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The Rhetoric of Shell Shock



When I was a teenager, one of my favorite comedians was George Carlin. In 1990, Carlin released a CD called Parental Advisory: Explicit Lyrics. The last track on the CD was a routine in which Carlin decried the use of euphemistic language and its effects on society. He began by describing an early medical term called shell shock and how, over time, the term had changed into something that, only 70 years later, was hardly recognizable from the original.

There's a condition in combat. Most people know about it. It's when a fighting person's nervous system has been stressed to its absolute peak and maximum -- can't take any more input. The nervous system has either snapped, or is about to snap.

In the First World War, that condition was called "shell shock." Simple, honest, direct language. Two syllables. Shell shock. Almost sounds like the guns themselves. That was 70 years ago.

Then a whole generation went by, and the Second World War came along, and the very same combat condition was called "battle fatigue." Four syllables now. Takes a little longer to say. Doesn't seem to hurt as much. Fatigue is a nicer word than shock. Shell shock. Battle fatigue.

Then we had the war in Korea. 1950. Madison Avenue was riding high by that time, and the very same combat condition was called

“operational exhaustion.” Hey, we’re up to eight syllables now. And the humanity has been squeezed completely out of the phrase. It’s totally sterile now. Operational exhaustion. Sounds like something that might happen to your car.

Then of course came the war in Vietnam, which has only been over now for about 16 or 17 years, and thanks to the lies and deceptions surrounding that war, I guess it’s no surprise that the very same condition was called “post-traumatic stress disorder.” Still eight syllables, but we’ve added a hyphen! And the pain is completely buried under jargon. (Carlin, track 15)

While not entirely accurate, George Carlin’s routine has stuck with me since I heard it 19 years ago. I’m not entirely sure why. Maybe it’s because I’ve worked as a writer and editor since my mid-twenties, and putting words together is how I make a living. Maybe it’s because my father is a Vietnam veteran who has struggled with the effects of post-traumatic stress disorder himself for more than 30 years. Whatever the reason (or reasons), I thought it would be an interesting subject to investigate. What exactly is shell shock? How did the term originate, and how and why did it eventually come to be known as post-traumatic stress disorder? What influence did rhetoric have on this change, and what implications does it have for changes to the language in the future? These are the questions this paper will attempt to answer.

I. Shell Shock: Origins and Definitions

While historical and literary references to the effects of trauma on mind and body date back for millennia, the first scientific analyses of the condition date back only to the late 1850s. In Great Britain, technological advances such as the railway system made travel more convenient, but also significantly more dangerous, and the number of railroad crashes occurring in Britain at the time was shockingly high. Among those affected was the writer Charles Dickens, who was involved in a horrific railroad crash in Staplehurst. While not seriously harmed, he wrote of witnessing “terrific sights” at the accident, and admitted

afterward, “I am not quite right within ... but believe it to be an effect of the railway shaking” (Turnbull 87).

In 1861, Dr. Waller Lewis created the term “railway spine”, and attributed it to post office employees who had been involved in railway crashes. People diagnosed with this condition suffered a range of physical and psychological problems, including difficulty sleeping, tinnitus, irritability, nightmares, and chronic pain (Lasiuk & Hegadoren I 15). Shortly after the first cases of railway spine were diagnosed, serious medical and legal debates arose concerning its origins, or etiology. In many cases, the symptoms of railway spine were present, but without any obvious sign of injury or neurological damage. As a result, it was often difficult to tell whether a person’s injuries were authentic, or whether they were only pretending to be injured so that they could receive financial compensation. Physicians and legal experts were left to deal with a series of difficult questions. Was the condition organic – that is, was it caused by some physical injury or wound – or psychological in nature? Did an accident cause railway spine, or was a person’s own experience with or interpretation of the event the actual source of the condition? These questions would continue to be played out in courts and medical circles over the next century.

War was another setting for research into the physical and psychological impact of trauma. In 1870, Dr. Arthur Meyers coined the term “soldier’s heart” to describe the effects of active duty on the cardiovascular system; symptoms included fatigue, heart palpitations, sweating, and tremors. The condition was thought to occur from having to carry extremely heavy amounts of equipment for long periods of time without rest, which forced the major blood vessels supplying the heart to pump excessively hard to maintain circulation (Jones 535). The following year, Jacob Mendez Da Costa, who had served as an Army surgeon in the American Civil War, expanded on Meyers’ description, and concluded that soldier’s heart (renamed Da Costa’s syndrome in the U.S.) was a strictly biological response to the stress of combat.

Following the Civil War, interest in the study of trauma essentially disappeared until the outbreak of World War I, which elevated

the numbers of death and injury from warfare to levels never before seen in human history. In a little over four years of fighting, an estimated 16 million people were killed, another 21 million were wounded, and the world's geopolitical structure would be forever changed.

World War I was also the first war in which both sides employed high numbers of ordinance such as mortars, grenades, and artillery shells, some of which could be fired upon enemy troops from a distance of several miles. The constant threat of death from artillery, combined with the grisliness of trench warfare, miserable living conditions, and the sight of killing on a massive scale, inevitably took their toll on hundreds of thousands of servicemen whose minds and bodies could no longer take the strain of accumulated trauma. Increasing numbers of soldiers who had been close to a shell explosion, but showed no outward signs of injury, began to present a puzzling array of symptoms, ranging from amnesia and headache to tinnitus, dizziness, an inability to concentrate, and hypersensitivity to noise.

British physicians, unsure of the exact cause of the symptoms, began using the term “shell shock” to describe cases that occurred as a result of close exposure to exploding shells and ordinance. The first published article on shell shock appeared in the *Lancet* in 1915; between 1915 and November 1918, dozens of articles describing the effects of shell shock would appear in medical journals throughout Europe and North America.

Whether the result of a physical wound or psychological stress, shell shock was one of the leading causes of casualty in World War I. By some estimates, 10 percent of all British battle casualties were categorized as shell shock. 80 percent of servicemen who were diagnosed with severe shell shock never returned to active duty because of their disabilities (Anderson 212). In October 1917, an American officer, Thomas Salmon, estimated that shell shock was responsible for one-seventh of all discharges from the British Army – a number that rose to one-third when physical wounds were excluded (Jones, Fear & Wessely 1642). One year after the war's end, 38 percent of all hospitalized

veterans in the United States were classified as mental or nervous cases. Similar results were seen among British, French and German troops (Anderson 205).

II. Shell Shock: Changes in Definition and Language

As was the case in the years following the Civil War, interest in the treatment of trauma and its effects on mind and body waned in the decades that followed World War I, only to re-emerge with the start of World War II in 1939. Instead of calling it shell shock, military physicians and psychiatrists in Great Britain came up with the phrase “postconcussion syndrome” to describe the condition. However, many of the symptoms used to diagnose postconcussion syndrome, such as headaches, fatigue, dizziness, and tinnitus, were identical to those used to diagnose shell shock a quarter-century earlier, and physicians were left to grapple with the same diagnostic problems seen in World War I. John Fulton, an American professor writing about the condition in the *New England Journal of Medicine*, admitted that it was “delicate and often difficult” to differentiate physical cases of postconcussion syndrome from psychological cases (Fulton 2).

New terms for shell shock continued to appear in the medical literature as World War II progressed. “Exhaustion” and “battle exhaustion” were first used by British medical personnel in 1942, based on the recommendations of Brigadier General W.B. James, a consultant in psychiatry to the British Middle East Force. Having studied the British Eighth Army’s desert campaign in North Africa for two years, he concluded that the campaign had “exhausted the Eighth Army both mentally and physically” (Jones and Wessely 229), and chose the terms to suggest that they were temporary physical and mental states from which soldiers could recover over time.

In the United States, a variety of terms were used during World War II. “War neurosis” was used by psychiatrists, but the more common phrase among soldiers in the field was “battle fatigue,” along with shell shock, especially by older servicemen who had served in World War I. In some instances, the rates of battle fatigue among American soldiers in World War II far exceeded what had been reported during World War

I; at times, up to 40 percent of all soldiers incapacitated in action were diagnosed with some type of neuropsychiatric disorder (Pols 145).

Alarmed at the high number of servicemen being diagnosed with battle fatigue and its impact on the Army's ability to wage war, General Omar Bradley issued a two-part directive in April 1943 regarding the treatment of all psychiatric casualties. First, casualties were to be held for a minimum of seven days and evaluated by a qualified medical provider before being sent to the rear for further treatment or returned to active duty. Second, terms such as shell shock and battle fatigue were to be discontinued; in their place, medical personnel were instructed to use the term "exhaustion" as the initial diagnosis for all combat casualties determined to be psychiatric in nature (Jones 87).

As the war progressed, battle fatigue and exhaustion continued to take its toll on the U.S. Army, and severely hampered its ability to wage war. In September 1943, for example, the Army inducted 118,600 new recruits, but at the same time, it evacuated or discharged 112,500 enlisted men due to combat fatigue and related ailments. By the war's end, more than 504,000 American servicemen were classified as psychiatric casualties and were permanently lost from service (Anderson 206).

In October 1945, the U.S. Army officially replaced "exhaustion" with "combat exhaustion." This change was instituted by Albert Glass, a psychiatrist and Army colonel, and was designed to eliminate diagnoses of psychoneurosis or personality disorder from battle casualties, while emphasizing the role of combat as the primary cause of trauma. The term, also sometimes referred to as "operational exhaustion," was first applied to soldiers serving in the Korean War.

In 1952, at the height of the Korean War, the American Psychiatric Association published its first edition of the Diagnostic and Statistical Manual of Mental Disorders. While not including shell shock or battle fatigue, the manual (DSM-I) included a diagnostic category for "gross stress reaction" that included combat as a causative factor. The diagnosis was seen as appropriate for cases involving exposure to "severe physical demands or extreme stress, such as in combat or civilian

catastrophe” (DSM-I 4).

Starting with the Vietnam War, “combat exhaustion” was phased out in favor of “combat fatigue.” Research on servicemen in the Second World War and the Korean War had shown that even the best soldiers could suffer from mental and physical breakdowns if they were subjected to prolonged fighting. Combat fatigue, a term also introduced by Albert Glass, was intended to convey the message that a normal person who had demonstrated previously satisfactory military service could also be overwhelmed by the stress of intense or prolonged combat (Jones & Wessely 226). Like the conditions before it, the symptoms of combat fatigue included irritability, sleep deprivation, nightmares, depression, and lack of food intake.

In 1980, the American Psychiatric Association published its third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Included in the DSM III, under a section on anxiety disorders, the association provided the diagnostic criteria for a new term, “post-traumatic stress disorder,” or PTSD. While avoiding any mention of combat, the diagnosis was written in such a way that it could be applied to any person who “has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone” (Lasiuk & Hegadoren II 73). Since its first incarnation, PTSD has undergone three minor revisions, but today, it remains the standard diagnosis used for anyone affected by a serious traumatic event.

III. Shell Shock: Rhetorical Implications

In less than 65 years, the term used to describe the physiological and psychological effects of prolonged exposure to combat was changed from a simple, two-word phrase to an eight-syllable term that is often replaced with an acronym. How and why did this change happen? And what are the rhetorical issues surrounding this significant change in language, not just for shell shock, but for language in general?

To answer these questions, one must first define the terms in question from a medical perspective. Dorland’s Medical Dictionary defines shock as “a sudden disturbance of mental equilibrium.” Shell shock is included as a subcategory of shock; in fact, it is referred to as

“a term used during World War I to refer to a wide variety of mental disorders associated with combat experience” that is “now called post-traumatic stress disorder.” Exhaustion is defined as “a state of extreme mental or physical fatigue.” Dorland’s defines fatigue as “a state of increased discomfort and decreased efficiency resulting from prolonged or excessive exertion.” Stress is considered “the sum of the biological reactions to any adverse stimulus, physical, mental, or emotional, internal or external, that tends to disturb the organism’s homeostasis,” and the dictionary warns that inappropriate or inadequate responses to stress “may lead to disorders,” but does not list what those disorders are. Curiously, Dorland’s does not include a definition for post-traumatic stress disorder.

As one analyzes the definitions, a pattern begins to emerge. Just as Carlin noted in his routine, the language is softened with each succeeding term. Exhaustion has less of a negative connotation than shock; fatigue is a softer term than exhaustion; and stress is defined in such a way that any type of factor can cause a stressful reaction. At the same time, one can see connections between the terms. Stress is a type of physical exertion, excessive amounts of which can lead to fatigue. Overabundance of fatigue causes one to become exhausted, which can lead, eventually, to post-traumatic stress disorder.

The same pattern emerges when one examines the actual terms used by the military. Shell shock, which was used predominantly during World War I, is an alliterative phrase with two syllables, and makes a direct reference to the cause of shock – an exploding shell. Battle fatigue and combat fatigue, which were used unofficially in the early parts World War II and again during the Vietnam War, still include a reference to causation: battle and/or combat. Yet both phrases are four syllables, double the number in shell shock, and they use a less negative descriptor in fatigue. Combat exhaustion and operational exhaustion, used during the Korean War, up the syllable count again, in one instance making the phrase four times as long as shell shock, and the direct references to the cause of the condition are removed completely. Post-traumatic stress disorder, a term which did not officially exist until 1980 but which

has been applied to veterans of the Vietnam War and all other military conflicts since, adds a hyphen and softens the language yet again. The person's body is no longer in shock or injured, but is in "disorder" as the result of some type of "stress," which may have nothing to do with combat. (Similar changes are seen in the diagnostic criteria for shell shock, gross stress reaction and post-traumatic stress disorder, all of which are included at the end of this article; please see Tables I-III for review.)

The use of rhetoric, therefore, seems to have played a defining role in the use of shell shock as a medical diagnosis, along with its subsequent derivations. In *Rhetoric*, Aristotle states that "the use of persuasive speech is to lead to decisions" (Aristotle 219), and offers various lines of argument to help prove or disprove a statement. One line of argument that can be used is "the assertion that some possible motive for an event or state of things is the real one" (Aristotle 230). Another line recommended by Aristotle is to show that if the cause is present, the effect is present, and if absent, absent. For by proving the cause you at once prove the effect, and conversely nothing can exist without its cause" (Aristotle 231).

These rhetorical arguments can be seen at work in the earliest discussion over the etiology of shell shock. In fact, almost immediately after the term "shell shock" was first used, critics began calling for it to be modified, if not completely removed from the medical literature, due to questions about the condition's origins and the inability of physicians to render a correct diagnosis. Because soldiers presented with symptoms that were remarkably similar to those experienced by servicemen who had suffered an actual head wound, diagnosing the condition became difficult. Many of the symptoms of shell shock, such as irritability, tinnitus, and difficulty sleeping, had also been seen in people diagnosed with railway spine in the 1860s. As a result, the same questions that had been posed about the etiology of railway spine a half-century earlier were soon being asked about shell shock.

At the outbreak of World War I, the medical profession was divided into two rival schools of thought as to the cause of shell shock.

Dr. Frederick Mott, Britain's leading neuropathologist in the early 20th century, believed that the forces of compression and decompression that occurred in close proximity to an explosion damaged "the delicate colloidal structures of the living tissues of the brain and spinal cord," adversely affecting "the functions of the vital centers in the medulla" (Jones, Fear & Wessely 1642). Carbon monoxide released by an exploding shell or mortar, he thought, could also damage the central nervous system. In either case, while the exact nature of shell shock remained unclear, Mott considered it "an organic problem," a physical injury that produced an array of debilitating side-effects (Jones, Fear & Wessely 1642).

In the other camp were members of the psychiatric and psychological professions, led by Captain Charles S. Myers, a specialist in psychology and consultant to the British Expeditionary Force and the author of the seminal *Lancet* article on shell shock. Based on personal observations of wounded soldiers, and the discovery that many veterans suffering from shell shock were nowhere near a shell explosion when the condition first appeared, but nevertheless developed symptoms identical to those who had, Myers surmised that shell shock was psychological, rather than physical, in origin.

Essentially, it seems that Myers was using Aristotle's cause and effect argument to disprove Mott's theory that shell shock was physical in nature. Mott theorized that shell shock was caused by physical changes to the brain, or the presence of gases that damaged the nervous system. Myers used Aristotle's proofs to refute those claims. If a soldier exhibited all of the signs of shell shock, but wasn't physically wounded by a shell or hadn't inhaled any noxious gases, then how could it be caused by physical trauma alone? And if it was possible that shell shock was a psychological reaction to combat, couldn't it be a real reaction?

The Army Council eventually sided with Myers' explanation. Based on his recommendations, in 1915 the Army Council created two distinct classifications for shell shock: W and S. Shell shock (W) cases were those wounded by direct action, such as an exploding shell, while shell shock (S) cases were those suffering from "nervousness" and

anxiety. This decision had significant ramifications for the professions of psychiatry and psychology. Had the Army Council accepted Mott's theory that shell shock was caused by physical injury only, then psychiatrists and psychologists would have been largely unable to improve the condition of many servicemen, and the standing of Myers and his followers would have been greatly reduced in the eyes of the military. However, labeling shell shock as the result of some kind of psychological trauma allowed for the possibility of recovery, at least on a limited basis. Perhaps something considered untreatable could be treated after all, and perhaps the fledgling psychiatric profession – of which Myers was a leading member – could reach new levels of respect, legitimacy and influence.

There is little doubt that financial considerations also factored in the decision to abandon the use of shell shock, and that rhetorical arguments were used to justify these considerations. In December 1916, the Ministry of Pensions was placed in charge of benefits and duties for wounded veterans in Great Britain, and the awarding of pensions was revised so that wounded soldiers would receive compensation, depending on the severity of their injuries. The loss of two or more limbs merited a 100 percent pension, while the loss of a leg above the knee qualified one for a 60 percent pension; below the knee, a 50 percent pension (Jones, Palmer & Wessely 375).

While it was easy for doctors to administer pensions for the loss of a limb, shell shock often manifested with no visible signs of injury, making it far more difficult to categorize. Moreover, the different diagnoses of shell shock conferred different benefits. Shell shock (W) cases were entitled to wear a wound stripe on their uniform, were usually invalidated from the front to Great Britain and, depending on the severity of injury, were entitled to receive a pension for their wounds. Shell shock (S) cases, on the other hand, were not entitled to a wound stripe or pension, usually received treatment at a field hospital close to the front, and could be returned to active duty after receiving care.

One month after World War I ended, approximately 32,000 pensions had been given to British soldiers diagnosed with shell

shock and other nervous disorders. By March 1921, that number had more than doubled to 65,000, creating an annual expenditure of approximately six million pounds, presenting a substantial financial problem to a government struggling to deal with a global financial downturn (Jones & Wessely 151). In the United States, the cost was even higher. By some estimates, the federal government spent as much as a billion dollars treating the psychiatric problems experienced by veteran soldiers between World War I and World War II. In 1940 alone, the cost amounted to \$42 million (Anderson 214).

It should come as little surprise, then, that the British government made a concerted effort to discourage the use of shell shock as a medical term, and that it enlisted the help of the psychiatric profession to do so. In 1920, the War Office appointed the Southborough Committee to essentially prevent outbreaks of shell shock from occurring in future military conflicts. In 1922, the committee issued its official report, which recommended that the term be “eliminated from official nomenclature,” and that “no case of psycho-neurosis or mental breakdown, even when attributed to a shell explosion or the effects thereof, should be classified as a battle casualty any more than sickness or disease is so regarded” (Southborough 190). In July 1939, two months before the start of World War II, the Ministry of Pensions assembled a committee of representatives and psychiatrists to make policy recommendations on war syndromes. The committee expanded on the conclusions of the Southborough report, and recommended that “such terms as ‘shell shock,’ which may suggest that these nervous symptoms have a physical basis or are due directly to injury, must be rigidly avoided” (Jones, Palmer & Wessely 376).

Here – and throughout all of the manifestations shell shock has undergone in the past 90 years – one can see Michel Foucault’s description, taken from “The Archaeology of Knowledge,” of the psychiatric profession as a group that limits and defines objects. According to Foucault, “In these fields of initial differentiation ... psychiatric discourse finds a way of limiting its domain, of defining what it is talking about, of giving it the status of an object – and therefore

of making it manifest, nameable, and describable” (Foucault 1437). Both the Southborough and Ministry of Pensions committees were staffed by psychiatrists, and the Southborough report provided the first working definition of shell shock in the scientific literature, using phrases such as “emotional shock” and “nervous and mental exhaustion” (Southborough 92). Thus, the psychiatric profession played a significant role in determining what shell shock was; by including exhaustion in the definition, it may have acted as a precursor to the U.S. Army’s decision to rename the term exhaustion in 1943.

One also sees examples of “the authorities of delimitation” such as the medical profession at work. Foucault writes that “in the nineteenth century, medicine ... became the major authority in society that delimited, designated, named, and established madness as an object,” (Foucault 1437). It functions as one of many “systems of exclusion” that “have to do with the part of discourse which puts power and desire at stake” (Foucault 1464). While he is writing about the definition of madness, the medical profession’s ability to name conditions and diagnoses can be applied just as easily to shell shock. At the same time the profession could provide a definition of what shell shock was, it also excluded criteria; the recommendation of the Southborough Committee that “no case of psycho-neurosis or mental breakdown ... be classified as a battle casualty” indicates the committee’s power in this area. In essence, the committee was given free reign to decide what shell shock was (or was not), what conditions caused it (or did not cause it), and whether or not it should be treated as an actual casualty (or a type of sickness or disease). The members of the committee were essentially hand-picked by officials from the War Office, which suggests that while its intentions may have appeared objective on the surface, the decision to not classify shell shock as a type of physical trauma may have been formulated well before the committee first convened. This indicates the power of the state and the medical profession in general, and the committee in particular, in determining whether shell shock is a physical or psychological disorder – determining, in a way, whether the condition actually exists.

IV. Shell Shock: Final Thoughts and Observations

George Carlin ended his routine on shell shock and post-traumatic disorder by telling the audience, “I’ll betcha, if we’d have still been calling it shell shock, some of those Vietnam veterans might have gotten the attention they needed at the time. I’ll betcha” (Carlin, track 15). As the son of a Vietnam veteran, I agree with this statement completely. I’ve witnessed some of the effects of PTSD first-hand – the flashbacks, the memory lapses, the inability to concentrate. And I’ve seen the same effects in colleagues who have served in Iraq and Afghanistan. Some of them have been diagnosed with PTSD; others with a new term, traumatic brain injury (TBI).

For my father, the effects of the physical and mental injuries he suffered in combat linger to this day, and by a twist of irony he is reminded, at least indirectly, of his experiences in Vietnam on a regular basis. In 1982, the Vietnam Veterans Memorial – often referred to as “The Wall” – was dedicated in Washington, D.C. Two years later, a portable scale model of the wall known as “The Moving Wall” was created; it is still displayed at numerous sites throughout the country each year. The creator of the Moving Wall is a Vietnam veteran named John Devitt – which also happens to be my father’s name (The Virtual Wall). Occasionally, he is asked if he is “that” John Devitt. One can see his shoulders slump and his eyes fall toward the ground before offering a simple, “no,” and then doing his best to change the subject.

The unfortunate part of this experience is that changing the subject is exactly what the psychiatric profession, the military, and various government agencies have tried to do with shell shock since the term was first used in the scientific literature. For decades, military physicians and government officials have devised new ways to describe the effects of prolonged stress and trauma under combat, without fully exploring the consequences of their actions. What they have failed to realize is that changing the name of the condition does not change the condition, nor does it relieve the pain and suffering that thousands of American soldiers continue to feel. At best, they are guilty of misdirection and obfuscation; at worst, they are guilty of deluding people

and creating false hope where none should exist.

By no means am I a Luddite. In some instances, I do think changes in language are necessary, even justified. For instance, many companies now have a chairperson or chair instead of a chairman, which has helped to remove the gender bias that was endemic to the American business sector for centuries. Most people refer to the human race as humankind instead of mankind. And if a person needs help, they can flag down a police officer or firefighter instead of a policeman or fireman. As the example of shell shock in this paper shows, however, I think there are times when the shorter and more direct the language is, the better. I also think that the amount of soft, politically correct, euphemistic language we use today is a significant reason why so many people have difficulty communicating with one another. What we really want to say to someone is buried under layers of jargon, and we're so concerned about saying the wrong thing, or something that might insult the other person, that we essentially end up saying nothing. There are times where softening the language is appropriate, but I think that most of the time, this softer, euphemistic language ends up causing more harm than good. If you don't think so, just ask someone who's been diagnosed with post-traumatic stress disorder – or their son.

Table I: Diagnostic Classification of Shell Shock, Army Council, 1915

- Shell Shock, Wound (W) = Wounded by direct action, i.e., exploding shell.
- Shell Shock, Sickness (S) = Sickness, i.e., mental disturbance/nervousness

Table II: Diagnostic Criteria, Gross Stress Reaction (Diagnostic and Statistical Manual of the American Psychiatric Association, First Edition (DSM-I), 1952

Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of neurosis or

psychosis chiefly with respect to clinical history, reversibility of reaction, and its transient character. When promptly and adequately treated, the condition may clear rapidly. It is also possible that the condition may progress to one of neurotic reactions. If the reaction persists, this term is to be regarded as a temporary diagnosis to be used only until a more definitive diagnosis can be established.

This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.). In many instances this diagnosis applies to previously more or less "normal" persons who have experienced intolerable stress.

The particular stress involved will be specified as (1) combat or (2) civilian catastrophe.

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**Table III: Diagnostic Criteria, Post-Traumatic Stress Disorder
(Diagnostic and Statistical Manual of the American Psychiatric
Association, Third Edition (DSM-III), 1980**

- A. Existence of recognizable stressor that would evoke significant symptoms of distress in almost anyone.
- B. Re-experiencing of the trauma as evidenced by at least one of the following:
1. Recurrent and intrusive recollections of the event.
 2. Recurrent dreams of the event.
 3. Sudden acting or feeling as if the traumatic event were recurring, because of an association with an environmental or ideational stimulus.
- C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following.
1. Markedly diminished interest in one or more significant activities.
 2. Feeling of detachment or estrangement from others.
 3. Constricted affect.

- D. At least two of the following symptoms that were not present before the trauma:
1. Hyperalertness or exaggerated startle response.
 2. Sleep disturbance.
 3. Guilt about surviving while others have not, or about behavior required for survival.
 4. Memory impairment or trouble concentrating.
 5. Avoidance of activities that arouse recollection of the traumatic event.
 6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

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