen were able to return 30 percent of the soldiers to their units within thirty hours and 70 percent in 72 hours.[129]

When General George S. Patton slapped a soldier suffering from "war neurosis" in 1943, the issue of combat exhaustion was brought to the public's attention. After this event, Senator Bridges from New Hampshire suggested that General Patton might be suffering from combat fatigue. Senator Bridges is quoted as saying:

> That a general himself, long and frequently exhausted due to the rigors of actual battle as he personally leads his troops into combat, might be a victim of battle fatigue without realizing it. After all the condition is a human affliction and is not visited

[128] Shephard, *War of Nerves,* 223.

[129] C.S. Drayer and A.J. Glass, "Introduction," in A.J. Glass, ed., Medical Department, United States Army, *Neuropsychiatry in World War II*, Vol. 2, Overseas Theaters (Washington DC: Office of the Surgeon General, 1973), ii.

> according to rank; a general as well as a private can be its victim. [130]

Following this, the War Department authorized a psychiatrist to be in every division at the organizational level. By 1943, it was suggested that the term be changed from "war neurosis" to "combat exhaustion." This was done with the hopes that the name "combat exhaustion" would refer to a more natural, short-term condition.

One out of three of American soldiers in Europe were diagnosed with “combat exhaustion” during World War II. About 400,000 soldiers were invalided back to the United States for psychological problems.[131]

When soldiers returned home, they were greeted with a hero's welcome and a variety of new benefits that had not existed in previous wars. The GI Bill provided former service members with education, training, employment, and housing. With all of this support, it was a surprise when the “combat fatigue” did not disappear.

Soldiers’ relationships with each other and their units allowed for them to be able to cope with the exhaustion that came from fighting. This helped prevent breakdowns and, in the long, term more serious psychological damage. Soldiers’ relationships with their commanding officers showed the same results. In units where soldiers had good relationships with their leader,

[130] "Congress May Order Probe of Patton Attack." The Times (New York), November 24, 1943.

[131] Glass, History of Neuropsychiatry in World War II, 735-737

the rates of “combat exhaustion” were fairly low.[132] “Everyone in the Army is part of a team, and all members have an inherent responsibly to that team.”[133]

When leaders addressed mental health as being on par with physical health and when soldiers embraced learning about combat stress, the rates of combat fatigue in the unit were significantly lower.[134] While this worked for some units, not every unit was successful in preventing combat exhaustion in their soldiers. In the Pacific Theater, the 169th Infantry Regiment was known for its low morale and poor leadership. When the unit was first involved in a battle, it lost 10 percent of its personnel to combat exhaustion. By late 1942, the unit had lost 50 percent of its men to combat exhaustion. The majority of this was due to problems in the leadership of the unit and the lack of soldier discipline.[135]

The screening systems, while appearing to be an efficient and logical solution, gave the idea that combat exhaustion was only going to affect a preset group of people. By the end of the war, and the terminology change, it was shown that every soldier could be vulnerable to combat exhaustion. The

[132] Herbert Spiegel, "Preventive Psychiatry with Combat Troops," American Journal of Psychiatry 101 (November 1944): 311-312.

[133] *FM 6-22: Army Leadership*. (Washington, D.C.: Headquarters, Deptartment of the Army, 1999),viii.

[134] Marlow, “Delayed and Immediate Onset of Post Traumatic Stress Disorder.” 5.

[135] Jules V. Coleman, “Division Psychiatry in the Southwest Pacific Area,” in W. Mullins and A.J.Glass, eds., *The History of Neuropsychiatry in World War II*, Volume II (Washington, DC: Government Printing Office, 1973): 637.

number of cases covered a wide spectrum of soldiers of every race and rank.[136]

While the Army tried to remove soldiers who could be prone to “combat exhaustion,” they were unable to eliminate it from their ranks. There were 68,000 World War I veterans in veterans’ hospitals in 1943 and 80,000 World War II veterans with “combat exhaustion” were added to this number.

In 1952, the first edition of the Diagnostic and Statistical Manual of Mental Disorders was published. The diagnosis of “gross stress reaction” was brought to the psychiatric world. The disorder at this time was: “under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear.”[137]

Throughout World War, I and in World War II, the preferred method of treatment for soldiers suffering from “shell shock” and “combat exhaustion” was the forward psychiatry method developed by Dr. Thomas Salmon. While Dr. Salmon's treatment worked on the more acute cases of combat exhaustion, it did not help those who had been engaged in prolonged, persistent combat.[138]

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[136] Roy L. Swank and Walter E. Marchland, "Combat Neuroses," Archives of Neurology and Psychiatry 55 (March 1946): 212.

[137] American Psychiatric Association, *DSM-I: Diagnostic and Statistical Manual Mental Disorders* (Washington, DC: American Psychiatric Association, 1952), 40.

[138] Hans Pols, “War Neurosis, Adjustment Problems in Veterans, and an Ill Nation: The Disciplinary Project of American Psychiatry during and after World War II,” Osiris 22, no. 1 (January 1, 2007): 77-78.

Those soldiers who returned home with “combat exhaustion” and received treatment from medical professionals were subject to a wide array of treatments. The most common treatment was electroshock therapy. The next was a water therapy where jets sprayed alternating hot and cold water on the patient. Patients were also subject to insulin-induced comas and lobotomies.[139]

Insulin coma therapy was where patients were given a shot of insulin at a certain hour every morning then left to sleep for an hour or two. They were then woken up, fed, and dressed. Following this, they would be given some activity to do. This ranged from playing ball to doing things to help the war effort. They would do this treatment for about a month and most of the time it rehabilitated them enough to rejoin their units.[140]

About 2,000 service members from World War II received lobotomies between 1947 and 1953. One of these service members was Roman Tritz. Roman was a pilot with the 782nd Squadron and the 452nd Bombardment group. When he returned home from the war he had many of the symptoms of "combat exhaustion" and by 1949 it had gotten to the point where his parents had him committed to a mental institution. In 1952, after going through electroshock, water, and insulin induced coma therapy, the hospital performed

[139] Wall Street Journal, “The Lobotomy Files: Forgotten Documents Reveal Government Lobotomy of U.S. Troops,” WSJ.com, accessed December 30, 2015, http://projects.wsj.com/lobotomyfiles/?ch=one&mg=inert-wsj.

[140] "Veterans Stories: Margaret Guildford (nee Bartlett)," Interview, The Memory Project, accessed December 30, 2015, http://www.thememoryproject.com/stories/1912:margaret-guildford-bartlett/.

a lobotomy on Roman. Following the lobotomy, Roman had a hard time finding work and developed new psychoses that were worse than the ones that came with the "combat exhaustion." Over the years, Roman has had problems distinguishing between reality and fiction.[141]

Amphibious, tank, and air warfare were expanded during World War II. The scale of amphibious and tank warfare grew tremendously, but what advanced the most was air warfare. While soldiers had parachutes in World War I, they were not used very often. Airborne soldiers were used to great effectiveness during World War II. From the moment that the soldier left the plane until he landed, he was a floating target. Even landing could be perilous, due to the parachute getting caught on things and missing the target.[142]

Arial warfare had started with World War I, but it gained real significance during World War II. Between World War I and World War II, planes grew faster and climbed higher and higher. As the planes were made to fly higher and higher, the effects on the air crew's bodies were noted. The "combat exhaustion" that air crews developed was called "operational fatigue." It manifested itself with the same symptoms as "combat exhaustion" but generally appeared as a state of anxiety. Unlike "combat exhaustion" in most cases it did not appear immediately but after a number of stressful events.

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[141] Ibid.

[142] Stephenson, *The Last Full Measure,* 263-264.

Bomber crews were more likely to suffer from “operational fatigue” due to the crew’s inability to move during flight.

When the United States entered the Korean War in 1950, the process of treating “combat exhaustion” had changed to evacuating the soldiers away from the front. During the first part of the war, the “combat exhaustion” rates were three times higher than the early years of World War II. Forward psychiatry was started again, and the process of mid-deployment breaks was implemented. The Army still practices "rest and relaxation", commonly known as "R&R," in its current engagements.

Many of the soldiers involved in the first few months of the Korean War were pulled from occupation duty in Japan. They were ill-equipped and had no training in what they were going to face in Korea. The forces that they faced were experienced Chinese and North Korean soldiers. This caused large numbers of psychological casualties. Most diagnosed with "combat fatigue" would display looks of terror, dilated pupils, rapid pulse, sweating, tremors, and occasionally tears. They would also have insomnia, anorexia, and nightmares. [143]

Evacuating the soldiers suffering from “combat exhaustion” caused two problems with front line troops. The first problem that was created was a sense of despair that their comrade would not be returning. The second

[143] Elspeth C. Ritchie, "Psychiatry in Korean War: Perils, PIES, and Prisoners of War." *Military Medicine* 167 (November 2002): 898-909.

problem that was created by evacuating soldiers was the idea evacuation would be the only way to get out of the battle alive. The number of soldiers evacuated for psychological reasons was about 6 percent, but the number of soldiers who were evacuated for nonbattle related or preventable injuries was about 25 percent.[144]

A side of World War II and the Korean War that gets over looked at times is the treatment of the prisoners of war. Conditions in POW camps were harsh in both wars. Not every prisoner of war developed psychological issues, but prisoners of war were more prone to develop psychological issues as well as many other health problems that were a result of their time as prisoners. When soldiers were liberated, they were evaluated psychologically and given a medical exam to assess any problems they may have.

Leonard Kingcade died in 1967 at age 46. His obituary noted that he was a veteran of World War II and that for three years he had been a prisoner of war under the Japanese. Before being taken prisoner, Kingcade had been stationed on Corregidor, an island at the mouth of Manila Bay. The Japanese attacked this area after bombing Pearl Harbor for months with air bombardments. They did capture the island, and those defending it became their prisoners.

[144] US Army Medical Department, Office of Medical History, "Battle Casualties and Medical Statistics," accessed September 20, 2015, http://history.amedd.army.mil/booksdocs/korea/reister/ch5.html

In the three years that he had spent as a prisoner of the Japanese, Kingcade had already been classified as mentally ill. After he was liberated from the prisoner of war camp, Leonard was sent to a mental hospital in Indonesia and declared "mentally incompetent." He was then sent to a hospital in Walla Walla, Washington. During his stay at this hospital, he was subject to insulin coma therapy. He was discharged from the Army eight months after being liberated from the Japanese and sent to a Veterans Administration Hospital in American Lake, Washington. He was released to his family for awhile, but they returned him due to his increased erratic and disturbing behavior. This time, he underwent electroshock therapy, but this, too, did not help. In 1951, the VA preformed a lobotomy on Leonard. He was still unable to take care of himself and lived with his mother until her death.[145]

During the Korean War, soldiers were not prepared for the possibility of being captured. At the beginning of the war, the North Koreans did not take prisoners. Americans who surrendered to the North Koreans were usually executed. There are instances of the soldiers being tortured and mutilated before being killed. There were about 6,656 soldiers taken prisoner and kept in prisoner of war camps. This was only after the Chinese entered the war.[146]

[145] Wall Street Journal, “The Lobotomy Files: Forgotten Documents Reveal Government Lobotomy of U.S. Troops,” WSJ.com, accessed December 30, 2015, http://projects.wsj.com/lobotomyfiles/?ch=one&mg=inert-wsj

[146] Ritchie, "Psychiatry in Korean War: Perils, PIES, and Prisoners of War." 901.

The Chinese and North Koreans had what they called a “lenient policy” toward prisoners of war. Under this policy, prisoners were given food and medical treatment. They were not abused and were treated fairly well. They were then to be “re-educated” about the real nature of the war and the societies to which the soldier belonged. After this, soldiers would then be released to rejoin their side and spread demoralization among their units or held for longer “re-education.” The purpose of this type of captivity was to destroy any personal loyalties and any group cohesiveness among the prisoners.[147]

There were about 3,743 soldiers given psychiatric examinations after being returned. About 3,073 of the soldiers who were prisoners of war were found to be in good mental health and have good morale. Thirty seven were found to have some kind of psychoses; 219 had some kind of behavior and character disorders, and 33 were diagnosed with some kind of mental deficiency.[148]

There are many stresses put on a soldier during combat. The first and foremost stressor is the fear of being killed or wounded. The next stressor is the fear of not performing in a satisfactory manner in the eyes of other soldiers

[147] David McK Riock, Report on Temporary Duty in Japan and Korea (14 April to 17 July 1953). Washington, D.C.: Neuropsychiatry Division, Army Medical Service Graduate School, Walter Reed Army Medical Center, 1953.

[148] Frank A Reister, *Battle Casulties and Medical Statistics U.S Army Experiance in the Korean War*. Report.(Washington, D.C.: Department of the Army, 1973).

or those above him. The third and last stressor was the physical nature of war and the stress that it put on a soldier's body. All of these had been proven stressors from previous wars. These, along with the quality of leadership and the soldier's training, affected a soldier's level of stress. The most important factor in preventing combat stress was having effective leaders.

By the time of the Korean War, the Army knew that it could control some of these things to a degree. The Army set out to study the effects of combat stress on the body. Blood and urine samples were analyzed, and it was noted that physiological changes occurred. The new physiological changes that were found during the Korean War were dehydration and the absence of adult white blood cells. These two things could indicate how stressed out a soldier's body was.[149]

In 1944, Clifford Lee was stationed in the Pacific. He sent a copy of a poem called *A Hitch In Hell* home to his younger brother, R.D. There have been various authors attributed to this poem, but the first stanza summarizes the overall feeling of the war:

> I'm sitting here and thinking of the things I've left behind
> And I have to put on paper, what is running through my mind
> We've dug a million ditches, and cleared ten miles of ground
> A meaner place this side of hell, is waiting to be found
> But there's one small consolation --- gather closely while I tell

[149] *Study of Combat Stress in Korea 1952*. Report. Washington, D.C.: Operations Research Office, 1952.

When we die we'll go to heaven -- for we've done our hitch in hell[150]

World War II and the Korean War were only fought five years apart, so many of the lessons that were learned about "combat stress" in World War II were carried over to Korea. The biggest problem that the military faced during the Korean War was the lack of trained professionals. Following World War II, as with previous wars, the military had downsized cutting those they had deemed superfluous.[151]

Also, the biggest change between World War II and the Korean War was the nation's changing opinions about war. After spending years fighting in Europe and Asia, the public began to question the reason for becoming involved in another war. In studies on "combat stress", the military notes that news about the war had been regulated to the back pages of the news papers and that an anti-war feeling had begun to grow in the United States.

The generation that fought in World War II and to an extent is sometimes referred to as "the greatest generation." They were largely children of the depression who rallied together to fight a war on two fronts with extreme patriotism. The military knew that war could cause psychological problems after World War I, but the public was largely ignorant of this fact. There was a big stigma associated with mental illness, and many veterans did not seek

[150] Anonymous, *A Hitch in Hell.*

[151] *Study of Combat Stress in Korea 1952*. Report. Washington, D.C.: Operations Research Office, 1952

help for their problems. When they did seek help, their claims were either denied or they were subjected to a wide array of harsh therapies. While these treatments are deemed harsh by today's standards, they produced positive results at the time.

Chapter Four

Are We in the Clear Yet?

The late 1960s and the early 1970s were times of social unrest for the United States. The government noted during the Korean War that war was becoming unpopular with the American public. The Vietnam War was very unpopular with the public and anti-war demonstrations were held in Washington, D.C, New York City, and on many college campuses. American support for the war dropped drastically after the Kent State Massacre. This was when four students were killed by members of the Ohio National Guard during an anti-war protest.

Society, at this time, was undergoing major changes. Death and mourning had fully transitioned to private matters. Due to further advancements in medicine and healthcare, the life expectancy was now 70 years old. The “baby boomer” generation pushed new ideas dealing with sexuality, women’s rights, and experimented with psychoactive drugs.[152]

The American involvement in Vietnam began in the late 1950s with increased ground troop involvement starting on March 8,1965. An amphibious landing was made by 3,500 Marines who were part of the 9th Marine Expeditionary Brigade. They landed in response to an increase in fighting between the South Vietnamese forces and the forces of the Democratic

[152] Legacy.com, "1950-2000," Life Expectancy Surges!, accessed January 30, 2016,. http://www.legacy.com/life-and-death/life-expectancy-surges.html.

Republic of Vietnam. During the previous 15 years, the United States had only provided money and military advisors to help the South Vietnamese defend them against the North. The United States would spend another decade with ground troops helping the South Vietnamese.[153]

The draft in the United States had always been somewhat unpopular with portions of the public; but due to the social climate of the Vietnam era, it was very unpopular. Prior to World War I, Italy had required military service of all of its male citizens. Many of the men found it hard to adapt to life in the army, and this led to problems such as desertion and rebellion.[154] Earlier European doctors had also noted that forcing a man to serve away from his home could cause him to go into a state of melancholy.[155] The soldiers that were drafted most likely had never considered joining the army. This caused a lot of dissent among officers and enlisted men.[156]

The military noticed during the Korean War that negative articles were published about the war and the trend continued with the Vietnam War. The Vietnam War would be the first war that was covered by television. The events

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[153] Norman M. Camp, *US Army Psychiatry in the Vietnam War: New Challenges in Extended Counterinsurgency Warfare* (Fort Sam Houston Texas: Office of The Surgeon General Borden Institute, US Army Medical Department Center & School, 2014), 1-2.

[154] Mark S. Micale, and Paul Frederick Lerner, *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (Cambridge, UK: Cambridge University Press, 2001), 223-224.

[155] Gerard William Northcote Swieten and John Ranby, *The Diseases Incident to Armies. With the Method of Cure*.(Boston: Philadelphia, 1777), 7.

[156] "Colonel Danny Rhodes," Interview by Schuyler Easterling, Clemson Veteran's Project,accessed September 15, 2015, http://www.clemson.edu/veterans-history/index.php/vietnam-war/colonel-danny-rhodes.

that happened earlier in the day would be reported to Americans on the six o'clock news. This "instant" access to war news would sour the public's opinion about the war and the military.[157]

The United States military trained its soldiers to fight conventional wars and at the time, this was still a possibility. When soldiers arrived in Vietnam, they soon realized that the North Vietnamese would be fighting a nonconventional war. Those higher up in command of the military were unable and unwilling to change their tactics. This caused frustration among lower ranking troops.[158]

In Vietnam, Huey pilots, Bob and Ted were best friends. Every day, they flew supplies and people everywhere in the combat region. For almost nine months, they flew every mission together. While resupplying a Special Forces camp, they came under heavy fire. While Ted was concentrated on getting the Huey out of the area as quickly as possible, a bullet came through the windshield and hit Bob. Ted landed the helicopter and tried to help his friend. When Ted pulled Bob's helmet off, the top of Bob's head came off.[159]

Ted was able to finish his tour of duty, but Bob's death affected Ted greatly. When he returned to Fort Rucker, after Vietnam, he was plagued with

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[157] Frank A Reister, *Battle Casulties and Medical Statistics U.S Army Experiance in the Korean War*, (Washington, D.C.: Department of the Army, 1973).

[158] "Colonel Danny Rhodes," Interview by Schuyler Easterling, Clemson Veteran's Project, accessed September 15, 2015, http://www.clemson.edu/veterans-history/index.php/vietnam-war/colonel-danny-rhodes.

[159] Robert Saperstein and Dana Saperstein, "The Emotional Wounds of War." *Military Review*, January 1992, 54-61.

nightmares. There were nights where he would not sleep and when he did sleep, he slept with the light on. At Fort Rucker, Ted was an instructor pilot at the Army helicopter training school. There were times during combat simulation flights when Ted would experience flashbacks. These flashbacks would cause his flying ability to decrease. This caused Ted to start to drink and take drugs to help him sleep. This also began to affect his flying. He was given a medical discharge because he was unable to deal with his drug addiction. Once he was discharged, Ted withdrew from his friends and family. Within two years of coming back from Vietnam, Ted committed suicide.[160]

It was in 1970 when Dr. Robert Lifton developed the term "post-Vietnam syndrome". This was due to a large number of Vietnam veterans coming into Veteran Administration Hospitals seeking help. It was only in 1980 was the name changed to Post-Traumatic Stress Disorder.[161]

The treatment for "combat stress" in the Vietnam War was very similar to the treatment methods of World War I. The exception was that the focus was not on helping the soldier recover quickly, but was on not evacuating the soldier from the combat zone. There were five principles that were used when treating a soldier suffering from combat stress. Soldiers were to be treated as close to the front lines as possible. They should be treated as soon as symptoms began. The evacuation of soldiers was only allowed by a small

[160] Ibid, 54.
[161] Dean, *Shook Over Hell*, 41.

number of medical professionals. Medical professionals were to convince the soldier that what he was experiencing was only temporary and that he was going to get better. Lastly, a soldier would be given a short break from the battle.[162]

Dr. Robert Rankin was a Navy doctor during the Vietnam War. He explained how he treated soldiers with combat stress:

> The understanding we had then was that the closer to the battlefield you can treat them the better. That to an extent was good. If they had the ego strength if they were able to be treated close in, I didn't send them out of 'Nam if I didn't have to. If I did, I sent them to the ship. If I didn't have to send them off the ship I wouldn't. If I didn't have to send them beyond Yokosuka I didn't. So I tried to keep them as close in as I could.[163]

Dr. Rankin goes on to say that if the soldier was beyond his help, he got them out of there as quickly as he could. If a soldier had any kind of attachment to his unit, Dr, Rankin tried to keep him close to his unit. He felt that the practice of forward psychiatry was the best way to help those afflicted with "combat stress."[164]

These methods had been used to some extent since World War I. It had been proven during World War II, that soldiers who were treated closer to the front were more likely to return to combat. A lot of the treatment in Vietnam

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[162] Scurfield, *War Trauma*, 169.

[163] Robert Rankin, "The Vietnam Archive Oral History Project," Interview by Laura Calkins, The Vietnam Archive at Texas Tech University, accessed June 14, 2015, http://www.vietnam.ttu.edu/oralhistory/interviews/browse/?page=R.

[164] Ibid.

was based on the limited number of resources available to psychologists and psychiatrists with the military.

The United States military had gained knowledge of "combat stress" from World War II and the Korean War and understood that war could cause psychological problems in soldiers. A change made by the military was to limit combat tours to one year with an "R&R" break in the middle of the tour.

When the United States entered the Vietnam War the military focused medical treatment on large bases but as the war continued, medical treatment was focused on being more forward. To deal with "combat stress" cases, the Army issued a new plan called United States Army Vietnam Regulation Number 40-34. At the brigade level, there would be psychiatrists, social workers, surgeons, and psychologists to deal with “combat stress” cases. The field evacuation hospitals would now have their own psych wards. These hospitals would also have mental health providers and nurses trained to deal with psychiatric cases.[165]

There were some treatment methods for those diagnosed with "combat stress.” One of the most common was giving the soldier Thorazine and he was allowed to sleep.

Compared to previous wars, American troops had low occurrences of psychiatric casualties, about 12 per 1,000. In the Korean War the number was 37 per 1,000 and in World War II the numbers varied from 29 to 101 per

[165] USARV Regulation Number 40-34, dated March 30, 1966.

1,000.[166] There were only a small number of psychological cases that resulted from combat. Many cases were due to idleness, loneliness, and heroin dependency, the most common drug addiction, and interpersonal conflicts among the soldiers.[167]

The low rate of combat psychological cases is also due to the nature of combat in Vietnam. There were low cases of bombardments of artillery and air craft fire. Combat was directed from bases, and troops were transported by helicopter to and from the battle. These bases also had the basic comforts of life maybe, not the best but basics like toilets and cots.[168]

While psychological casualties during combat were low, there were a number of other psychiatric problems. There were some behavioral and disciplinary problems that began to arise. Since these problems were not limited to combat troops, they were not considered a result of combat. These behavior problems along with things like combat refusal and excessive combat aggression were deemed "hidden casualties." "Hidden casualties" were conditions that were not traditionally associated with psychiatric casualties during the war.[169]

There were those that were critical of the procedures implemented to prevent “combat stress” in Vietnam. They felt that the one year tours led to a lack of unit cohesion. Unit cohesion had been a major player in preventing

[166] Dean, *Shook Over Hell*, 200.
[167] Ibid, 200.
[168] Ibid,200.
[169] Camp, *US Army Psychiatry in the Vietnam War: New Challenges in Extended Counterinsurgency Warfare*, 146.

"combat stress" in World War II. They also argued that due to the unconventional warfare and the lack of support from those back at home, Vietnam was more psychologically damaging than World War II.[170]

The most common problem seen by psychiatrists in Vietnam was soldiers dealing with drug abuse. As the war went on and drug-related incidents grew, the Army reduced the number of trained psychiatrists. By downsizing the number of mental health professionals in the combat zone, the Army also reduced the number back in the United States to help veterans.[171]

Those who returned home from Vietnam were able to arrive home quicker than soldiers from previous wars. Soldiers coming home arrived home by commercial airplanes within 24 hours. These soldiers were expected to adjust back into civilian life fairly quickly. Whereas soldiers coming back from World War II sailed home on a boat which took about three to six weeks. The long voyage gave the men time to unwind and transition back into back into civilian life.[172]

Vietnam veterans also arrived home to a very unwelcoming public. While World War II soldiers received ticker-tape parades, Vietnam soldiers had to deal with anti-war protestors, who at their best, only made undirected comments in a soldier's presence.[173] Soldiers who served in Vietnam

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[170] Ibid, 200.
[171] Camp, *U.S. Army Psychiatry in Vietnam: From Confidence to Dismay*, 6.
[172] Ibid, 200.
[173] "Colonel Danny Rhodes," Interview by Schuyler Easterling, Clemson Veteran's Project, accessed September 15, 2015. http://www.clemson.edu/veterans-history/index.php/vietnam-war/colonel-danny-rhodes.

frequently felt unappreciated and victimized by their nation. Servicemen who defended what they did in Vietnam were disliked; but also, servicemen who spoke out against the war were shunned by the government. The media also showed Vietnam veterans as drug addicts, alcoholics, and criminals.

In previous wars, the rate of "combat stress" cases rose as battle intensified. But with the Vietnam War, the opposite appeared to happen. In 1970, there were twice as many admissions for a psychological disorder than there had been for the year 1967. The military leaders began to believe that the intensity of combat was not the only source of "combat stress" among the soldiers.[174]

Military leaders felt that there were three reasons for the rise in "combat stress" cases. The first was that the idea of "winning" was changed by the government throughout the war. At the beginning of the war, there was a firm belief that the United States could win the war, but as time passed this idea faded. Instead of gaining ground, as had been the practice in previous wars, killing the most North Vietnamese was the goal.

The second reason was the increased dependency on prescription drugs and the use of illegal drugs by soldiers. These were used to mask the signs of “combat stress.” The third reason was guilt felt by soldiers after an engagement.[175]

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[174] Ronald Spector, *After Tet* (New York The Free Press, 1993), 30.

[175] Herbert Hendin, and Ann Pollinger Hass. *Wounds of War. (*New York: Basic Books, 1984), 7.

Military Leaders in the Vietnam War worked together to address "combat stress". Early in the war, there were a number of mental health providers in the field. The 95th Evacuation Hospital and the 67th Medical group were stationed in Vietnam from 1968 to 1974. The 95th Evacuation Hospital established a 320 bed hospital in 1968. This hospital was able to treat neurological cases, provide counseling, and give psychiatric consultations.[176] Also, in 1968, the 67th medical group had 25 “combat stress” teams to support medical units in Bien Hoa, Da Nang, and Tuy Hoa regions. These teams helped treat “combat stress” from the beginning and were able to link up with other hospitals to provide care.[177]

From 1962 to 1973, between 7,500 to 11,000 women served in Vietnam. There were a number of stressors that female veterans reported. These included being overwhelmed with casualties, the severity of the injuries suffered by the soldiers, and the overall youth of the patients. Other stressors included having to learn new skills quickly, lack of sleep, sexual harassment, and the overall difficult living conditions. This included dealing with unfamiliar tropical diseases, the fear of chemical warfare, and to the possibility of being wounded by enemy fire.

Nursing in a warzone was very different from civilian nursing. Many of the nurses who were sent to Vietnam were newly graduated and had very little

[176] “Medical units where women served during the Vietnam War”, Civilian Account Report On-line, Accessed January 20, 2016, http://www.illyria.com/evacs.html#medcaps..
[177] Ibid.

training.[178] However, the reported number of female Vietnam veterans with post-traumatic stress disorder was lower than their male counterparts.

Physicians and psychiatrists during the Vietnam war were trained in the administering of neuroleptic, tranquilizing, and antidepressant medications. These types of medications had changed the practice of psychiatry. They were used widely in Vietnam because they were less likely to effect a soldier's performance.[179] Most "combat stress" cases responded well to the use of psychiatric drugs. For 48 hours they were given heavy doses of Thorazine coupled with night time doses of sodium amobarbital. [180]

During the build-up phase in Vietnam, the psychiatric program was fully in place, with abundant mental health resources and psychiatrists trained in combat psychiatry. "Combat stress" casualties, however, failed to materialize. Throughout the entire conflict, even with a liberal definition of "combat stress", less than 5 percent (but closer to 2 percent) of casualties were placed in this category.[181]

The Vietnam War produced a number of contradictions concerning the traditional understanding of psychiatric casualties. Most spectacular was the

[178] Anica Pless Kaiser, Avron Spiro, Lewina Onyi Lee, and Jeanne Mager Stellman, "Women Vietnam Veterans: Do PTSD Symptoms Mediate Effects of Warzone Service on Health?" *Research in Human Development* 9, no. 3 (2012): 210-28.

[179] Camp, *US Army Psychiatry in the Vietnam War: New Challenges in Extended Counterinsurgency Warfare*. 434.

[180] Ibid, 436.

[181] *War* Psychiatry, 50.

low rate of identified psychiatric casualties generally and the relative absence of “combat stress.”[182]

The DSM-I was published in 1950. Its description of “combat stress” covered four pages and stated that extreme stress reactions came from either catastrophes or combat. Also in its preface, the "value of the stress definitions to military psychiatrists [and] psychiatrists working with veterans" was mentioned. But in the DSM-II, published in 1968, all reference to such stress reactions were eliminated.[183]

Veterans were told that if their symptoms lasted more than six months after they returned from Vietnam, they had a "pre-existing" condition. This then made it a "transient situational disorder", and the problem was not considered connected to their time in Vietnam and would not be treated by the Veterans Administration.

Substance abuse problems were a major problem during the Vietnam War. Alcohol and drug problems have existed in the military throughout history. These things have always been an issue with soldiers overseas and in the United States. In the 1800s, soldiers were admitted to hospitals due to being intoxicated and delirious from bromides. In the 1900s intoxication from barbiturates resulted in the most hospital admissions. LSD was introduced in

[182] Ibid.

[183] Gerald Nicosia, *Home to War: A History of the Vietnam Veterans’ Movement* (New York: Carroll & Graf Publishers, 2001), 170-189.

the 1950s, and this caused new psychological problems admitted to hospitals.[184]

Historically, alcohol problems have been classified with mental disorders. In the Russo-Japanese war, there were three types of "mental" cases identified by the Russian military. These cases were classified as a depressive syndrome, general paralysis, and alcohol psychosis. In the decade prior to the United States entering World War I, alcohol problems occurred in 16 per 1,000 troops every year.[185] During World War II this number was 1.7 per 1,000 troops every year. The drug addiction rate among troops at this time was 0.1 per 1,000 every year. Together these rates made up 4.7 percent of all psychiatric cases diagnosed.[186]

There were a number of psychiatric disorders beyond "combat stress" that developed during the Vietnam war. The most common were classified as disorders of frustration and loneliness. These were things like venereal disease, alcohol, and drug abuse. The low combat intensity led to less unit cohesion. This in time led to the reoccurrence of "nostalgia" cases among the troops.

Character and behavior disorders were the most frequently reported psychiatric disorders among troops. It was felt that a majority of the soldiers were exaggerating their symptoms in order to avoid combat. Character and

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[184] Franklin D. Jones, *Military Psychiatry: Preparing in Peace for War* (Falls Church, VA: Office of the Surgeon General, U.S. Dept. of the Army, 1994). 63.

[185] Ibid, 63.

[186] Brill NQ, Hospitalization and disposition. In: *Zone of Interior*. Vol. 1. In: AJ Glass, RJ Bernucci, eds. *Neuropsychiatry in World War II*. (Washington, DC: GPO; 1966): Chap 9.

behavior disorders were a more socially acceptable way of getting out of combat.[187]

The second most reported psychiatric disorder was the psychological reaction to unconventional warfare. The basic training of most of the soldiers was focused on conventional warfare, and they were unprepared for the guerrilla warfare used by the North Vietnamese.[188]

Soldier dissent was the third most common psychological problem. The social climate in the United States led to the breakdown in military discipline. Then a heroin epidemic became the military's focus along with the anti-military actions by soldiers against their superiors.[189]

There were a number of factors that were the reason for the low number of "combat stress" reactions. 65 to 75 percent of troops had noncombat assignments. The fighting was usually irregular, and troops were transported to and from the battles by helicopter. Communication between the troops their support systems was improved as well. The majority of combat was planned out and conducted in areas that could be resupplied easily. The access to alcohol and marijuana provided ways of reducing stress after combat and allowed for bonding among the troops. This also did lead to addiction problems. The one-year tour of duty, while criticized by some,

[187] Camp, *US Army Psychiatry in the Vietnam War: New Challenges in Extended Counterinsurgency Warfare,* 435.
[188] Ibid, 435.
[189] Ibid, 435.

reduced "combat stress" by letting soldiers know that they had a date to leave the war.[190]

There were also a number of factors that caused psychological disorders during the Vietnam War. The fact that Vietnam was so far away from the United States and a completely different culture than the culture of the United States was the first stress factor. The enemy had the ability to be very elusive, and had was able to blend in with the local population, which made no place feel completely safe.

As the war dragged on, the stressors changed. Morale was depleted as the number of casualties grew and the government changed policies on how they wanted to war to progress. The huge anti-war and anti-military movements were also a cause for stress for the soldiers.

The term post-traumatic stress disorder came about because of the high number of psychiatric and behavior problems in Vietnam veterans. In 1988, the Veterans Administration concluded a five-year study. This study found that 15 percent of Vietnam veterans were suffering from post-traumatic stress disorder. This number included 7,000 female veterans who mostly served as nurses. It was found that in many veterans the trauma of war was dormant or manageable until the veteran experienced another traumatic event.[191]

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[190] Ibid, 438.
[191] Saperstein, "The Emotional Wounds of War."

After the war, there were limited programs available to veterans.[192] From studies of veterans after the war, it emerged that “combat stress” and suicide were related. About 9,000 Vietnam veterans had committed suicide within five years of being discharged.[193]

The prisoner of war experience in Vietnam was a unique one. Many of those who were taken prisoner believed that they were made stronger by the experience. They felt they became more patient, more optimistic and did not worry about the little things. In 1990, there were about 73,435 former prisoners of war alive. As prisoners, they had suffered from malnutrition, untreated diseases, torture, and other psychological trauma. These things would have lasting effects on their physical and mental health.

From 1966 to 1969, Jim Pfister served with the Army in Vietnam. He was a company clerk with the 148th Ordinance Company as well as a door gunner for the 71st Assault Helicopter Company. His helicopter was shot down in January of 1968, and he was captured by the North Vietnamese. He remained a prisoner of war until 1973. Like many Vietnam prisoners of war, Pfister felt that the experience made him grow up and not take things for granted. He knew that he got post-traumatic stress disorder from being a prisoner of war. He talked about his diagnosis of post-traumatic stress disorder in the following way:

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[192] Matthew Tull, “Rates of PTSD in Veterans,” accessed November 17, 2015, http://ptsd.about/com/od/prevalence/a/militaryPTSD.htm.

[193] F. Don Nidiffer and Spencer Leach, “To Hell and Back: Evolution of Combat-related Post Traumatic Stress Disorder,” *Developments of Mental Health Law* 29 (2010): 13.

> But once you have PTSD there is no cure for it. There is relief, there is help like counseling with the vet centers and VA regional offices. There's help, but there's not a cure for it and I'm not going to B.S. anybody. There is not a cure for it. I quit going to counseling because I got tired of talking about Vietnam because it always led me back to the same place that I started out going to counseling for; the people that died in my camp. I never have, I never had dreams of flying and shooting and getting shot at. It's burying eight people in my camp.[194]

In 2000, Pfister still had nightmares from his time as a prisoner of war and took 250 milligrams of bupropoin. It is the fourth medication that he had been on since his diagnosis. He felt that dealing with post-traumatic stress disorder was more about dealing with what was going on around a person than dealing with what had happened.

Even though the Vietnam war ended forty years ago, the research on those who fought in it is still changing. More and more Vietnam veterans are going to the Veterans Administration for help. While drug and alcohol problems were a major concern for leaders during the war, it is commonly known that those dependencies can be used to mask other problems. After the war, there were programs set up to help veterans with their addiction problems, but very few in place to help them with their psychological issues. The breakdown of military discipline continued into the 1980s, and the anti-military feeling lasted almost that long.

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[194] Jim Pfister, "The Vietnam Archive Oral History Project," Interview by Stephen Maxner, The Vietnam Archive at Texas Tech University, accessed June 4, 2015. http://www.vietnam.ttu.edu/QuickSearch.php?srch=PTSD.

Prior to the Vietnam War, it was believed that soldiers who had a mental breakdown during combat and recovered would have no long-term side effects. Any psychiatric problems that occurred after returning home from war were due to a prior existing condition and not related to combat. It was only after the Vietnam War that there was a great interest in psychiatric disability that resulted in being in combat.[195]

The Vietnam War showed the military the limits that forward psychiatry had in prolonged, low intensity, conflict. These types of conflicts were to be approached with prevention as the main focus.

In combat and noncombat settings, the rate of mental illness was about two per 1,000 troops every year. This rate doubled in 1969 and 1970; but this is thought to be due in part to the rise of illegal drug use. In 1971, when treatment centers opened to help the soldiers, this number dropped.[196]

The legacy of the Vietnam war is something that the military and the United States is still struggling to accept. This was the first war where the television and media played a big part in demoralizing the American public. While people had protested previous wars for various reasons but the anti-war movement during the Vietnam war was the largest. This played a part in demoralizing the three million troops who were sent to fight. Those who returned from Vietnam returned on commercial airplanes. One moment they

[195] Hans Pols, and Stephanie Oak, "WAR & Military Mental Health." *Am J Public Health American Journal of Public Health* 97, no. 12 (2007): 132-142.

[196] War Psychiatry, 19.

are in a combat zone, and less than 24 hours later they were back in the United States. They were not welcomed back with the parades and good will that had been shown to soldiers in previous wars. This also played a part on the veterans' mental health.

Chapter Five

One Day, I'll Face the Hell Inside

Following the Vietnam War, the United States refrained from becoming involved in long drawn out combat missions. Most operations at this time were done for humanitarian aid. The rate of soldiers with post-traumatic stress disorder occurring from these engagements is not known. Post-traumatic stress disorder did not reoccur in large numbers until the Persian Gulf War in 1990.

The period from 1990 until 2012 is marked by a number of tragic events. Some of these events, like the school shootings at Columbine and Sandy Hook and the Oklahoma City bombing, were civilian in origin. Events like Hurricane Katrina and Hurricane Sandy were of environmental origin. Then there were the terrorist attacks that occurred on September 11, 2001, that were the start of the wars in Afghanistan and Iraq.

Also during this time movies, television shows, and video games began to become more violent. Children of this era, born before or after the Gulf War, became desensitized to seeing violence. Yet it was still rare for the average person to see a violent act or even violent death.

The Persian Gulf War, also known as the First Gulf War, began August 2, 1990, and lasted through April 6, 1991. This was a quickly fought war in Iraq

where the most intense combat was seen in the first 96 hours that the United States began its invasion of the country.

The term Post-Traumatic Stress Disorder had been created and accepted by the psychiatric community in 1980. There have been a number of studies to determine the rates of post-traumatic stress disorder. In most studies the rate is below ten percent. Most studies stated that since post-traumatic stress disorder can develop months or even years after the traumatic event, it is still hard to gage the complete number of soldiers from the Gulf War that may have post-traumatic stress disorder.[197] These same studies have looked at other psychiatric disorders occurring in Gulf War veterans. These studies found that anxiety and depression occurred in higher rates in Gulf War veterans that were deployed compared to veterans who were not deployed.[198] The studies also reported that Gulf War veterans who have been diagnosed with post-traumatic stress disorder have higher rates of self-reporting their symptoms when compared to other veterans.[199]

Gulf War veterans have a lower number of rates of post-traumatic stress disorder compared to Veterans of other wars. Most of their health problems are multi-symptom, and it has yet been discovered if their illnesses were caused by exposure to hazardous material or if they were caused by

[197] *Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations*. (Washington, D.C.: Research Advisory Committee on Gulf War Veterans' Illnesses, 2008), 69.
[198] Ibid, 70.
[199] Ibid, 71.

psychological stress. In early studies, it was speculated that Gulf War veteran's illnesses were caused by their deployment. [200]

There are about 250,000 Gulf War Veterans who have constant and unexplained medical symptoms. The collection of symptoms has been given the name "Gulf War syndrome." The only clear illness that has been diagnosed in Gulf War veterans is post-traumatic stress disorder. By 2010 between two and 15 percent of Gulf War veterans had been diagnosed with post-traumatic stress disorder.[201]

Veterans from the Gulf War reported fatigue, cognitive impairment, headaches, depression, insomnia, dizziness, joint pains, and shortness of breath. These have all been symptoms of post-traumatic stress disorder throughout the years, but they could also be side effects from the hazards that soldiers encountered during the war. Veterans believe that their symptoms come from the hazards they encountered and shy away from associating them with any psychological trauma. This is believed to be because of the cultural stigma associated with mental illness and post-traumatic stress disorder.[202]

The wars in Iraq and Afghanistan have been headline news for the past 14 years. After the Vietnam War, these wars have been the longest war that

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[200] Ibid, 72.

[201] David Brown, "Up to 250,000 Gulf War Veterans Have 'unexplained Medical Symptoms," The Washington Post, accessed December 5, 2015, http://www.washingtonpost.com/wp-dyn/content/article/2010/04/09/AR2010040904712.htm.

[202] Pols and Oak, "WAR & Military Mental Health."

the United States has fought. The war in Afghanistan, also known as Operation Enduring Freedom, began on October 7, 2001. Operation Enduring Freedom ended on December 14, 2014. A follow-up engagement in Afghanistan called Operation Freedom's Sentinel began on January 1, 2015. The war in Iraq, also known as Operation Iraqi Freedom, began in mid-2002, and all combat missions ended on August 31, 2010. Operation New Dawn lasted from September 1, 2010, until December 15, 2011.

While the Persian Gulf War had still largely used conventional warfare tactics, the wars in Afghanistan and Iraq were fought with unconventional methods. Having not sufficiently understood these tactics during the Vietnam War, it took the military a number of years to become proficient in fighting an unconventional war. Recently, the military has implemented drone warfare. This takes the soldier off the battlefield but allows him to see his actions on a video screen.

In a report done by the Walter Reed Army Institute of Research on the Mental Health and Well-being of Soldiers in Operation Iraqi Freedom, the following information was gathered. Data for this report was collected as part of the Mental Health Advisory Team Mission to Iraq and Kuwait, August through October 2004. Fifty-four percent of Operation Iraqi Freedom II soldiers reported that unit morale was low, compared to soldiers from Operation Iraqi Freedom I when unit morale was seventy two percent felt that unit morale was

low. Thirteen percent of Operation Iraqi Freedom II soldiers screened positive for mental health problems as opposed to 18 percent of Operation Iraqi Freedom I soldiers.[203]

Soldiers who were in transportation and nonmedical combat service support, National Guard, and Reserve units had significantly higher rates of mental health problems and lower perceptions of combat readiness and training than soldiers in other units. Forty percent of soldiers with mental health problems in Operation Iraqi Freedom II reported receiving professional help during the deployment. This was up from the 29 percent who reported receiving help in Operation Iraqi Freedom I.[204]

A big concern for soldiers involved in this study was the organizational barriers and the stigma that remains with receiving help. Fifty-three percent of soldiers who had mental health problems believed that their leaders would treat them differently. Fifty-four percent thought they would be seen as weak for receiving help 39 percent felt it would be hard getting time off work so they could seek help. 20 percent felt that it was too difficult to get to the mental health specialist's location.[205]

For those who have moderate to mild post-traumatic stress disorder, group therapy has been proven to be effective. In this type of therapy, a

[203] The US Army Surgeon General, "Walter Reed Army Institute Of Research (WRAIR) Report On The Mental Health And Well-Being Of Soldiers In Operation Iraqi Freedom." Washington DC, 2005.

[204] Ibid.
[205] Ibid.

soldier can talk about traumatic memories and the symptoms of post-traumatic stress disorder with other veterans who are experiencing the same things.[206]

Treatment of mental health issues during the conflicts in Iraq and Afghanistan is done through different levels of care. There are mental health teams that make up “combat stress” control units, division mental health sections and combat support hospitals.[207]

The first level of care is done by a soldier’s “battle buddy” and medics. A “battle buddy” is another soldier who is assigned to watch out for the other soldier both in combat and outside of combat. Soldiers are trained in basic medical care. This includes how to start an IV to help with hydration and blood loss and how to identify the signs of “combat stress.”[208]

While this first level of treatment can recognize and start treatment for "combat stress," most cases are referred to the next level for more evaluation. The second level of treatment is done at Combat Stress Control Detachments or Division Mental Health Sections. The soldier is at this second level for one to three days. The goal of this level is to determine if a soldier can return to his or her unit or if they need to be sent on to level three. Any medical professional who evaluates the soldier at level two can recommend that they are sent to the next level. A soldier can be recommended to the next level if he

[206] Matthew Friedman,"PTSD: National Center for PTSD." PTSD History and Overview, accessed August 3, 2015, http://www.ptsd.va.gov/professional/pages/ptsd-overview.asp.

[207] Robert Forsten and Brett Schneider, "Treatment of the Stress Casualty during Operation Iraqi Freedom One." *Psychiatry Q Psychiatric Quarterly* 76, no. 4 (2005): 343.

[208] Ibid, 344.

or she has displayed any suicidal intention, homicidal behavior, or mania or have not responded to treatment.

At the second level of treatment routine evaluation and follow up on patients can be performed. The combat support hospital is the third level of care. If the soldier's behavioral health can not be fixed at this level, they can be referred to level 4 or 5, which is in Germany or the United States. Referral to these levels can only be made by a psychiatrist.[209] The main goal of these teams is to brief units on suicide prevention, stress management, identification of depression, and preparing soldiers for reconnecting with their families. These teams also hold Critical Event Debriefings for units involved in traumatic events.[210]

Division Mental Health Sections are specific medical units that are made up of a psychiatrist, psychologist, social worker and seven to eight mental health technicians. This section is responsible for the mental health needs of 10,000 to 15,000 soldiers. Typically, the section breaks up into three teams and performs the same actions as a Combat Stress Control unit. During the conflicts in Iraq, divisions sometimes grew to about 20,000 to 30,000 soldiers. To deal with this, a Combat Stress Control unit was assigned along with the Division Mental Health section.[211]

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[209] Ibid, 344.
[210] Ibid, 346.
[211] Ibid,348.

Due to a large number of soldier suicides, the Army implemented a new program called the Battle Mind Program. The goal of this program was to develop and implement a behavioral health resilience system that would support soldiers' mental health from training to deployment, and when they came home.[212] In this program soldiers who had been in combat, help prepares new soldiers for combat. This program is meant to help identify soldiers who may be more prone to post-traumatic stress disorder. Those soldiers are then given more training to prepare them for combat.[213]

The military has recognized that many soldiers do not seek help with dealing with post-traumatic stress disorder because they are afraid of losing the careers that they have built. The military is actively working at removing this stigma by implementing some action. The first is the establishing of hotlines for soldiers to call if they feel they are not getting the support they need from their superiors. There are also many hot lines available to veterans.

The next measure that the Army has established is the Wounded Warrior Transition Program. This is not be confused with the Wounded Warrior charity. The Wounded Warrior Transition Program is completely focused on the soldier's healing. Soldiers in this program are placed in a small medical unit where their only commitment is to get treatment. The soldiers are watched and made sure that they are able to attend any appointments and get the

[212] *Battlemind Training II Continuing the Transition Home*. (Washington, D.C.: Walter Reed Army Institute of Research, 2006).

[213] Bill Lindsey, *Post Traumatic Stress Disorder Within The Army*. Report. (United States Army Sergeants Major Academy, 2007).

therapy that they need. When soldiers are proven to be healthy again, they return to their original duty assignment.[214]

The military has also recognized that the soldier's family needs to be supported along with the soldier. While the internet can provide many resources to a soldier's family, the military has established things like free childcare and support groups specifically for military family members. The military has also established ways to help military children whose parent is suffering from post-traumatic stress disorder. These programs are designed to help children understand what their parent is going through and the nature of post-traumatic stress disorder. These programs also help children deal with their own stress associated with a parent having post-traumatic stress disorder.[215]

On average, servicemen have been through two deployments with some having four or more. The multiple deployments were due to fighting the two wars at the same time. There were policies put in place to keep soldiers fighting longer, but they were extremely unpopular.[216]

In 2008, studies revealed that among combat veterans who had served in Iraq, there had been a huge increase in suicides, divorce, and overall discipline problems. From 2001 to 2008 the suicide rate among service

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[214] Ibid, 6.
[215] Ibid,7.
[216] Raymond M Scurfield, *War Trauma: Lessons Unlearned, From Vietnam to Iraq*. (New York, NY: Algora Publishing, 2006). 68.

members steadily rose. The rates of military members diagnosed with post-traumatic stress disorder also grew from 2,500 to over 15,000.[217]

Still, soldiers would be labeled as malingerers by military commanders and mental health professionals. They felt that these soldiers were abusing the system to avoid work or avoid being deployed. Madigan Army Medical Center at Joint Base Lewis-McChord in Washington came under fire in 2012 due to their mismanagement of post-traumatic stress disorder. It was found that over 40 percent of the post-traumatic stress disorder dealt with by the psychiatry team were overturned or denied. These cases were being denied based primarily based on what it would cost the United States Government to care for the disabled soldier. Due to the problems at Madigan, there were the reworking of psychology programs in the Army.[218]

In recent studies done on soldiers returning from Iraq and Afghanistan, between five and 18 percent of the soldiers had a number of symptoms that were related to post-traumatic stress disorder. [219] This rate is an ever changing number since soldiers return from these combat zones everyday and due to the nature of post-traumatic stress disorder, it could be years before there is a definitive number. Also, during the past decade, the connection

[217] Rajeev Ramchand et al., *The War Within: Preventing Suicide in the U.S. Military* (Santa Monica, CA: RAND Corporation, 2011).

[218] Hal Berton, "Madigan Memo on PTSD Costs Sparked Army Review," *Veterans Today*, accessed September 30, 2015, http://www.veteranstoday.com/2012/02/08/madigan-memo-on-ptsd-costs-sparked-army-review/.

[219] Alan L Peterson, Monty T. Baker, and Kelly R. Mccarthy, "Combat Stress Casualties in Iraq. Part 2: Psychiatric Screening Prior to Aeromedical Evacuation." *Perspectives in Psychiatric Care* 44, no. 3 (2008): 159-68.

between a person suffering a traumatic brain injury and them developing post-traumatic stress disorder had been established. It must be stated that not all people who suffer a traumatic brain injury develop post-traumatic stress disorder and not all people who develop post-traumatic stress disorder have suffered a traumatic brain injury.

Conclusion

The history of post-traumatic stress disorder is long and complicated. Treating and diagnosing things that effect a person's mental well-being is hard because symptoms can present differently in each person. In the 17th century, medical professionals started to recognize that soldiers could develop depression when forced to fight far away from their homes. The term given to this disorder was "nostalgia."

The United States started recording rates of “nostalgia” during the Civil War. During the 19th century, conditions like hysteria and nostalgia were considered female afflictions. The rate of men developing "nostalgia" and the condition called "Da Costa's syndrome" during the Civil War alarmed the medical professionals in the Union Army and they sought ways to solve the problem. The most common treatment was a few days of rest, a few strong words of encouragement, and in the Confederate army, a drink of whiskey.

After the Civil War, the United States was involved in a number of small engagements with the Native Americans and then the Spanish in Cuba. The British began fighting the Dutch in South Africa, and the Russians fought the Japanese. During this time, the fields of psychology and psychiatry began to be developed.

It was not until the world was thrown into turmoil with World War I that militaries began to associate war with mental trauma. World War I marks the first time that militaries began to make policies on how to treat what would be called "shell shock" and later "war neurosis." The treatment plans that were developed during this war were used as guidelines for the wars that would follow.

The idea of forward psychiatry was developed during World War I. Forward psychiatry is where the treatment is given to the soldier as close to the front lines as possible. This type of treatment was and has been proven the most effective type of treatment. Variations of the forward treatment would be used from World War I until the current conflicts in Iraq and Afghanistan.

The treatment of "war neurosis" would go largely unchanged after World War I. The name would change a number of times and finally end up as “post-traumatic stress disorder.” Over time, it was realized that post- traumatic stress disorder could appear in soldiers years after they had left the war zone. The late development could be caused by experiencing another traumatic event. This late development caused problems for veterans seeking treatment. For a long time, the policy of the Veterans Administration was that if symptoms lasted longer than six months or appeared after returning from war, then the condition was not connected to their time in the service.

From the 19th century until the present time society's views about death, dying, and mourning changed. The mid-19th century was known for the elaborate etiquette that governed every part of life, including death. Mourning in the 19th century was an elaborate process, which as time went on became less and less elaborate. As healthcare was advanced, people began to live longer and having to deal with the death of a loved one became something that was dealt with later in life.

The battlefield also changed during the span covered by this work. In the Civil War, there were advancements in guns and heavy artillery. While these improvements were meant to help with aim, the majority of soldiers died within 100 yards of their enemy.[220]

Throughout the 19th century, armies charged into battle as they had for centuries. When World War I began, a problem arose when these old tactics were used against the new machine gun, tank, and air plane. The tactics changed to incorporate these new advancements in war. Warfare remained the same until the Vietnam War.

During the Vietnam War, the military struggled to adapt to the guerrilla warfare was used by the North Vietnamese. There were no long bombardments keeping troops stuck in one place for weeks at a time as there

[220] Stephenson,*The Last Full Measure, 121*.

had been in the previous wars. Any lessons that were learned from fighting guerilla war during the Vietnam War were quickly forgotten with the conventional fighting used in the Persian Gulf War. It was not until the wars in Iraq and Afghanistan that the military again encountered guerilla warfare again.

The advancements on the battlefield and society have had a massive effect on the treatment and acceptance of post-traumatic stress disorder. Prior to the Civil War, there had been movements fighting for the better treatment of the mentally ill. While these movements did not greatly affect those diagnosed with "nostalgia," they began a step in the right direction. It also must be remembered that the majority of doctors had yet to accept germ theory, so understanding the interworking of the human mind was a bit farfetched.

The advancements on the battlefield during World War I had the biggest effect on the treatment of post-traumatic stress disorder. Many soldiers diagnosed with "shell shock" had been shocked by the blasting of a shell. The cause and effect of the disorder was easily identified. What confused medical professionals were the number of soldiers who were presenting symptoms and had been nowhere near the shell blast. Military psychiatrists began to realize that any soldier could develop these symptoms regardless of how close he had been to any shell blasts. The problem at this time was society's perception of mental illness. Civilian psychiatrists did not

regularly read what had been published by the military psychiatrists, and therefore, their treatment methods were rooted in the past.

The inventions that were debuted during World War I were further advanced by World War II and even more advanced by the Vietnam War. The airplane allowed soldiers to move from one place to another quickly and by the time of the Vietnam war, it allowed them to return from the war zone in the span of a day. The Vietnam war changed the nature of war. After the war, smaller armies began to realize that they had a small chance of victory when trying to engage major powers in a conventional fight. By engaging the superior power in small, sporadic engagements, they would drag the war out until popular opinion called the larger power to retreat.

The Persian Gulf War and the wars in Iraq and Afghanistan were further advanced by new technology and the speed of transportation. While the Persian Gulf War was largely a conventional war, guerrilla warfare was reintroduced in the latter wars. Society grew accustomed to seeing violence on television. The wars in Iraq and Afghanistan have become long and drawn out like the Vietnam War; the biggest difference has been the reception of soldiers when they return home.

War is a traumatic event, and every person experiences and deals with traumatic events differently. This is what makes treating post- traumatic stress disorder so difficult. Unlike gunshot wounds, post- traumatic stress disorder

does not always follow a set diagnostic line. Post-traumatic stress disorder does not leave visible wounds like gunshots do, but it can be just as fatal. There is a stigma that still exists with post- traumatic stress disorder, and that is harder to fight than any army.

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