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FROM “COWARDICE” TO “SHELLSHOCK”: THE DEFINITION AND TREATMENT OF MENTAL HEALTH IN THE UNITED STATES MARINE CORPS DURING THE AGE OF THE GREAT WAR

A Thesis

by

ITZEL MÁRQUEZ

Submitted in Partial Fulfillment of the

Requirements for the Degree of

MASTER OF ARTS

Major Subject: History

The University of Texas Rio Grande Valley

May 2023

FROM “COWARDICE” TO “SHELLSHOCK”: THE DEFINITION AND TREATMENT OF

MENTAL HEALTH IN THE UNITED STATES MARINE CORPS

DURING THE AGE OF THE GREAT WAR

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ITZEL MÁRQUEZ

COMMITTEE MEMBERS

Dr. Michael Faubion
Committee Chair

Dr. Friederike Bruehoefener
Committee Member

Dr. David Fisher
Committee Member

Dr. Irving Levinson
Committee Member

May 2023

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ABSTRACT

Marquez, Itzel, From "Cowardice" To "Shellshock": The Definition and Treatment Of Mental Health In The United States Marine Corps During The Age Of The Great War. Master of Arts (MA), May, 2023, 73 pp., 1 figure, references, 94 titles.

The aim of my master's thesis is to study how the United States' Marine Corps recognized, defined, and treated mental health issues during the Great War and how this translated into the treatment of Marines by their peers and commanding officers. Similar to other countries that fought in the Great War, also referred to as World War I, the United States witnessed intense discussions about the psychological effects of war. The question of whether and how modern warfare affected troops' mental health was addressed by all branches of the United States' military. Yet, the issue of mental health in the Marine Corps has received little scholarly attention. To fill this gap, my thesis will analyze official Marine Corps' documents such as protocols, orders, communiques, as well as medical reports, bulletins, and journals. In addition, it will gauge soldiers' personal narratives such as diaries, letters, and memoirs. The analysis of these primary sources mirrors the approach taken by Joanna Bourke and is classified as a New Military History. I found a gradual shift within the Marine Corps towards acceptance of mental illness as an injury to be treated as opposed to cowardice. This was seemingly a gradual increase in recognition of mental illness as seen through various editions and publications of officer's manuals, legislative actions, and medical journals and bulletins.

DEDICATION

The completion of this master's thesis would not have been possible without the love and support of my family, friends, and dearest pets. Thank you, Omar, for bringing me coffee, allowing me to brainstorm and brain dump, and cry when writing became too much. I would also like to dedicate this thesis to the early mornings, sleepless nights, tears, countless drafts, and hours of procrastination. Those moments and sacrifices brought me to the completion of this thesis.

ACKNOWLEDGMENTS

I will be forever grateful Dr. Friederike Bruehoefener, Committee Chair during much of the development of this thesis, for her advice guidance, and patience. Your feedback, recommendations, and advice have helped me develop into a better researcher and writer. Thank you for always reminding me there is such a thing as enough research.

I would like to thank the United States National Archives at Washington D.C. for the countless hours of help and assistance they graciously provided.

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CHAPTER I

INTRODUCTION

Mental health and illness are stigmatized subjects even though discussed on television, in movies, the news, or even social media. The manifestation of mental illness was even more stigmatized in the past. Servicemen and women experienced physical and psychological trauma during their deployment. The current military practice is for recruitment officers to screen prospective servicemen and women prior to signing their enlistments in order to prevent those most susceptible to mental health problems from joining the military, a practice started in 1944 with the introduction of the Neuropsychiatric Screening Adjunct.[1] However, the Neuropsychiatric Screening Adjunct was not uniform and an investigation by the Surgeon General found the screening to poorly predict concerns with mental health.[2] A standardized screening was not introduced until 1974.[3] Currently, servicemen and women in all branches of the military who experience mental illness as a result of service are diagnosed and can receive treatment.

The question remains: how were soldiers treated prior to the 21st century? During World War I, were the same approaches taken for servicemen? In short, no. Just as medical knowledge

[1] Robert A. Cardona and Elspeth Carmon Ritchie, "U.S. Military Enlisted Accession Mental Health Screening: History and Current Practice," *Military Medicine* 172, no.1 (2007): 31-32.
[2] Cardona and Ritchie, "U.S. Military Enlisted Accession Mental Health Screening: History and Current Practice," 32.
[3] Cardona and Ritchie, "U.S. Military Enlisted Accession Mental Health Screening: History and Current Practice," 33-34.

has improved, so too has psychiatric knowledge. In the wake of World War I, the term "coward" was used by military officials to refer to soldiers who were manifesting symptoms of mental illness. For example, in a 1922 report to the British Parliament by King George V's Stationary Office, cowardice was a crime because "cowardice is showing signs of fear in the face of the enemy."[4] Cowardice was seen as abandoning one's post, tremors, and fits of hysteria, among other things. In essence, "cowardice is a military crime for which the death penalty may be exacted."[5] Cowardice was defined as the absence of bravery. This was a subjective term as seen through the differing responses. These responses linked cowardice and shell-shock together, illustrating the stigma or lack of understanding towards mental health. Experts writing the report remarked that "with the second lieutenants it was their one fear that they shouldn't show cowardice in front of their men,"[6] while Dr. Farquhar Buzzard, a psychiatrist cited in the report, claimed, "I quite see that fear passes to cowardice. But fear is really an unconscious thing and has a very definite physical manifestation."[7] However, he remarked

> cowardice is a voluntary attitude taken up by an individual; he adopts a certain attitude that he will not face a situation in which he believes certain things will take place. That is cowardice, if you like to apply the term, but the fact that my knees shake when I am looking over the side of a building is an absolute physical thing over which I have no control.[8]

[4] *Report of the War Office Committee of Enquiry Into "Shell-Shock": Presented to Parliament by Command of His Majesty* (London: H M Stationary Office, 1922),138.
[5] *Report of the War Office Committee of Enquiry Into "Shell-Shock,"* 138.
[6] *Report of the War Office Committee of Enquiry Into "Shell-Shock,"* 138-139.
[7] *Report of the War Office Committee of Enquiry Into "Shell-Shock,"* 138.
[8] *Report of the War Office Committee of Enquiry Into "Shell-Shock,"* 141-142.

The above-mentioned opinions on mental health exemplify the uncertainty and lack of significant research on the topic at the time. This report exemplifies the perspective of British experts analyzing the experience of the British troops, not that of American servicemen, let alone Marines. The report does, however, bring to light the back-and-forth argument around what cowardice was and its role on the battlefield. The aim of my master's thesis is to analyze how the United States Marine Corps sought to prevent, address, and treat "mental illnesses" among servicemen who fought in the first world war. Focusing on the period between 1917 to 1937, I seek to investigate initiatives, trainings, or protocols that the Marine Corps' military and medical leadership developed in order to address mental disorders among its troops, and how these initiatives changed over time. This time frame is based on the participation of the United States military in World War I and the inter war period prior to World War II. As historical scholarship has shown, the wars constituted turning points for the United States' military strategy and technology. The war also saw the development of psychiatric treatment for Shell Shock casualties. At the same time, the nature of the two world wars and the ways they were fought led to the widespread emergence and recognition of, to use the contemporary term, "shell shock syndrome."[9]

While diving into historical works and psychological studies, I noticed an absence in Marine Corps military history; most scholars focus on the Army. While there are numerous studies that analyze this history for the U.S. Army, the questions that drive my research have not been answered for the Marines. What mental disorders did individual Marines report as a result of their time in combat? How did different members of what constitutes Marine Corps combat veterans

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[9] Mary McDonald, Marissa Brandt, and Robyn Bluhm, "From Shell-Shock to PTSD: A Century of Invisible War Trauma," *The Conversation*, https://theconversation.com/from-shell-shock-to-ptsd-a-century-of-invisible-war-trauma-74911?fbclid=IwAR3TBsMDbfatIT3RDlDD0RbH9EBMrSa9f__MldOKw4VIVyv2wJJg-1vBb1E

report mental distress and were their experiences at reintegrating into society different from their commanding officers? How were individual Marines treated by commanding officers and superiors during World War I when they experienced symptoms of shell shock: tremors, nightmares, anxiety attacks, and hysteria? How did their treatment during World War II differ from the previous war? These questions, though numerous, are all intended to assist in answering the main question: how was mental illness viewed within the Marine Corps?

There a total of 70,849 enlisted and 2,474 officers who took part in Worl War I as Marines. Generally speaking, there was a lack of available first hand accounts from individuals who experienced shell shock or the after effects and stigma. However, it was quickly identified and noted the Marine Corps did view Shell Shock as a war wound that was treated as any other injury. However, social stigmas were present, and the perspective of how Shell Shocked casualties should be treated and worked with changed over time.

CHAPTER II

HISTORIOGRAPHY, THEORY, AND METHODOLOGY

Due to the nature of my research, my thesis builds on and intersects with several disciplines including psychological studies and historiographical fields. According to recent studies in the field of psychology, mental disorders among soldiers are typically the product of their time in combat.[10] It is important to look at contemporary works that analyze soldiers who have experienced combat. Although this study does not consider the changes in culture as well as the emotional, social, and psychological differences between soldiers who fought between 1917 and 1947 as opposed to those who have fought in the twenty-first century, the knowledge of how mental illness can affect soldiers allows for a different perspective to be taken while reading historical works.

Overall, researchers agree that leadership and successful screening of soldiers who may have a predisposition to mental illness are essential in order to prevent or decrease the likelihood of having large percentages of soldier's experience symptoms of mental illness. For example, *Hero or Coward Pressures Facing the Soldier in Battle* by Elmar Dinter combines psychology and history[11] to analyze the connection between officers and soldiers and the effect commanding officers have on their subordinates, correlating with Marcus VanSickel's co-produced articles

[10] Alyssa Boasso, et. al. "The Relationship Between Course of PTSD Symptoms in Deployed U.S. Marines and Degree of Combat Exposure," *Journal of Traumatic Stress* 28, no.1 (2015): 73.
[11] Elmar Dinter, *Hero or Coward: Pressures Facing the Soldier in Battle*. New York: Frank Cass (1985), 1-3.

analyzing the effect officers have on preventing suicide among members of their unit.[12] Alyssa Boasso and Allison Levin argue in favor of a correlation between combat exposure, meaning the time spent on the front lines, and the symptoms of PTSD.[13] Levin states that symptoms are further affected by sociodemographic factors.[14] These psychological studies are based on Marines who fought in the 21st century. However, the amount of time spent on the front lines, the type of action seen, and the available services intended to combat and suppress mental distress have a direct connection to symptoms of PTSD for Marines between 1917 and 1937.

In comparison to the psychological approach taken above, traditional military history focuses mainly on the analysis of strategy, battles, or individuals.[15] Traditional military history is the origin of many of my research questions and provides background information for my research. Several studies that are relevant for my research, have been written by veterans or military historians and focus specifically on strategy, policy, battles, and most importantly a history of the Marine Corps. For instance, Colonel William Miller and Carolyn Tyson's studies provide context for understanding the practices of the United States Marine Corps during World Wars I and II.

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[12] Marcus VanSickle, et. al., "Perceived Barriers to Seeking Mental Health Care Among United States Marine Corps Noncommissioned Officers Serving as Gatekeepers for Suicide Prevention," *Psychological Assessment* 28, no.8 (2016): 1020-1025.
Both authors cite the importance of a commanding officer and their ability to lead and create a bond within the unit as a deterrent to major symptoms of mental illness. In the case of VanSickle's article, suicide is the main focus of the research, and how non-commissioned officers require adequate training to support the mental health and integrity of their unit.

[13] Alyssa Boasso, et. al. "The Relationship Between Course of PTSD Symptoms in Deployed U.S. Marines and Degree of Combat Exposure," *Journal of Traumatic Stress,* 76 (2015): 73.

[14] Allison Levin, et. al. "Predictors of Post-Traumatic Stress Disorder, Anxiety Disorders, Depressive Disorders, and Any Mental Health Condition Among U.S. Soldiers and Marines, 2001-2011," *Journal of Traumatic Stress* 31, no. 4 (2018): 568.

[15] William M. Miller and John H. Johnstone, *Chronology of the United States Marine Corps, 1775–1934* Vol. 1 (Washington: History and Museums Division, Headquarters, U.S. Marine Corps, 1965), 3. Carolyn Tyson, *A Chronology of the United States Marine Corps, 1935-1946,* Vol. 2 (Washington: History and Museums Division, Headquarters, U.S. Marine Corps, 1965) 107-110. Tyson, Miller, and Johnston focus heavily on strategy and military policy used during their respective time periods. See also: Joanna Bourke, "New Military History," in *Palgrave Advances in Modern Military History*, (Basingstoke: Palgrave Macmillan, 2006), 273.

Miller and Tyson wrote separate volumes of United States Marine Corps history from 1775 through 1934: *Chronology of the United States Marine Corps, 1775-1934,* Vol. 1 by William Miller, and *Chronology of the United States Marine Corps, 1935-1946,* Vol. 2 by Carolyn Tyson. These volumes provide broad insights into the Marine Corps' history. This is best exemplified through the discussion of how the military organized itself and functioned.[16] At the same time, however, the authors omit any negative information or questions regarding the morality of war. They also fail to provide any information regarding mental health or steps taken to prepare soldiers to cope with mental illness. Although the authors do not answer questions about how soldiers internalized what was happening, it is possible to identify causes and triggers for mental health within these books.[17] The foundation created by these authors allows for a basic understanding of policy and practice. For example, Miller makes the first reference to rest and relaxation being used during World War I as a deterrent for battle fatigue.

Battle fatigue is cited by recent studies as being a precursor to shell shock.[18] Annette Amerman's *United States Marine Corps in the First World War: Anthology, Selected Bibliography, and Annotated Order of Battle* continues the discussion initiated by Miller and Tyson on basic training, daily life, the front lines, and organization within the Marine Corps. This book is a streamlining of Colonel William Miller's original historiography of the United States Marine Corps. Amerman, unlike her predecessors, focuses more on World War I and has some

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[16] Miller and Johnstone, *Chronology of the United States Marine Corps,* 5-10.
Tyson, *A Chronology of the United States Marine Corps*, 117-119.
[17] Miller and Johnstone, *Chronology of the United States Marine Corps,* 119-120;
Tyson, *A Chronology of the United States Marine Corps*, 1-5. Both books are organized like a large timeline. There is only reference to strategy, engagements, and actions taken by the Marine Corps.
[18] Col. William Miller, *Chronology of the United States Marine Corps, 1775-1934,* Vol. 1, 117-127. The last sections of the volume focus on the military events leading up to and immediately following World War I. The volume's time period in question is not the result of wanting to condense history. Instead, much of military practice and policy remained the same during the time period in question.

mention of internalization of external factors. She adds to and develops Miller's discussion regarding battle fatigue.[19] In addition, Dave Grossman's *On Killing: The Psychological Cost of Learning to Kill in War and Society* is another important study that focuses on the psychological ramifications of killing and teaching soldiers how to kill.[20] Grossman analyzes the processes taken to train soldiers to kill as well as the types of diagnoses given during this time period. In 1946, Grossman cites fear of death and injury as psychiatric casualties that until the late 1950s would remain classified as mental illness.[21] This shows the level to which men were expected to function. If fear of death was a mental illness, then the expectation for a soldier would be to not fear death. Similarly, historian Edward Holmes analyzes the behaviors of soldiers and how they were indoctrinated into acting differently than their morals would typically allow.[22] These three historians take into account the effects war had on the soldier rather than focusing on battle strategy, locations, and dates like Miller and Tyson had previously. Further they note external factors that shaped how soldiers internalized their experiences. Mental health as mentioned by other historians had been an issue and a question since World War II. However, doctors were reluctant to provide a diagnosis for fear of the stigma that soldiers would experience.[23] "From Shellshock to PTSD" cites that shock therapy was used to attempt to reprogram soldiers during World War II.[24]

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[19] Annette Amerman, *United States Marine Corps in the First World War: Anthology, Selected Bibliography, and Annotated Order of Battle* (Quantico, VA: History Division, United States Marine Corps, 2016), iv.
[20] Dave Grossman, *On Killing: The Psychological Cost of Learning to Kill in War and Society* (Boston: Back Bay Books, 2009), 1-4. Grossman notes that in order to truly understand war, one must experience it.
[21] Dave Grossman, *On Killing: The Psychological Cost of Learning to Kill in War and Society*, 51.
[22] Edward R. Holmes, *Acts of War: The Behavior of Men in Battle* (New York: Free Press, 1985), 47-61.
[23] Mary McDonald, Marissa Brandt, and Robyn Bluhm, "From Shell-Shock to PTSD: A Century of Invisible War Trauma."
[24] Mary McDonald, Marissa Brandt, and Robyn Bluhm, "From Shell-Shock to PTSD: A Century of Invisible War Trauma."

My thesis's focus and approach intersect with new military history studies. New military history emerged in the 1960s and 1970s. It fuses military history with other theoretical and methodological approaches. The inclusion of gender, psychology, and perception of the military allows for a broader perspective on the same time period in question. Whereas traditional military history focuses on battles, strategies, and tactics, as well as great military leaders, new military history focuses more on the "ordinary soldier" fighting in the battle, the perception of the battle, how the battle affected soldiers, and how the act of killing was taught.[25]

One of the earliest books that represents new military history is the 1972 study *Citizen Soldiers: The Plattsburg Training Camp Movement* by John Garry Clifford. The book was influenced by the turmoil of the long 1960s. Clifford repeatedly argues that civilians lacked any kind of military experience and were not prepared for war. The Plattsburg Training camp, which existed between 1913 and 1920, was part of the so-called Plattsburg or Preparedness Movement that emerged in the wake of World War I's outbreak. It served to train citizens to be soldiers, but according to Clifford it also served to prove that civilians lack the expertise, the preparation, and the psychological training to handle killing and war.[26]

In addition to John Clifford's work, my thesis will also engage with the studies of Jason Crouthamel and Peter Leese, Elmar Dinter, Edward Holmes, Christina Jarvis, Beth Linker, and Tracey Loughran. Much of their research focuses on how psychiatric practices at the turn of the century viewed mental illness, and how these mental illnesses were addressed within the United States' military during and after the war. These new military historiographies mentioned above are exclusively focused on the United States army. The same analysis and attention to detail are not

[25] Joanna Bourke, "New Military History," in *Palgrave Advances in Modern Military History,* 258-260.
[26] John Garry Clifford, *The Citizen Soldiers: The Plattsburg Training Camp Movement, 1913-1920* (Lexington: University Press of Kentucky, 1972), 296.

available for the United States Marine Corps. This lack of historiography is what led to my research question.

There are, nonetheless, several important studies that focus on or include a discussion of the Marine Corps. Paul Fussell's *Wartime Understanding and Behavior in the Second World War*, for example, discusses the chivalric portrayal in propaganda of the military seen in the trenches of World War I and how that image played a role in World War II.[27] Similarly, Michael Eggleston's *The 5th Marine Regiment: Devil Dogs in World War I* analyzes the social interactions and the development of unity within the 5th regiment of the Marines by citing their experiences and fears.[28] George Clark's books, *The Fourth Marine Regiment Brigade in World War I* and *Devil Dogs Chronicle: Voices of the 4th Marine Brigade,* analyze a smaller unit of the Marine Corps. Both books focus on the Marines who served in the fourth brigade and their experiences in the trenches during World War I.[29] Both Eggleston and Clark analyze soldiers' diaries and letters to convey how Marines remembered or how they experienced, in the moment, their time in the trenches.[30] By doing so, these authors write about the perception of trauma like Clarke, Fussell, and others. Matthew Rozell's study *The Things Our Fathers Saw* analyzes how the World War II Marine Corps veterans internalized traumas from their time in Japan and Okinawa.[31] Further, the book attempts to interpret how the veterans and their families perceived the war, their experiences, and the war's effects. Rozell adds to the narrative by explicitly citing the fear veterans felt during their

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[27] Paul Fussel, *Wartime Understanding and Behavior in the Second World War* (New York: Oxford University Press, 1990), 282.
[28] Michael A. Eggleston, *The 5th Marine Regiment Devil Dogs in World War I: A History and Roster* (Jefferson, NC: McFarland & Company, Publishers, 2016), 72-83.
[29] George B. Clark, *Devil Dogs Chronicle: Voices of the 4th Marine Brigade in World War I* (Lawrence, KS: University Press of Kansas, 2013).
[30] Eggleston, *The 5th Marine Regiment*, 239-249;
Clark, *Devil Dogs Chronicle*, 399-404.
[31] Matthew Rozell, *The Things Our Fathers Saw: The Untold Stories of the World War II Generation* (Hartford, NY: Woodchuck Hollow Press, 2018), 2.

"down time" and concern for what their families would think of them.[32] This take on the internal conflict and family dynamic adds a layer to the perception by focusing on the family history as opposed to the individual oral histories presented by historians like Crouthamel and Leese who analyze psychological trauma during the First World War. In this case, Crouthamel and Leese are analyzing and detailing the medical approaches taken, and how they reflected the stigmas of the time. Crouthamel and Leese reference interdisciplinary sources from the United States and Great Britain.

In addition to these studies, my research engages especially with the work of historian Joanna Bourke. Bourke is a new military historian who focuses on the perception of war and the psychology behind the actions taken in war. Her study *Dismembering the Male: Men's Bodies, Britain, and the Great War*, for example, analyzes the relationship between war trauma and gender. She stresses the importance gender plays in the psychological effects experienced by soldiers. Focusing on Great Britain, Bourke studies not only how the psychological effects of war produced physical trauma and injury, but also how war shaped gender norms. Similarly, Christina Jarvis's work, *The Male Body at War: American Masculinity During World War II*, analyzes the gendering of men. She focuses on what was and was not acceptable for men in military uniform, and how this expectation changed over time.[33] The gender norms and expectations discussed by Bourke and Jarvis are external factors that relate to how mental health was viewed in the military and play a direct role how trauma would be internalized by combatants. The internalization of external factors may have played a role in the frequency and detail reported by Marines suffering from mental

[32] Rozell, *The Things Our Fathers Saw,* 11-12.
[33] Christina S. Jarvis, *The Male Body at War: American Masculinity During World War II* (DeKalb: Northern Illinois University Press, 2004)*,* 3-5 and 21-27.

illness. Further, the external factors would have undoubtably created biases that affected how commanding officers treated Marines.

Another book by Bourke is *An Intimate History of Killing* in which she analyzes tactics used to normalize killing as well as early arguments connecting mental illness to heroic acts caused by desperation.[34] She describes how society and media shape not only men's views of war but women's view as well during World War II and the Vietnam war. According to Bourke, war could be seen as a noble cause or just part of being a patriot. Burke argues that killing was often seen and taught as being part of the job.[35] Bourke furthermore focuses on how society and media indoctrinated civilians into soldiers. Bourke's and Jarvis's studies relate to research conducted by Christy Connell, author of "PTSD in the 20th Century American Military," and Edgar Jones and Simon Wessley, authors of *Shell Shock to PTSD*. They chronical how mental illness and distress were perceived whether they were seen as cowardly or not. The discussion of how mental illness was viewed and perceived correlates to the idealized and gendered image of what a man should be.[36] As mental illness became more accepted as a product of combat exposure, the negative stigmas decreased.[37] The above-mentioned works and authors focus on detailing the gradually changing viewpoints on gender roles for men and how these changes correlated with more access to treatment or decreased stigma. This does not mean, in any way, that the authors claim that mental illness was not stigmatized, simply that doctors and officers gradually became more

[34] Joanna Bourke, *An Intimate History of Killing: Face-to-Face Killing in Twentieth-Century Warfare* (LaVergne, TN: Basic Books, 2010), 102-103.
[35] Joanna Bourke, *An Intimate History of Killing: Face-to-Face Killing in Twentieth-Century Warfare,* 13-31. Bourke makes reference to the joys of killing, the fantasy of the glory of war, and the collection of war trophies.
[36] Jason Crouthamel and Peter Leese, eds. *Psychological Trauma and the Legacies of the First World War* (Cham: Springer International Publishing, 2018), Their work references Bourke's work.
[37] This is a trend seen within different works, but never explicitly noted in any one work.

accepting and understanding of the effects war had on soldiers.[38] The shift in perspective would have directly correlated to how Marines with symptoms of mental illness were treated medically and socially. The increase in acceptance by doctors and officers would have also led to an increase in Marines' willingness to seek treatment or, most important for my research, report their symptoms and experiences dealing with mental illness.

"New military historians," as Joanna Bourke highlights were and are also at the forefront of developments in the history of 'memory and commemoration.'[39] The insight into the effect of trauma and how it was perceived comes from the inclusion of oral histories and the perception of war or battle over time by veterans and civilians. Some of the newer works, specifically those written in the 2010s, cover a great deal of public opinion on war.[40] Scholars such as Pamela Ballinger, Frances Clarke, Renee Dickason and Stephanie Belanger, and others introduced the perceptions of trauma in 1998. Pamela Ballinger published a short article analyzing how trauma has been perceived over time; in short it is a historiography of the perception of trauma.[41] Other works build on this. Dickason and Belanger's edited work, *War Memories: Commemoration, Recollections, and Writings on War,* introduces the notion of perception of trauma by including oral histories and how civilians remembered wars.[42] Even Paul Fussell's *The Great War and Modern Memory* adds to the history of perception by analyzing public opinion, specifically, on

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[38] This is the consensus of historians and psychologists mentioned above.
[39] Joanna Bourke, "New Military History," 273.
[40] Francis Clark, Renee Dickason and Stephanie Belanger, Paul Fussell, Peter Leese and Jason Crouthamel all focus on the experience of veterans. Each author includes a greater amount of public opinion the newer the publication.
[41] Pamela Ballinger, "The Culture of Survivors: Post Traumatic Stress Disorder and Traumatic Memory," *History and Memory* 10, no. 1 (1998): 99-101.
[42] Renée Dickason and Stéphanie A. H. Bélanger, eds, *War Memories: Commemoration, Recollections, and Writings on War* (Montréal: McGill-Queens University Press, 2017).

World War I.[43] Fussell tracks the perception of bravery and what constituted bravery similar to how Grossman noted the indoctrination of the public through media. On the perception of trauma, Clarke's work, "So Lonesome I Could Die," ties closely to the oral histories edited by Peter Leese and Jason Crouthamel, *Traumatic Memories of the Second World War and After.* Clarke analyzes the recollections and internalization faced by Union Civil War soldiers in addressing emotional control.[44] He does this by noting that men in the frontlines dwell on the nostalgia of going home. This directly correlates to how Leese and Crouthamel have veterans recall and relive the nostalgia of their experiences during World War II. The nostalgia experienced by Marines on and off the battlefield directly correlates to their mental state and is reflected in letters and diaries.

The above discussed historiography analyzes the different facets and approaches to answering my research questions but lack a focus on the Marine Corps. Whereas the above-mentioned authors focused on recollection of memory, gender, or strategy, the aim of my thesis is the analyze how "mental illness" was prevented, addressed, treated, and when possible perceived. My thesis ties together the approaches taken by the above-mentioned authors while focusing exclusively on the perspective of the Marine Corps between 1917 and 1937, thus adding to the currently available historiography by focusing on the correlation between military psychiatry, the Marine Corps, and other approaches taken to address mental illness.

[43] Paul Fussell, *Wartime Understanding and Behavior in The Second World War* (New York: Oxford University Press, 1990).
[44] Frances Clarke, "So Lonesome I Could Die: Nostalgia and Debates over Emotional Control in the Civil War North," *Journal of Social History* 41, no. 2 (2007)*:* 254.

CHAPTER III

ENTERANCE INTO EUROPE AND MAJOR ENGAGEMENTS

World War I was a European war the United States seemingly had no part in. However, due to economic involvement and political actions by European powers, the United States entered the war on April 4, 1917. This war resulted in battles and confrontations that formed the identity of Marines that is still reference to this day: devil dogs. However, there is more to war than a story to be told. There are harsh realities that Marines witnessed, the sounds and sights of mangled bodies, death of those around you and your friends or comrades, the implicit question of "am I next" or "am I going to make it home?" These are all the realistic questions and experiences these military engagements resulted in for the individual Marine. These are, also, the experiences and memories Marines who survived took home with them.

On June 28, 1914, Gavrilo Princip, a Bosnian Serb and member of The Black Hand, assassinated Austro-Hungarian archduke Franz Ferdinand and his wife, Sofie Duchess of Hohenburg. The assassination set Europe on a path to war. During the subsequent July Crisis attempts to negotiate and prevent war failed. Treaties which had been agreed to in the later part of the 19th century and early 20th century were activated, and soon military planning and timetables planned during the preceding years went into effect. Two sides formed in this war: The Triple Entente and the Central Powers. The Allied Powers were comprised of France, Great

Britain, Russia, Italy, and eventually the United States. The Central Powers were comprised of Germany, Austria-Hungary, the Ottoman Empire, and Bulgaria. After the United States officially entered the war in April 1917, U.S. Marines fought at Belleau Wood in June 1918, Chateau Thierry in July 1918, and Soissons in July 1918, which were within the Allied controlled areas in France. Marines also took part in the Meuse-Argonne Offensive in September and November 1918, an Allied offensive on the Western Front in France intended to push the German lines back.

Prior to the start of the First World War, European powers had forged alliances meant to protect their borders or ensure there was another nation that would respond in the event of declarations of war. For example, the German Empire, under the rule of Otto von Bismarck, entered into the Austro-German Alliance also known as the Dual Alliance with Austria Hungary.[45] This resulted in an alliance intended to ensure Germany had an ally against Russia as Russia had recently taken a portion of the Balkans from the Ottomans after the Russo-Turkish War.[46] Italy was added to the alliance between Germany and Austria-Hungary in 1882 in an effort to gain political support. This led to the creation of the Triple Alliance in 1882, more commonly known as the Central Powers. The Central Powers created a central block, per say, that could protect multiple fronts. Shortly after the start of the war, Germany entered a treaty with the deteriorating Ottoman Empire on August 2, 1914. Italy, who had been a member of the Triple Alliance since 1882, chose to side with the Allies by signing the Treaty of London on April 26, 1915 as Italy was promised Austro-Hungarian lands with Italian populations.[47] A

[45] Gordon Martel, *The Origins of the First World War* 3rd ed. (London: Longman, 2003), 21.
[46] Gordon Martel, *The Origins of the First World War,* 20-22.
[47] David R. Woodward, *The American Army and the First World War* (Cambridge: Cambridge University Press, 2014), 7.

previous secret pact had also been signed between France and Italy in 1902, known as the Franco-Italian Agreement, in order to secure political support towards Italy's claim on Tripoli, modern Libya.

The Triple Entente, or Allied Powers, began with the Franco-Russian Alliance in 1894. This alliance led to presence of two fronts the Central Powers would have to defend, a Western and Eastern front. Furthermore, this agreement was to be activated if either nation was attacked by Germany. In 1904 the Entente Cordial was agreed to by France and Great Britain. Then in 1907, the Anglo-Russian Convention provided both nations the opportunity to outflank Germany. However, Russia was later forced to withdraw from the war after the outbreak of the Bolshevik Revolution which saw an end to the Russian tsars and the introduction of a Communist government. The new Communist government agreed to end their participation in the war on March 3, 1918, through the Treaty of Brest-Litovsk, thus closing the Eastern front. The war to end all wars had begun, but it would not end quickly, nor would it leave the land and the minds of those who served unscarred. The Western Front, located along the French western border with Germany and Austria-Hungary, saw a large amount of trench warfare. According to James Robinson and Charles Beard, trenches were longer, deeper, and better defended by steel, concrete, and barbed wire than ever before.[48]

During the first years of the war, the United States maintained its neutral stance. Political leaders, including President Woodrow Wilson, did not show any urgency to prepared for entry into the war.[49] An article published in the *U.S. Department of State Dispatch* indicates the delay

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[48] James H. Robinson and Charles A Beard, *The Development Of Modern Europe Volume II The Merging Of European Into World History* (Ginn and Company, 1930), 324-325.
[49] David R. Woodward, *The American Army and the First World War*, 31, 35.

in action was, in part, due to the majority of political leaders being on vacation.[50] According to Robinson and Beard, President Woodrow Wilson declared strict neutrality.[51] A claim that is corroborated with President Wilson's proclamation number 1271, issued on August 4, 1914, indicating the United States would remain neutral and openly prohibit citizens from enlisting in the service of any belligerent nations.[52] Efforts were also made to bring American citizens in war torn areas back to the United States.[53]

However, the actions of the *German Kaiserreich* soon led to a change in US policies. During those three years of neutrality, Germany significantly increased its arsenal of submarines, U-boats and repeatedly engaged in unrestricted submarine warfare. By firing on civilian ships carrying American citizens German U-Boats gradually amplified American sentiment in favor of abandoning isolationism and joining the Allied Forces. *The Lusitania*, a ship carrying civilians, was torpedoed on May 7, 1915 by a U-Boat. The Lusitania was carrying 128 American passengers. This led to public outrage and newspaper publications calling for war.[54] German U-Boats, *Unterseeboot,* were long cylindrical under sea vessels that lacked sufficient space to hold more than their crew. Additionally, U-Boats were vulnerable if they surfaced, so crews were not going to surface in order to provide civilian ships with warning for fear of being sunk themselves. However, *Blinders, Blunders, and Wars* argues there was significant internal debate

[50] "Feature: World War I and Isolationism, 1913-33." *U.S. Department of State Dispatch* 2, no. 17 (Apr 29, 1991): 310-311.
[51] James H. Robinson and Charles A Beard, *The Development of Modern Europe Volume II The Merging Of European Into World History*, 361.
[52] Woodrow Wilson, "Proclamation of Neutrality by the President of the United States of America," *The American Journal of International Law* 9, no. 1 (1915), 110-111.
[53] "Feature: World War I and Isolationism, 1913-33." *U.S. Department of State Dispatch* 2, no. 17 (Apr 29, 1991): 311.
[54] Woodward, 41;
George B. Clark, *Devil Dogs Chronicle: Voices of the 4th Marine Brigade in World War I* (Lawrence, KS: University Press of Kansas, 2013), 35.
John Garry Clifford, *The Citizen Soldiers: The Plattsburg Training Camp Movement, 1913-1920* (Lexington: University Press of Kentucky, 1972), 52-53.

between the German military leaders and Civilian leaders. Kaiser Wilhelm II initially sidelined the recommendations for unrestricted submarine warfare. Chancellor Theobald von Bethmann-Hollweg warned the targeting of neutral ships, including those from the US, would "inevitably cause America to join" on the side of the Allies.[55] Over time, the Kaiser relented and agreed to the recommendations of his Prussian admirals and generals. In January 1917, the German military lifted the restrictions of targeting neutral ships.[56]As a result, U-Boats did not provide a customary warning to civilian ships nor did they take on civilians before or after firing torpedoes at enemy vessels.[57] When the Germans continued their unrestricted submarine warfare in early 1917, they achieved considerable victories. German admirals had promised the Kaiser they would sink 600,000 tons per month.[58]

During this time, the United States' government took measures to prepare the country for war. The National Defense Act of 1916 gave the President the power to force industry to produce goods and machinery for the purposes of war.[59] Furthermore, the President was given the power to establish a Council of National Defense, which he exerted on August 24, 1916. The council informed President Wilson of the "strategic placement of industrial goods" for "future use in times of war.[60] The Naval Act of 1916 allotted for the creation of 10 battleships, 16 cruisers, 50

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[55] David C. Gompert, Hans Binnendijk, and Bonny Lin, "Germany's Decision to Conduct Unrestricted U-Boat Warfare, 1916" in *Blinders, Blunders, and Wars: What America and China Can Learn* (Santa Monica: Rand, 2014), 64.
[56] Gompert, David C., Hans Binnendijk, and Bonny Lin, 65.
[57] Woodward, 161-162.
[58] Gompert, Binnendijk, and Lin, 65.
[59] Edward Brooke, P*olitics of Our Military National Defense: History of the Action of Political Forces within the United States Which Has Shaped Our Military National Defense Policies from 1783 to 1940 Together with the Defense Acts of 1916 and 1920 as Case Studies,* (Washington: Government Printing Office, 1940), 30.
[60] Edward Brooke, P*olitics of Our Military National Defense: History of the Action of Political Forces within the United States Which Has Shaped Our Military National Defense Policies from 1783 to 1940 Together with the Defense Acts of 1916 and 1920 as Case Studies,* 30.

destroyers, 72 submarines, and 14 auxiliaries.[61] The US broke diplomatic relations with Germany after taking into account Germany's decision to proceed with unrestricted submarine warfare.[62] During this period, German U-boats sank 25% of transatlantic voyages, leading to the US introduction of convoys escorted by US Naval ships.[63]

In addition to practicing unrestricted submarine warfare, the German government also attempted to subvert U.S.-Mexico relations through a now infamous telegram sent by Arthur Zimmerman to the German ministers in Mexico.[64] However, the telegram was intercepted in Great Britain and provided to the United States. Within the telegram, which was publicized in early 1917, was an offer to be made to the Mexican government. If Mexico was willing to start a war or conflict with the United States and keep the United States from entering the war in Europe, Germany would assist Mexico in regaining their territories lost during the Mexican-American War after the Germans won the war in Europe.[65] The publication of the Zimmerman telegram fundamentally changed public opinion in the United States. After three years of failed isolationism, Woodrow Wilson signed the Joint Resolution of April 6, 1917.[66]

Historians have argued that the U.S. military was not ready for war. According to historian David R. Woodward, the U.S. military was limited in the quantity of enlisted men due to illiteracy, racial prejudice, and "alien" status.[67] The Marines were no exception, for their active

[61] Naval Act of 1916.
[62] Gompert, Binnendijk, and Lin, 66.
[63] Gompert, Binnendijk, and Lin, 66.
[64] David R. Woodward, 43;
Robert. H. Zieger, *Americas Great War: World War I and the American Experience* (Rowman and Littlefield, 2002), 51.
[65] Woodward, 43;
Robert. H. Zieger, *Americas Great War: World War I and the American Experience*, 51.
[66] Declaration of War Against Germany, M1326, roll 52, Enrolled Acts and Resolutions of Congress (1893-1956), National Archives, Washington, D.C.
[67] Woodward, 11.

servicemen numbered less than that of the Army. At the start of World War I, there were 511 officers and 13,214 enlisted Marines. On April 6, 1917, the United States declared war on Germany and entered the war with a combined military force of 200,000 soldiers and Marines. However, enlistment campaigns drew in thousands of men to serve. The numbers rose sharply by 1918 with an enlisted population of 70,000 Marines and 2,400 officers. As previously mentioned, the United States had been making industrial preparations to increase the naval fleet by 10 battleships, 16 cruisers, 50 destroyers, 72 submarines, and 14 auxiliaries.

The 2nd Army Division, an infantry division and part of the American Expeditionary Force, was comprised of regiments of the United States Army and included the 5th and 6th Regiments of the Marine Corps' 4th Brigade as well as the 6th Machine Gun Battalion of the Marine Corps. In order to understand the scale at which the Marine Corps was involved, and the sheer volume of men engaged, it is important to understand the military structure. Regiments are comprised of five battalions. A battalion is broken down in five companies (800 men): three rifle companies, a combat support company, and a headquarters company. Companies are further broken down four platoons (160 men) with each platoon containing four squads (40 men). Each squad consisted of about 10 men. The 6th Machine Gun Battalion consisted of the 77th and 81st companies with a later addition of the 15th and 23rd companies.[68] The 5th and 6th regiments each consisted of the 1st, 2nd, and 3rd battalions. During the war, the 5th and 6th were awarded the French Croix de Guerre three times. The 1st Battalion was comprised of the 74th, 75th, 76th, and 95th companies.[69] The 2nd Battalion was comprised of the 78th, 79th, 80th, and 96th companies.[70] The 3rd Battalion was lastly comprised of the 82nd, 83rd, 84th, and 97th companies.[71] The 5th

[68] George B. Clark, *Devil Dogs Chronicle: Voices of the 4th Marine Brigade in World War I*, 251.
[69] George B. Clark, 149
[70] Clark, 185
[71] Clark, 214.

Regiment was also comprised a 1st, 2nd, and 3rd Battalion. The 1st battalion of the 5th regiment comprised of the 17th, 49th, 66th, and 67th companies, totaling 22 officers and 953 enlisted men.[72] The second battalion consists of the 18th, 43rd, 51st, and 55th company, totaling 4 officers and 200 enlisted.[73] The 3rd Battalion consisted of the 16th, 20th, 45th, and 47th companies.[74] While the 5th and 6th Regiments of the Marine Corps' 4th Brigade were forming, General John J. Pershing was sent ahead of his expeditionary forces.

The 6th Marine Corps Regiment— "Devil Dogs"— became famous for being the first in France.[75] The 6th Regiment was comprised of new recruits drawn in by campaigns and propaganda intended to spark a patriotic fervor like the Marine Corps' "First to Fight" campaign. Men like Carl Andrew Brannen, a Texas A&M cadet, resigned from the university, to enlist in the Marine Corps at the age of 18 because he was impressed by the propaganda campaign.[76] The Marine Corps was exceptionally fortunate, compared to other branches, because most Marines in the 5th Regiment already had experience in other conflicts and were brought from different posts around the United States and abroad.[77] Their prior experience included conflicts in Veracruz, Cuba, the Philippines, and other places on vessels like the *USS Helena*.[78] One such man was Matej Kocak, born in Gbely, Slovakia, of the 5th Regiment who was already enlisted at the time the United States entered the war.[79] Known as an "old Marine," Kocak enlisted in 1907 and

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[72] Clark, 26 ,32
[73] Clark, 67.
[74] Clark, 106.
[75] Michael A. Eggleston, *The 5th Marine Regiment Devil Dogs in World War I: A History and Roster* (Jefferson, NC: McFarland & Company, Publishers, 2016), 37.
[76] Michael A. Eggleston, 16.
[77] Clark, 26, 67, 106.
[78] J. Michael Miller, *The 4th Marine Brigade at Belleau Wood and Soissons: History and Battlefield Guide* (Lawrence, KS: University Press of Kansas, 2020), 212.
[79] Eggleston, 18.
Robert. H. Zieger, 92-93.

served as a Sergeant during World War I. Kocak served in Belleau Wood and Soissons, where he earned a Medal of Honor.[80] He reportedly ordered his men to remain under the cover of the woods as he crawled towards the German position. He began close quarter combat and charged with his bayonet affixed.[81] His actions demonstrate valor and an aptitude for running toward battle commented on in various publications. Officers also had similar tenures with the Marine Corps, having served in the aforementioned areas as enlisted servicemen. The Marine Corps arrived in France on June 27, 1918—only five months before World War One would come to an end—under the leadership of General John Pershing.[82] Pershing had the 4th Brigade trained by the French and British prior to experiencing combat. According to accounts of the trainings, American Marines soon learned that the British were fond of using bayonets, and the French preferred to use hand grenades. As a result, the 4th Brigade learned the importance of using both the bayonet and the grenade a well as their purpose in trench warfare.[83] Pershing, however, preferred assault tactics that had been used effectively by the United States military since the time of the Civil War.[84] He and many of the Marines under his command were accustomed to these tactics as opposed to a war of attrition which had been going on in Europe with the use of trenches. During the last phase of their training, the 5th and 6th were taken to the Verdun sector in order to learn proper trench warfare tactics.[85]

The Germans had attempted to push the Allies and the Western front back prior to the arrival of U.S. reinforcements due to Russia surrendering on the Eastern front in the Treaty of

[80] J. Michael Miller, *The 4th Marine Brigade at Belleau Wood and Soissons: History and Battlefield Guide*, 221.
[81] Miller, 220-222.
[82] Eggleston, 26-27, 37.
[83] Eggleston, 38-39.
[84] Eggleston, 39, 72.
[85] Clark, 28-30, 108-110.

Brest-Litovsk on March 3,1918.[86] While the Easter front was closing, the Western front continued to be in a stalemate of trench warfare. After arriving at the front, Marines took part in two major engagements in the Western front: Belleau Wood and the Meuse-Argonne Offensive. On June 6, 1918, Marines from the 5th and 6th Marines were part of an Allied attack intended to push the Germans back. The Battle of Belleau Wood was fought by the 5th and 6th Marine Battalions in a square mile of well-fortified terrain. Belleau Wood is a forest near the French commune of Château-Thierry, which is located at the Marne River. Unbeknownst to the Marines, the German infantry had dug themselves in. The German fortification included two hundred machine guns.[87] Companies of Marines were fired upon, yet they pushed forward passing their target. The true cost of Pershing's preference for assault tactics was seen as the Marine Corps had a 55% casualty rate yet continued to push forward. The first day of fighting was described by Marine Harrison Cale. American artillery began striking Belleau Wood just before daylight.[88] Sketches by Captain J. Andre Smith, who fought at Belleau Wood, depict men in foxholes, man-made holes in the ground intended to provide cover for troops. These images depict the destruction of the forest, but do not show the mustard gas lingering in the air, the "blood-curdling" yells.[89]

The Marines who served recalled being told by the French who were falling back that there were many Germans.[90] According to different historical accounts, French soldiers were seen fleeing the fight while a U.S. officer yelled at the "Devil Dogs" to "go take'em," "you're

[86] Zieger, 98.
[87] Eggleston, 49.
[88] Harrison Cale, "The American Marines at Verdun, Chateau Thierry, Bouresches, and Belleau Wood," *Indiana Magazine of History* 15, no. 2 (June 1919), 188.
[89] Cale "The American Marines," 188-189.
[90] Eggleston, 50.

needed up there," and "go get'em, Marines."[91] Marines from the 3rd Battalion of the 5th Marines filled in gaps left by hardened French soldiers who fled the battle. Captain Lloyd W. Williams of the United States Marine Corps sent word to the Battalion commander indicating the 82nd and 84th Companies were "on their way to fill the gap."[92] According to retired U.S. Army Colonel Michael A. Eggleston, the fresh-faced Marines shot down Germans 500 meters away, sparking terror in the enemy. Because of their apparent ferocity in the face of a well-entrenched enemy as well as their tenacity to push forward, the 4th Brigade became known as *teufelshunde*, devil dog. Marines who fought in World War I recalled their unorthodox methods of attack, choosing any opportunity to rush the enemy rather than restrict attacks to morning hpurs served to help take Belleau Wood over a few weeks.[93] Marines pushed forward through woods, being forced to remove their gas masks in order for the voices of leaders to be heard by subordinates.[94]

Marines fought in the wooded area near Château-Thierry over the period of a month. They fought against entrenched Germans who had the benefit of a defensive position. Much of the engagements in which Marines were involved, involved mustard gas. Mustard gas, first used in World War I on July 12, 1917, was a chemical compound developed in the 1800s.[95] Mustard gas resulted in 2% of the total deaths but comprised 77% of the casualties which included temporary blindness and skin lesions.[96] The chemical compound for mustard gas is a human

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[91] Eggleston, 48. For a more nuanced account of the French soldiers that describes them as "dispirited," "perhaps ashamed," possibly shell-shocked, "and simple, dead-tired," see Alan Axelrod, *Miracle at Belleau Wood: The Birth Of The Modern U.S. Marine Corps* (Lanham: Rowman & Littlefield, 2007), 85-86.
[92] Eggleston, 52.
[93] Eggleston, 72;
Elton E. Mackin, George B. Clark, and Victor H. Krulak, *Suddenly We Didn't Want to Die: Memoirs of a World War I Marine* (Novato, CA: Presidio Press, 1996), 50.
[94] Harrison, 189.
[95] Sharon Reutter, "Hazards of Chemical Weapons Release During War: New Perspectives," *Environmental Health Perspectives*, no. 12 (1999), 985.
[96] Sharon Reutter, "Hazards of Chemical Weapons Release During War: New Perspectives," 985.

carcinogen which acts as a blistering agent which could then affect one's ability to properly oxygenate due to damage to the lungs, resulting in increased fatigue.[97]

Figure 1: Image taken at Belleau Wood.[98]

Numerous official military documents detail the impact the battle on individual Marines. Photographs taken during the battle show soldiers on the ground surrounded by shredded trees and what appears to be fog. Official injury reports filed by 5th and 6th regiments, on average, reported half of their casualties as "gassed." One example from the 6th regiment, reported on June 18, 1918 by Lieutenant Colonel Harry Lee, show 82 gassed casualties out of 150 total reported casualties for the day.[99] This testifies to the heavy use of mustard gas during the battle: the weekly reports for the month of June 1918 show most men who fought at Belleau Wood were injured by gas.[100] It should be noted that the casualty lists document only one injury, the most pressing at the time of being treated. It can be inferred that the gunshot wound and shell

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[97] Reutter, 985.
[98] Keystone View Company, Publisher. Strong dugouts in holes under huge rocks, in Belleau Woods, France. Bois De Belleau France, None. [Meadville, PA.; New York, NY; Chicago, IL.; London, England: Keystone View Company, Photographed between 1914 and 1918, published 1923] Photograph. https://www.loc.gov/item/2016646018/.
[99] Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[100] Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.

shock victims were likely subjected to gas but did not have severe enough symptoms for them to be documented. They likely smelled of gun powder, blood, sweat, wood, and mud. As the battle dragged on, more and more medical reports showed men suffered from "accidental wounds" as they were phrased in the reports. These included gunshot wounds to the feet and hands.[101] Furthermore, the official military files also show that some men were labeled as suffering from shell shock. Based on the official record's labelling, many of the men did not return to duty. One can imagine the sounds of bullets whizzing through the air and making contact with trees, metal, and bodies. Grenades exploded and maimed many. Men were asphyxiated by mustard gas, leaving them forever scarred or dead. The various secondary publications refer to the effects of gas on the individuals, noting the difficulty in breathing. Survivor, Harrison Cale, described Gunnery Sergeant Fred W. Stockman pulling men from their foxholes to save their lives. Stockman, one of the men not wearing his gas masks, succumbed to the gas.[102]

The next confrontation with the Germans were at Soissons. This battle was planned twenty-four hours prior to the assault, in haste, during a major overhaul of the leadership who were expected to relay these orders to their corresponding men six hours before a night march.[103] Marines were rushed to the front in *camions*, trucks, by French-Vietnamese drivers who, as an unnamed Marine stated, were "drinking alcohol to make their vision clearer in the night."[104] This was likely metaphorical and a way to ease the nerves of the drivers. The night was described as rainy and pitch black with Marines holding on to one another in order to not get lost.[105] These

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[101] Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[102] Harrison, 190.
[103] Miller, 189.
[104] Miller, 190-191.
[105] Miller, 202-203.

men carried 340 rounds.[106] Marines pushed through the German front line towards Soissons-Chateau Thierry Road. One officer noted they fought "against boys of sixteen fighting in the Boche ranks beside men of forty."[107] With the front line taken, Marines and the French forces began pushing towards Retz Forest to take Soissons. The 5th Marines and 1st Moroccan division of the French Army pushed through the forest firing aimlessly into the trees in order to take out any snipers hiding in the trees. Lieutenant Cooke of the 5th Marines noted "sometimes something fell out," referring to the bodies of German snipers hit by the machine gun fire. Various companies were all pushing towards Soissons separately. The 66th Company charged towards German cannon fire in the face of a volley of artillery and reached the German line before another volley could be fired. The 43rd and 18th companies arrived shortly after, followed by the 17th and 55th. These companies, assisted by French forces including six light tanks, pushed forward meeting minimal resistance and coming across German fighter planes.[108] After the first day of fighting, water was scarce. Lieutenant Taylor recalled struggling to keep his men from refilling their canteens from pools of stagnant water. Although the archival material is limited for this confrontation, the available reports show a percentage of reported gassing injuries similar to Belleau Wood. The archival record seems to lack material for Soissons and skips to the Meuse-Argonne Offensive with a particular emphasis on early October 1918.

Almost four months after the Battle of Belleau Wood, Marines were engaged in the Meuse-Argonne Offensive, was one of the most important and largest battles of the First World War. This offensive was the largest documented operation in which the American Expeditionary Forces participated during the war; just over a million servicemen from the Army and Marines

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[106] Miller, 211.
[107] Miller, 232.
[108] Miller, 248.

joined their French counterparts. The American and French offensive lasted for forty-seven days from September 26, 1918 to November 11, 1918. With more than 120,000 casualties, it was also one of the deadliest campaigns of the war for the U.S. military. This offensive was the final push East in order to keep the German trench lines unstable and put an end to the war. It was an American and French joint offensive against the German line. The 4th Brigade along with the rest of the American forces were assigned to the southernmost quarter of the front.[109] By this time, Marines had already earned a reputation of being "too apt to get themselves killed."[110] German troops were on higher ground and were well-fortified. Machine gun nests and artillery, which could easily mow through American charges, were positioned throughout the German line. Pershing wanted to continue sending offensive strikes at the German line.

Archival records, though incomplete, reveal the immediate impact this battle had on U.S. Marines. They show pages of Marines who were killed in action during these final months of World War I.[111] Altogether, 2,461 Marines were killed in action during the war. The bulk of those deaths came from the Meuse-Argonne Offensive. Marines were sent in waves to assault the German line. With each passing strike more and more bodies lay on the ground. Soldiers saw friends dying, screaming in agony as they slowly died. Perhaps others begged for the comfort of their mothers and fathers. Historian Donald Smythe is quoted by Zeiger noting the infantry charged bravely, even foolishly, compelling the admiration of enemy soldiers.[112] According to Rexmond Cochrane, gas was also freely used and negatively impacted all American troop.[113]

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[109] Zieger, 99.
[110] Zieger, 98.
[111] Miscellaneous 1918, NN3-127-97-002, box 52, Records Relating to Marine Participation in World War I, 1916-1945, National Archives, Washington, D.C.
[112] Zieger, 101.
[113] Rexmond C. Cochrane, *The Use of Gas in the Meuse-Argonne Campaign, September-November, 1918*, (Army Chemical Center, MD: U.S. Army Chemical Corps Historical Office, 1958), 28-29.

Historian Robert. H. Zieger furthermore claims that approximately 550 American soldiers died each day. The casualty record, though incomplete for the Marine Corp, includes multiple pages listing men as "killed in action" for October 4th and October 5th.[114] The 5th and 6th Marines started October at Blanc Monte in order to push the German lines back. The 1st Battalion of the 5th Marines, known as the 1/5, were assigned to assist the 6th Marines and later push ahead toward St. Etienne. Casualty reports submitted on October 15, 1918, resulted in 1,059 total enlisted casualties and sixty-one officer casualties. Of those casualties, six officers were killed in action, three died of wounds, sixteen were severely wounded, thirty slightly wounded, four gassed, and two sick. Enlisted Marines suffered ninety-one killed in actions, twenty subsequently died of wounds, 209 were severely wounded, 484 slightly wounded, 151 missing, eighty-three gassed, and twenty-one shell shocked. This is congruent with the archival muster rolls.[115] The 66th Company was encircled during combat and were assisted by thirty men organized by Gunnery Sergeant Arthur S. Lyng of the 49th Company. These thirty men charged towards 250 German soldiers, killing most and capturing prisoners. These men were referred to as Lyng's Comanches because of their use of battle cries similar to Comanches. The 66th and the 49th, both assigned as assault companies, were highly decorated for acts of valor. The 1/5 was ordered on October 31, 1918, by Lieutenant Colonel Logan Feland to move towards the Meuse River the next day. They began with an artillery barrage from 3:00 AM to 5:00 AM, effectively weakening the German line enough to push two and a half kilometers by 8:00 AM. The 2nd Battalion of the 5th Marines, 2/5, pushed passed the 1/5 to take Landreville. The 2/5 continued pushing forward to a southeast position at Le Champy Haut then pushing north with the U.S. Army 9th Infantry and 89th

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[114] Miscellaneous 1918, NN3-127-97-002, box 52, Records Relating to Marine Participation in World War I, 1916-1945, National Archives, Washington, D.C.
[115] Clark, 59.

division.[116] Over the coming days, the 1/5 continued pushing towards the Meuse River, reaching their target on November 10, 1918, and was ordered to hold their position in support of the 6th Marines. The 2/5 continued to push north. While the 1/5 served as support, the 2nd Battalion of the 5th Marines, 2/5, were hit heavily on October 4, 1918, suffering major losses and running from the "box." The documented casualties were, in total, 30 killed in action, 191 wounded, 107 missing, 7 gassed, and 14 sick. A distinct difference between the 1/5 and the 2/5 is the absence of documented shell shock cases in the 2/5. The 2/5 was documented to have fled from a difficult confrontation with the enemy whereas the 1/5 held their positions, suffering greater casualties. It is suspected the 2/5 did not document shell shock cases due to the already tarnished reputation of their commanding officer, Major George Hamilton, who spent the remainder of the war as a non-person.[117] This perception of Major Hamilton identified him and those under his command as cowards and serves as an example of the social perception and stigma. If commanding officers had positive reputations their shell shock casualties would be interpreted as valiant injuries, while those with a negative reputation did not.

The November 11, 1918, cease fire allowed participating nations diplomats to impose the Treaty of Versailles. Marines fought in a war that introduced new technologies intended to end a battle quickly and spark fear into the enemy.[118] However, new technology also mangled and maimed the minds and bodies of Marines who fought those battles. As, the following chapters will show, "shellshock" was documented in all of the medical reports of the aforementioned confrontations.

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[116] Clark, 52-63, 100-105.
[117] Clark, 101.
[118] Eggleston, 43;
Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, MA: Harvard University Press, 2003), 1-3. Shephard notes the effects of shell shock and the element of fear involved in the development of symptoms.

As mentioned in the onset of this chapter, these military engagements are not simply numbers to recount. Rather, these are individual lives that were affected, traumatized, and scared either physically or mentally. War, in an industrial scale, where movement was limited and weapons you may not be able to see was a new invention.

CHAPTER IV

INDUSTRIALIZED KILLING AND SEVERITY OF CASUALTIES

This chapter will explain the types of injuries servicemen witnessed, experienced, and in some cases survived. By doing so, the intent of this chapter is to establish a clear understanding of the physical environment and break down the types of injuries, and the statistical data associated with a variety of casualties. This breakdown will serve to demonstrate the environment which provided the traumatic experienced which caused shell shock. It is imperative to remember that human beings who were in the early stages of adulthood were experiencing these traumatic events. It is imperative to remember and note that battlefields are only silent before a confrontation or when most of the belligerents are dead: when survivors are left to retrieve their fallen comrades.

Photographs demonstrated the physical environment and the destructive capacity of war on towns, roads, and forests. Buildings had walls blown off, some were levelled to the ground. Forests were left visibly barren without leaves or signs on new growth. Roads with trenches or potholes large enough for a grown man to crouch for cover. World War I resulted in carnage to the physical landscape and the bodies of those who fought in it.

The Great War was arguably the first truly industrial war with the implementation of chemical warfare and large scale killing in the form of mustard gas. Additionally, trench warfare tactics, which were not a modern concept were incorporated. Trenches were dug into the ground

or built up depending on the terrain with the goal to provide cover to combatants. Both sides of the conflict implemented this technique with a middle ground known colloquially as no-man's-land. Trenches, at their fronts, were fortified with barbed wired. The setup of the trenches created a stagnant battle ground with areas of limited movement with charges of small units jumping over their line and typically being fired upon. Bullets, barbed wire, trenches, and mustard gas, coupled with trench warfare created death traps resulting in approximately six million deaths and twelve million wounded for all allied forces between 1914 and 1918. Rather than being fired upon, servicemen witnessed and were victims of a silent killer, mustard gas, that did not require anyone to enter no-man's land between the trenches. Rather, the gas slowly killed the enemy by burning their lungs. However, this new weapon was prone to failure as changes in the wind could send the gas in the opposite direction. That is not to say bullets and hand grenades were not used, but these were not new weapons and did not require new techniques for their implementation. This war also saw the introduction of tanks and electrified barbed wire. The War saw the traditional use of horses and bullets while introducing industrial killing through machine guns, early airplanes, and chemical weapons. According to the United States census, American casualties totaled 116,708 deaths and 204,002 wounded with Marines total being 2,361 killed in action and 9,520 wounded in action between 1917 and 1918.[119] This number does not include the lives lost to disease or accidental deaths, nor does it include the deaths associated with shellshock and its long-term effects. Marine Corps casualties were approximately 6% of the United States casualties.

[119] N.F. DeBruyne, *American War and Military Operations Casualties: Lists and statistics*.

Types of Injuries

Marines sustained a variety of injuries during the war. Injuries were classified by type, then by severity in the documentation created by officers known as the muster rolls. These muster rolls identified the names, injuries, and severity of each Marine listed. Men suffered through simple ailments like lice and more serious concerns like trench foot, a type of injury caused by excess moisture on the foot which could result in infection and amputation. Simultaneously, medics treated victims of gas and gunshot wounds. Others were treated for sexually transmitted diseases. In all, medics had the gambit of medical conditions to treat while also under risk of enemy fire. In this section, common injuries will be described and broken down in the following manner: venereal diseases, gunshot wounds, mustard gas, and shellshock.

Sexually transmitted diseases, referred to then as venereal diseases, were not common among the archival records. However, cases were still documented on occasions. In the complete casualties rolls, multiple cases of syphilis and gonorrhea are documented.[120] Recent psychological studies have associated increased risky sexual behavior with experiencing trauma. There was a high possibility Marines were using their rest and relaxation leave to decompress and process their experienced trauma in trenches in sexually risky ways. In total, 3.5 million servicemen were admitted for diseases of any kind, of which 10% were for gonorrhea and syphilis.[121] It has been argued venereal diseases became common due to the development of a culture of servicemen attending brothels and being seen as acceptable while they were on leave. However, this went against the hygiene requirements of the military at the time. Even so, brothels were commonplace in the adjacent areas where servicemen were encamped in France. The United States required all servicemen who may have been exposed to venereal disease be

[120] Miscellaneous 1918, NN3-127-97-002, box 52, Records Relating to Marine Participation in World War I, 1916-1945, National Archives, Washington, D.C.
[121] Journey Steward and Nancy M. Wingfield, "Venereal Diseases," *1914-1918 Online: International Encyclopedia of the First World War*, September 23, 2016.

examined on a bi-monthly basis.[122] They were then required to take prophylactic medication at any sign of venereal disease and continued to be on a watch list. Additionally, the military favored "sexual discipline," meaning abstaining from sex while on leave.[123] However, this was not a realistic solution and was, based on the large number of cases, an unrealistic approach to the prevention of spreading communicable diseases. Risky sexual interactions, meaning unprotected intercourse, were notably common. Simultaneously, the French government required any sex workers to undergo routine pelvic examinations in order to ensure they did not have any form of venereal disease.[124] These two efforts served to decrease the spread of venereal diseases minimally but did not eliminate them entirely. This widespread presence of venereal disease among Marines and servicemen in general correlates with risky sexual behavior. The military would not have developed protocols if it was not an issue.

Why then, in research that focus on shell shock, would wide spread presence of venereal diseases be noteworthy? A 2018 psychological study found that high-risk sexual behavior occurred in 49.8% of patients with severe mental disorders.[125] The study also identified younger aged individuals as being generally more prone to this type of behavior due to being more "impulsive, altered judgement, […] and low self-esteem."[126] This criteria directly reflects the

[122] E. L. Keys Jr., "The Management of Venereal Diseases by the United States War Department During the Past Two Years," *The Public Health Journal*, October 6, 1919, 254.
[123] Michelle K. Rhoades, "Renegotiating French Masculinity: Medicine and Venereal Disease during the Great War," *French Historical Studies* 29, no. 2 (April 01, 2006), 295.
[124] Journey Steward and Nancy M. Wingfield, "Venereal Diseases," *1914-1918 Online: International Encyclopedia of the First World War.*
[125] Daniel A. Gebeyehu and Missaye Mulatie, "Risky Sexual Behavior and Its Associated Factors Among Patients with Severe Mental Disorder in University of Gondar Comprehensive Specialized Hospital, 2018," *BMC Psychiatry* 21, no. 51 (2021).
[126] Daniel A. Gebeyehu and Missaye Mulatie, "Risky Sexual Behavior and Its Associated Factors Among Patients with Severe Mental Disorder in University of Gondar Comprehensive Specialized Hospital, 2018."

Marines who served in the war. These are, predominantly, young men who are in life or death situations on a daily basis and have likely witnessed their friends die near and around them.

Gunshot wounds were notably documented in the muster rolls on a nearly daily basis with significant increases during major offensives. However, within these roles were injuries to hands and feet. These injuries are seemingly odd. If Marines happened charged over their trench into no-man's-land, it is unlikely their chief complaint would be a bullet to the foot or hand as they would have been easy targets. Additionally, trenches covered the feet and hands. Thus, leading to the reasonable assumption these slight and accidental injuries were intended to give Marines a moment of reprieve away from the gunshots, shelling, and mustard gas. These hand and foot injuries may have been a way out of the front by Marines who were shell shocked but did was not or did not want to be recognized as having shell shock. Sadly, there are no available first-hand accounts. Wounds were documented as either slight, moderate, or severe, which determined the importance in the triage train a casualty would be given. Slight wounds included injuries to extremities which were not life threatening or could be easily treated in the field. Moderate injuries required convalescing, healing, at field hospitals located at the back end of the front line where they could be easily evacuated should the need arise. Severe cases would be evacuated to hospitals behind the front. Gunshot wounds resulting due to accidental injury were documented separately.[127] However, the cause, mainly the accident, is not described. During many of the major conflicts, there are documented cases of men having been shot in the foot or the hand.[128] This type of injury was not documented as accidental. These injuries commonly occurred during days with large casualty counts and could be due to the sheer number of bullets

[127] Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[128] Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.

fired. However, these types of injuries could also have been self-inflicted in order to leave the battlefield with a physical injury. This is worth noting as medical reports document the most severe injury or chief complaint only. This knowledge coupled with the consistent use of trench warfare tactics such as charges into enemy lines, waiting for orders to move, or anxiously waiting for the possibility of mustard gas, makes these types of injuries highly unlikely as hands and feet are not generally exposed unless there is a charge. Trenches were intended to provide cover while standing.

The industrial component to this war, mustard gas, resulted in 77% of all casualties sustained during the War and 2% of the deaths.[129] This killer, though delivered by artillery, was comparatively silent and, towards the end of the war, invisible. Again, considering the sleepless nights, general unease of being at war, and a constant fear that mustard gas may be released it is reasonable to infer that Marines were at a heightened state of nervousness. Gas victims were commonly listed under the daily injury reports as mild and moderate injuries due to the open use of gas by all belligerents, though the Germans tended to favor its use more than the Allied forces. Gas use was contingent on the wind being in your favor as a change in wind direction would result in the gas entering friendly trenches as opposed to that of the enemy. Mustard gas was a chemical irritant to the body and a carcinogen.[130] Gas would irritate the nasal passages and airways, burning the lungs. This type of damage, if severe enough, would result in immediate death. However, for most the damage was minimal at the time of exposure. The short-term exposure did result in long term damage, however. Gas was described as not being unpleasant but did result in a burning sensation and a sense of fatigue.[131] This is due to the chemical

[129] Sharon Reutter, "Hazards of Chemical Weapons Release During War: New Perspectives," 985.
[130] Reutter, 985.
[131] Reutter, 985.

composition of mustard gas resulting in blistering of the airways affecting the ability to properly oxygenate due to damage to the lungs, resulting in increased fatigue.[132] Mustard gas has never been argued to cause shell shock. However, the injuries which affected someone's ability to breath and psychological effects of a constant state of anxiety, waiting for gas to be released, would have an effect on shell shock. The fear that comes with sleeping, fearing that mustard gas could be releases during that time, changes in the wind, or the sudden silence before a conflict, would have caused mental strain.

Shellshock or War Neurosis cases were charted similarly to other injuries: mild, moderate, or severe. This diagnosis came about during the War.[133] It was commonly associated with neurological symptoms such as tinnitus, amnesia, headaches, hypersensitivity to noise, becoming mute, dizziness and tremors.[134] It was theorized these neurological symptoms were common in combat due to damage to the brain. However, the distinction with shell shock was the lack of neurological damage or physical injuries. Symptoms varied and were psychosomatic as servicemen presented injuries that were not rooted in a physical injury. This absence of external injuries resulted in medical experts of the time theorizing the symptoms were caused by compression and decompression of the brain when in close proximity to an explosion.[135] By the time the American Expeditionary forces arrived, British and French medical personnel, commanding officers, and governments had already made attempts to understand and classify

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Harrison Cale, “"The American Marines at Verdun, Chateau Thierry, Bouresches, and Belleau Wood,”" *Indiana Magazine of History* 15, no. 2 (June 1919), 188.

[132] Reutter, 985.

[133] Edward A. Strecker, “Experiences in the Immediate Treatment of War Neurosis,” *Journal of Insanity* (1919): 45-69.

[134] Edgar Jones and Simon Wessley, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (New York: Psychology Press, 2015), 8-10.

[135] Edgar Jones and Simon Wessley, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Guld War*, 23.

shell shock. British contemporaries began identifying shell shock cases as early as 1915. It was noted the “gradual psychic exhaustion from continued fear” played a role in causing shell shock amongst troops.[136] These cases were initially documented as being a war wound. However, by 1916, the additional category of “shell shock (sick)” was added by leadership. This category was used to identify shell shock cases that were not directly and evidently caused in relation to battle. This new designation removed access to honors and pensions as a veteran with a war wound. The French forces used electro-therapy as a treatment with reportedly positive results and return to the front lines.[137] These early treatments would aid in the development of the American treatment protocol developed by Major Thomas Salmon, discussed in the next chapter.

Shell shock cases were well documented and were commonly seen after days of heavy artillery fire. Notably, the accidental gunshot wounds occurred in a less frequent but congruent rate as shell shock during major offensives and heavy artillery fire. I speculate, there is a high probability these injuries were associated with shell shock. That being said, it is impossible to know the exact number of shell shock cases due to medical rolls only listing the injury which is most pressing at the time of admittance.

Casualty Statistics

Between June 1 and June 26 1918, the Battle of Belleau Wood in the Chateau Thierry Sector resulted in a 55% overall casualty rate with an estimate of 4,000 wounded to include those

[136] Wilshire, 24.
[137] Wilshire, 25.

gassed as well as 1,000 Marines died during this offensive. Marines got their first experience of mustard gas during this confrontation.[138]

From July 18, 1918 through July 22, 1918, the 5th and 6th Marines fought in Soissons as part of the Aisne-Marne Counter Offensive.[139] The 5th Marines sustained significant casualties on July 18, 1918 which resulted in pulling the 6th Marines from reserve.[140] The bulk of the reported casualties were reported as being gunshot wounds.[141] Companies were losing between 30% and 60% per company with the 5th and 6th Marine's losing, on average, two-thirds of their men.[142] In total, Marines sustained 2,015 enlisted and 76 officer casualties. Of those casualties 2 officers and 39 enlisted were gassed. Enlisted Marines sustained 1,750 wounded, the bulk of which were listed as being unknown and severe in order of magnitude. 260 either died of their wounds or were killed in action. The remaining casualties were listed as missing in action.[143]

One million Marines and soldiers fought at Meuse-Argon for forty-seven days from September 26, 1918 to November 11, 1918 with over 120,000 casualties documented. It was the largest and tactically most important operation Marines participated in during this war. Marines charged through no man's land in order to destabilize the German lines and continue pushing

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[138] Sharon Reutter, "Hazards of Chemical Weapons Release During War: New Perspectives," Environmental Health Perspectives 107, no. 12 (1999), 985.
[139] Edwin N. McClellan, *The United States Marine Corps in the World War*, 3rd ed. (Marine Corps, 2014), 118.
[140] Annette D. Amerman, *United States Marine Corps in the First World War: Anthology, Selected Bibliography, and Annotated Order of Battle* (Quantico, VA: History Division, United States Marine Corps, 2016), 167.
[141] Edwin N. McClellan, *The United States Marine Corps in the World War*, 118.
Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[142] Annette D. Amerman, *United States Marine Corps in the First World War: Anthology, Selected Bibliography, and Annotated Order of Battle,* 167.
[143] McClellan, 118.
Amerman, 187-188.

east.[144] The overly zealous Marines placed along the southern quarter of the front sent wave after wave. Marines jumped over their trench lines and charged through enemy fire. Six officers were listed as killed in action, three died of wounds. Zeiger postulates an average of 550 Marines and soldiers died daily during the forty-seven day offensive.[145] The archival records for October 4, 1918 and October15, 1918, which were the best documented, support this argument. October 4, 1918, listed 30 killed in action, 191 wounded, 107 missing in action, and 7 gassed.[146] October 15, 1918 lists 1,059 total enlisted casualties.[147] Of those casualties the bulk of the injuries came from gunshot wounds of which 16 were severely wounded and 30 officers were slightly wounded with 4 listed as being gas victims, for officers specifically. Enlisted Marines suffered 91 killed in action, 20 died of their wounds, 209 severe gunshot wounds, 484 slight gunshot wounds, 83 gassed, and 21 shell shocked.[148] A further 151 were listed as missing in action. As previously mentioned, medical reports list only the most severe injury sustained. It can then be reasoned there was a higher percentage of gas victims who's injury was mild, at least, not as severe as the gunshot wound which was sustained. These two dates of conflict are collected from the 1st Battalion and 2nd Battalion of the 5th Marines, respectively with the dates. Interestingly, the 2nd did not document shell shock cases. As such, it is possible the casualties on October 4, 1918, were much higher due to possible undocumented cases of shell shock.

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[144] U.S. War Department. General Staff. War Plans Division. Historical Branch. Blanc Mont (Meuse-Argonne Champagne), monograph no. 9. Washington, DC: Government Printing Office, 1920.
[145] Robert. H. Zieger, *Americas Great War: World War I and the American Experience* (Rowman and Littlefield, 2002), 108.
[146] McClellan, 115.
Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[147] McClellan, 115;
Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[148] Battalion Special Order No. 24, NND-984104, box 31, Regimental Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.

There was a small portion of Marines on the Killed in Action roll which were listed as dying of disease. However, the disease is not listed. Others were specifically listed as dying of their wounds, pneumonia, etc.[149] A smaller portion of Marines were listed as "died of other causes," again the cause is not documented. Further analysis into the full casualty roll finds these individuals along with all those listed on the death rolls omitted from the casualty rolls.[150] This is likely in order to differentiate between statistics. However, due to this separation, and a lack of publicly available archival records it is unknown what their causes of death were. Based on the dates of death it can be postulated most of these individuals did not die due to a direct physical correlation to battle, otherwise they would have been listed as having died of their wounds. However, that is not the case. Instead, the lack of clarity and limited availability of daily or weekly medical intakes leads to an inability to determine what other causes of death were probable.

In total, 2,461 Marines lost their lives along with 9,520 wounded in action between 1917 and 1918. The modernization and introduction of more sophisticated forms of killing resulted in the Great War being the first war the United States fought where the deaths were greater due to combat as opposed to disease. The gunshot wounds and mustard gas casualties may not have directly caused shell shock. However, the gore, destruction, and the impending fear of an invisible killer that comes in the wind would create a significant amount of mental strain and trauma.

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[149] World War I Casualty Cards, Marine Corps University, United States Marine Corps History Division, Quantico, VA.

[150] World War I Casualty Cards, Marine Corps University, United States Marine Corps History Division, Quantico, VA.

CHAPTER V

TREATMENT PROTOCOLS DURING AND AFTER THE GREAT WAR

Treatment of medical emergencies and injuries during the First World War were a modern adaptation to trench warfare in the European front. The effort to organize the process of treating injuries of all types was a logistic effort intended to return servicemen to the front, when possible, or evacuate those who could not continue their service. Treatment of shell shock cases in both the short and long term changed over time, though one core similarity remained: how can shell shocked casualties continue serving the war effort without being a burden on the government?

Medical Aid Stations

Medical Aids stations were organized in a pyramid-like structure. Some medical stations were located at the front lines while others behind the lines took in the more difficult cases. Patients were assessed for evacuation or to be held for continued treatment at any of the given aid stations based on severity of the injury.[151] These stations were manned by a Navy corpsman, trained medics, as well as assigned officers.

The first stage of medical treatment was at the front lines whereby a Marine or Corpsman

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[151] Charles Lynch, Joseph H. Ford, and Frank W. Weed, *The Medical Department of the United States Army in the World War* Vol. VIII. (Washington DC: Government Printing Office, 1925), 41.

applied bandaging and basic pressure to a wound. Similarly, to issued ammunition, all members of the American Expeditionary Force including Marines were issued bandages to begin applying pressure as well as cover wounds from further injury and exposure to dirt and debris.[152] Theinjured would make their way to Regimental Aid Stations where medical corpsmen or Army medics would apply field dressings and basic aid.[153] Each of the stations was assigned four companies and would assess those injured to determine if they needed treatment further behind the lines. Marines would be sent to Battalion Aid Stations when they were found to be too severely wounded for Regimental stations to treat.

Battalion stations were located anywhere between 500 to 1000 yards behind the front lines and were typically housed in a protected area of some kind.[154] This could be within a building, shelter, or dugout dependent on where the front line was at a particular time.[155] These stations did, however, require greater planning as they would need to be accessible by foot when coming from the front and by road when evacuating the wounded or receiving supplies. Stations were assigned medical officer, 4 to 6 corpsmen, 2 runners, and a stretcher squad in order to treat a maximum of 30 patients.[156] Battalion stations would complete field cards which acted as a medical record and would be the station to determine a diagnosis for the wounded. This included finding Marines to be shell shocked or psycho-neurotic.[157] Wounded would be evacuated via Sanitary Trains that were dedicated to transporting medical supplies and those who required medical treatment.

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[152] Charles Lynch, Joseph H. Ford, and Frank W. Weed, *The Medical Department of the United States Army in the World War* Vol. VIII, 111.
[153] Charles Lynch, Joseph H. Ford, and Frank W. Weed, 107, 117-120.
[154] Charles Lynch, Joseph H. Ford, and Frank W. Weed, 105- 107, 117.
[155] Charles Lynch, Joseph H. Ford, and Frank W. Weed, 111.
[156] Charles Lynch, Joseph H. Ford, and Frank W. Weed, 114, 182.
[157] Jonathan H. Jaffin, "Medical Support for the American Expeditionary Forces in France During the First World War," 145-146.

The next step would be to enter a Field Hospital. Field hospitals housed Division Psychiatrists who evaluated those suspected to have war neurosis.[158] Most, approximately 65%, of war neurosis cases could be treated at the Field Hospital level. However, 35% of those with war neurosis were transported to neurological hospitals or units.[159] Diagnosis consisted of shell fright, gas fright, hysteria, mental or physical fatigue, malingering, and in some cases cowardice.[160]

Treatment During the War and Social Stigma

Base Hospital 117 served as the main treatment facility for shell shock cases: treating 3000 servicemen with success rates between 40% and 75% returning to the front.[161] By 1918, the Red Cross and the United States military operated hospital wards and full treatment facilities to treat Shell Shock cases. Facilities incorporated a range of treatment techniques to include rest, hypnotherapy, electrotherapy, crafts, and physical activities. Photographs of unidentified servicemen can be seen convalescing in these field hospitals established by the American Red Cross.

A variety of photographic evidence depicts servicemen convalescing at the American Hospital in London, England and at Chateau Chambord. They are seen fishing, playing baseball, and farming. “Farms proved the perfect medicine” for shell shocked servicemen.[162] The use of farming allowed a calm space to convalesce while simultaneously ensuring the usefulness of

[158] Charles Lynch, Joseph H. Ford, and Frank W. Weed, 72, 440;
Jonathan H. Jaffin, 146.
[159] Charles Lynch, Joseph H. Ford, and Frank W. Weed, 65, 555.
[160] Charles Lynch, Joseph H. Ford, and Frank W. Weed, 65
[161] Jones Wessely, 33.
[162] Davison, 146.

servicemen by providing food.[163] Contemporary publications cite the term "usefulness" repeatedly and treatments were aimed at ensuring the convalescing servicemen were assisting in the war front. These locations had farms that served to grow and provide food for the front.

Asylums and Post-War Treatment

After the war, General Hospital No. 43 in Virginia was designated to serve all "mental patients" meaning this hospital housed all shell-shocked Veterans, not just Marines.[164] However, they were also tasked with providing medical and surgical care for patients. This hospital included laboratory services and hydrotherapy. Hydrotherapy included placing patients in a continuous bath during a psychotic episode. The report admits this hospital was not intended to serve psychiatric patients which led to no standardization of wards. Barracks dormitories with capacities ranging from 35 to 200 were converted into wards.[165] Within some wards, screens were installed to ensure the "retention of the irresponsible cases."[166] This translates to the installation of barriers to prevent psychiatric patients from escaping or running out through doors and windows. Further treatment consisted of sedative baths, needle showers (water jets uses simultaneously on different parts of the body), electric heat, occupational therapies, and exercise.[167] Approximately six patients required the use of sedative drugs when other therapies like baths and the use of hot packs was no longer a feasible alternative.[168] A restraint sheet is also mentioned however the Surgeon General remarks it as being "practically never used."[169] A

[163] Davison 140.
[164] United States, *Report of the Surgeon General of the Army to the Secretary of War 1920* (Washington DC: Government Printing Office, 1920), 474.
[165] United States, *Report of the Surgeon General of the Army to the Secretary of War 1920*, 474.
[166] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 273, 474.
[167] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 474-475.
[168] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 474.
[169] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 474.

separate ward was established for "excitable cases" where heat treatments like baths and hot packs were made available.[170]

Occupational therapy was used, primarily, to "obtain general cooperation" and not to develop confidence.[171] Therapies for those deemed "helpless and irresponsible" began with tasks such as "winding string, unraveling of burlap, basket, rug weaving, knitting, etc."[172] These tasks were intended to regain control of oneself and be deemed more responsible. An increase in the level of responsibility led to being allowed more physical and mental tasks like "carpentry, printing, typewriting, and automobile repair."[173]

Exercise and recreation were also to maintain physical conditioning and entice patients to eat. Patients would be grouped together and allowed to exercise outdoors. Those deemed less responsible would be taken on walks. The report sites "a large number of mental cases" who were diagnosed "later had their mental faculties return almost to normal."[174] These patients would be discharged on their own responsibility.[175]

The Surgeon General states some cases were not identified until after armistice after a psychotic episode at demobilization centers. It was reported many of these individuals drank heavily in France which led to difficulty determining is the cause was psychosis or alcohol use in origin. This demonstrates increased risky and numbing behavior used to cope with the trauma sustained at the front.

In addition to the military operated facilities, the American Red Cross made plans for the treatment of Shell Shock and "various phases of psychoneurosis" as part of their planning for

[170] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 447, 474-475.
[171] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 474-475.
[172] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 474-475.
[173] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 475.
[174] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 475.
[175] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 475.

treatment of the disabled.[176] In addition, the Soldiers Rehabilitation Act was passed in June 1918 to train disabled veterans, shell shock victims included, a trade that could reintegrate them into the post-war workforce.[177] The purpose of this program was to ensure servicemen returned to "industrial efficiency" which meant they would not be a burden to society that required the financial and community supports. According to the Red Cross, "25% are suffering from some phase of shellshock or nervous disorder."[178]

The change of perception and the increased discourse over what to do with the large portion of shell shock casualties became more observable in the interwar period. This is likely due to the economic burden associated with the care and maintenance of veterans who were institutionalized or disabled due to shell shock.

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[176] Henry Pomeroy Davison, *The American Red Cross in The Great War,* (New York: Macmillan 1919), 124.
[177] Federal Board for Vocational Education, *Federal Act Providing for the Reeducation of Disabled Soldiers, Sailors, and Marines*, (Washington DC: U.S. Government Printing Office, 1919), 3-9.
[178] Davison, 130.

CHAPTER VI

EVOLUTION OF PSYCHIATRIC TREATMENT AND PERCEPTION

The United States Marine Corps during World War I required the use of the medical corps working in tandem with war psychiatrists. There are currently no historical studies that focus exclusively on the treatment of U.S. Marines who experienced forms of PTSD during and immediately after World War I. However, based on Ben Shepard's *War on Nerves,* Fiona Reid's *War Psychiatry,* and Edward Shorter's *A History of Psychiatry,* and other articles one can observe the varied approaches taken by the medical community during and immediately after the war, resulting in improvements to early psychiatric practices. Prior to The Great War, "diseases of the mind" were analyzed by general practitioners of medicine then neurologists. Medical psychiatry, however, took a variety of approaches and treatment which reflected the social and cultural stigma of the time.[179]

The History of Military Medicine and War Trauma in the late 19th Century

The scientific study of mental illness and its relation to modern warfare was a product of the Victorian Era during which general medical practitioners who previously treated all ailments began to specialize. Much of this research was closely connected to the major wars of the 19th

[179] Shephard, 187.

century, which were fought with mass armies, and had tremendous effects on soldiers. For example, during the era of the Crimean War in Europe and the American Civil War, many medical professionals focused on soldiers' cardiovascular system. In the 1860s and 1870s, the medical profession witnessed the emergence of the "Da Costa's Syndrome." At the time, Jacob Mendes Da Costa who worked as a physician at the US Army Hospital for Injuries and Diseases of the Nervous System—noticed that soldiers experienced palpitations, breathlessness, chest pain, and exhaustion.[180] He argued that these symptoms of what he called the "irritable heart," were especially familiar to many" who witnessed "the late war."[181] Costa's diagnosis associated these physical symptoms with mental strain.

Prior to the 1860s, symptoms of anxiety and fear during war were terms used to represent courage, valor, and strength. Symbolic of a soldier's bravery by going into battle in spite of those feelings. However, the symptoms developed a negative stigma. This corresponded with the early feminist movement and the rise of the "new woman" in the 1890s. Palpitations, breathlessness, and exhaustion were associated with women and became symbolic of cowardice, a lack of masculinity, and an inability to adapt to one's environment. Over time, certainly by the time of the War, nervousness and nerves became associated with two main diagnosis, hysteria and neurasthenia.[182] Hysteria was typically associated with "lachrymose and emotional" symptoms while neurasthenia was associated with someone who was "depressed and inert."[183] The general consensus among medical professionals was that the "nerves of men" had been put under heavier strain which the human mind was never meant to undergo.[184]

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[180] Edgar Jones and Simon Wessley, 8-10.
[181] Jacob Mandes Da Costa, *On Strain and Over-action of the Heart* (Washington: Smithsonian Institute, 1874), 7.
[182] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists, 1914-1994*, 7.
[183] Shephard, 9-10.
[184] Shephard 7-8.

These so-called "diseases of the mind," particularly Da Costa's Syndrome, were eventually labeled as "war neurosis" and "shellshock." War neurosis was described as having, most commonly, the following symptoms: fatigue, slower reaction times, indecision, disconnection from one's surroundings, and the inability to prioritize. Shellshock was associated with a nervous reaction to war associated with the following symptoms: tinnitus, amnesia, headaches, dizziness, tremors, and hypersensitivity. Shell-shock symptoms were notable because they were typically associated with physical head injuries. However, shell-shocked casualties did not have any head injuries. This diagnosis was documented within medical records maintained by the field hospitals and was used for enlisted servicemen and commissioned officers. The archival medical records do not associate any head injuries with shell-shock and maintain shell-shock as the only injury.

Due to its unprecedented nature, the First World War also fundamentally shaped and changed the field of psychiatry. Many of the effects that the war had on the profession played out in Europe first. Per the United States Library of Congress and The New York Times' *The War of Nations*, the United States suffered a total of 192,483 casualties between 1914 and 1919. Of these casualties the Marine Corps sustained 2,015 enlisted and 76 officer casualties. For comparison, Great Britain had 2,037,325 total casualties and France sustained 2,675,000 casualties.[185]

The ways that European powers treated their soldiers who exhibited "shell shock" differed greatly. Between 1914 and 1917, British medical and psychiatric providers preferred to send their soldiers with war neurosis to isolated locations, taking special care not to discharge or let others see these mentally ill patients while those with physical illnesses or injuries were being

[185] Fiona Reid, "War Psychiatry," *International Encyclopedia of the First World War* (October 8, 2014), 7.

unloaded from medical transports.[186] The French allowed for their soldiers to continue fighting and to be treated near the front lines, never truly being allowed to avoid the same sounds, smells, and sites which resulted in their shell shock.[187] The central powers were not very different. German soldiers were given "soft treatments" like good food, pine needle baths, and comfortable accommodations.[188] Austria would have their shellshock casualties brought to Vienna and treated through the use of electrotherapy.[189] By all accounts, soldiers on both sides of this war were against the use of electrotherapy due to the fear of electricity being overused.[190]

Furthermore, much of the language used at the time of the "discovery" of shellshock was related to the term hysteria. Hysteria was a term originating in the 16th century to describe an anxiety or obsessive compulsive disorder.[191] As a result, during the early phases of the war many Europeans believed shellshock to be more associated with avoidance of war or shell shyness, meaning that servicemen were not capable of handling military service.[192] This coupled with the current presence of eugenics in Great Britain and Social Darwinism resulted in a belief that mental health issues, specifically war neurosis, were products of an individual's inability to function and be a part of the modern world.

The emergence of "shell shock" and "war neurosis" among soldiers in Europe also caught the attention of American medical professionals as well as military personnel. Prior to the United States entering World War I, for instance, the U.S. military sent Major Thomas W.

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[186] Fiona Reid, "War Psychiatry," 8.
[187] Fiona Reid, 7.
[188] Fiona Reid, 8.
[189] Fiona Reid, 8.
[190] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley, 1998), 22.
[191] Fiona Reid, 4.
[192] Edward A. Strecker, "Experiences in the Immediate Treatment of War Neurosis," *Journal of Insanity* (1919): 45-69.

Salmon, a Psychologist with the U.S. Department of Public Health, to conduct a study in France and Great Britain regarding shell shock and war neurosis in 1916. The study was done with the intent to develop a protocol for treating shell-shocked casualties. His findings were published in *The Care and Treatment of Mental Diseases and War Neurosis ("Shell Shock") in the British Army.* He determined there were three main issues regarding war neurosis: a decrease in fighting forces, the difficulty in distinguishing war neurosis or shellshock from hysteria and other mental illnesses, and the limited knowledge of the cause of this "new" mental condition.

Based on his research, Major Salmon created a tiered system classifying symptoms as mild, moderate, and severe. These classifications were intended to treat shell-shocked servicemen, including Marines, at the front lines when possible and evacuate when necessary.[193] The first tier was used for servicemen who had mild forms of shell shock or war neurosis. Mild shell shock was identified by commanding officers early on and was identified by a minimal behavior change but still being able to function in the field. The goal was to identify these symptoms within 48 hours and begin treatment through the use of a period of rest, supportive psychotherapy, and informing servicemen that their reactions were perfectly normal and would disappear in a few days. Supportive psychotherapy was a form of talk therapy intended to help servicemen process through their experiences and understand their experiences were normal. According to one statistic 65% of soldiers—with no differentiation made between Army and Marines—were sent back to the front lines after 4 or 5 days.[194] The second tier was intended for more moderate cases and consisted of psychiatric and neurological wards in base hospitals which were 5 to 15 miles behind the front lines where soldiers remained in these facilities for

[193] Edward A. Strecker, "Experiences in the Immediate Treatment of War Neurosis," 45-69.
[194] Carol R. Byerly, "War Losses (USA)," *International Encyclopedia of the First World War* (January 8, 2017), 5.

approximately 3 weeks. However, the most severe cases were sent specifically to base hospital 117, under the direct supervision and treatment of Major Salmon, approximately 50 miles from the frontline.[195] Shell shock and war neurosis casualties remained at this hospital for long term treatment of 6 months.[196] A failure to demonstrate a return to a normal mental state resulted in servicemen being returned to the United States for further treatment.[197] Major Salmon's approach was modern and ahead of its time when compared to the experience of other allied nations.

Today, psychologists and historians agree shell shock and war neurosis were terms used to refer to post traumatic stress disorder. Shell shock or war neurosis was caused by prolonged exposure to trench warfare. The Manual of the Medical Department, published in 1917, provided general guidance for dealing with the "mentally defective" by providing guidance on condemnation to asylums. Medical personnel were not provided with examples of symptoms or stigmata in the Manual of Medicine in 1917 of what constituted a "mentally defective" individual, indicating psychiatrists would have needed to be briefed on or read Salmon's report. Additionally, the lack of a clear identification of symptomology needed to arrive at a diagnosis illustrates the lack of consistent screening. The societal bias that initially developed surrounding hysteria as a woman's ailment resulted in medical doubt regarding the validity of shellshock.[198] The social doubts were evident in the practice in which doctors were required to prove a Marine had become insane as a result of his service.[199] The 1917 Manual of Medicine notes Marines

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[195] Carol R. Byerly, "War Losses (USA)," 5.
[196] Fiona Reid, 3-4, 7.
[197] *Report of the Surgeon General of the Army to the Secretary of War 1920*, 474-475.
[198] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1914), 176.
[199] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1914), 175-176.

were to be “condemned” by a board of naval medical officers to the Government Hospital for the Insane in Washington, D.C.[200] Officers were encouraged to observe recruits for “stigmata of degeneration” and “mental abnormalities” in order to prevent those who are more susceptible to being classified as mental defectives from being an unnecessary burden on the United States Government. Meaning officers who did not have any psychiatric training were tasked with identifying an undefined group who could pose a financial burden by becoming mentally disabled. Again, there is no mention of what the stigmata is being referred to. It can be argued there was no uniform method of analyzing the mental state of recruits due to a lack of clear identifiable symptoms or stigmata.[201]

The *Manual of Medical Department*, a publication issued by the Department of the Navy for all medical personnel, indicates Marines who have been classified as insane due to their service are entitled to treatment and the Department of the Navy is authorized to make provisions for their care. In 1917, Marines were to be condemned to a “psychopathic ward” by a board of physicians and doctors.[202] The inclusion of psychopathic wards was directly against Salmon’s recommendation as he argued servicemen should be treated in outpatient facilities to avoid too long held stigma of insane asylums. According to social historian, Edward Shorter’s, *A History of Psychiatry*, asylums were “warehouses for the insane.”[203] These insane were either too numerous to be properly treated or included social misfits and outcasts. The 1914 and 1917 editions of the *Manual of Medical Department* use the term “mental defectives” to refer to any and all members of the Department of the Navy who require psychiatric treatment at “Hospitals

[200] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1914), 176.
[201] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1917), 227.
[202] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, 33.
[203] Edward Shorter, 33.

for the Insane."[204] The use of the term defective indicated that soldiers with war neurosis and shellshock were viewed as flawed individuals who were not capable of functioning at a proper capacity. This correlated with a belief that soldiers had a limit to the amount of bravery they could provide in battle and this required rest in order to replenish a soldier's fighting spirit.

Terms like condemned, indicate a negative stigma surrounding mental illness which was associated, most famously with hysteria or being work shy. Hysteria, a traditionally feminine illness commonly referred to as nerves, was initially argued to be the cause of shell shock by European nations. Shorter argues the term nerves became a socially acceptable form of madness.[205] Shorter then notes nervous clinics were preferred over insane clinics because of the negative image created by asylums going so far as to explain the specialization of neurology came as a result of a this negative stigma.[206] This coupled with allegations of "work-shyness" created a negative stigma regarding shell shock within the public perception. Shell shock was believed to be shell-shyness, similar to work-shyness. Psychiatrists at the time argued mental illness was a result of the increased modernization of technology.

The negative social stigma and biases developed during the early 20th century resulted in a belief that shellshock was caused by "work-shyness" or an avoidance of doing one's duty in the trenches. This negative stigma percolated into American psychiatric practice by maintaining treatment facilities near and along the front lines. By maintaining proximity to the front lines, Marines would know even if they were sent to treatment facilities, they would eventually go back to fighting in the trenches by the fourth or fifth day or moderate treatment. Furthermore, this proximity served to dispelled doubts held by doctors and members of the higher ranks which

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[204] Edward Shorter, 114.
[205] Edward Shorter, 119.
[206] Battalion Special Order No. 24, NND-984104, box 31, 6th Regiment-Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.

believed Marines and servicemen were simply trying to get out of fighting. It should be noted that muster lists and reports detailing injuries sustained by Marines did include shell shock as an injury. However, all but one documented case was labeled as "slight" and did not note if medical attention was warranted. Soldiers were sent back to the front lines.

One particular case of shell shock was listed as severe, Thomas Coyne of the 82nd Company of the 6th Regiment, who experienced this mental episode was evacuated from the front lines on June 25, 1918.[207] The 25th was a day of continuous artillery bombardment.[208] This coincides with the penultimate day of the Battle of Belleau Wood. Coyne was also one of many Marines who were identified as being honorably injured and granted permission to wear the wound chevron.[209] These men, unlike those who were shot or gassed, were listed as "SS" for shell shock.[210]

All available records identify shell shock in Marines during major conflicts and offensives: Belleau Wood and Meuse-Argonne Offensive. The highest rates were documented to have been between October 1st and October 10th, 1918, coinciding with Marines charging towards enemy trenches and being mowed down by German machine gun fire.

A characteristic trait of shellshock is avoidance and an inability to function efficiently. However, American shell-shock casualties were rarely evacuated. Interestingly, some injuries according to the archival records were "accidental" or of "one's misconduct."[211] This is an

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[207] Eggleston, 73.
[208] Battalion Special Order No. 24, NND-984104, box 31, 6th Regiment-Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[209] Battalion Special Order No. 24, NND-984104, box 31, 6th Regiment-Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.
[210] Hans Pols and Stephanie Oak, "War and Military Mental Health," *American Journal of Public Health* 97, no. 12 (2007): 7.
[211] Battalion Special Order No. 24, NND-984104, box 31, 6th Regiment-Casualties and Deaths (13 Apr-13 Oct18), National Archives, Washington, D.C.

important correlation and identification to make as accidental injuries can be associated with an effort to leave the trenches. These injuries were all associated with non-fatal injuries to physical extremities like the hands and feet. Muster lists from 1918 included injuries which were documented as gunshot wounds to non-lethal parts of the body like the right foot or the left hand. Others were documented to have had sprained ankles and skin conditions. The main issue is the gunshot wounds to non-vital parts of the body. Gunshot wound victims would be removed from the trenches in order to avoid infection of the body part and possible amputation. This could have been an easy way out for Marines who wanted to avoid being "condemned" to psychiatric wards or be sent to shell shock treatment facilities in the field. Unpublished enlistment recruitment posters note the Marines are not for those who "must be cushioned to shock."[212] This play on words is a jab at those who experienced shellshock and a sign of the negative stigma. Furthermore, it is reference to the initial beliefs that shell shock was caused by a shock to the brain caused by the explosion of artillery shells, hence the name shellshock. It should also be noted in many of these gunshot wounds documentation lack any other injuries. Marines were either slightly injured, gassed, had a gunshot wound, or experienced shellshock.

None of the archival record presents multiple injuries to Marines. This likely means injuries were documented based on the severity of the injury. Considering that mental illness and mental health were not fully understood at the time and not seen as being on the same level as a physical injury, it can be assumed that more Marines experienced shell shock but were not fully documented. Additionally, within the muster lists multiple Marines were labeled as AWOL, away without leave. Being away without leave meant that a Marine fled or was hiding from their

[212] Office of the Commandant, HM-2007, box 8, General Correspondence (1913-1938), National Archives, Washington, D.C.

superior. These men could have either been experiencing shell shock and sought to avoid their trauma triggers, or these men were viewed as cowards who were avoiding their patriotic duty.

War Trauma and Military Medical Practices After World War I

When World War I ended a large population of Marines were left scarred and broken both mentally and physically. The interwar period saw the continued use of negative terminology as the insane or defective. Medical treatments and increasing understanding of how to treat the different stages of an episode of war neurosis were gradually improved. The *Manual of the Medical Department* of 1917 was republished 1927. The 1927 edition made clear Marines would now be entitled to treatment if their mental illness was caused due to service.

Treatment for war neurosis continued after the end of World War I, one figure noting 27% of all hospitalizations of ex-servicemen, this includes Marines and US Army, were defined as neuro psychiatric cases which increased to approximately 46.7% by 1927.[213] This spike in servicemen manifesting mental illnesses coincides with the creation of another rendition of the manual for a medical Department in 1927.

Post-War Period and the Rise of Suicide in Servicemen

The number of deaths classified as suicide cases among veterans of the war seem to have increased based on the inclusion of a specific section in the *Manual of the Medical Department* focusing on suicide and the consideration of how suicide relates to one's mental condition or if mental or physical disability existed.[214] Government related publications are not updated unless

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[213] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1927), 333.
[214] Carol R. Byerly, 7-8.

there is a need for an additional section or the prior publication is severely outdated. During the post war period, commanding officers questioned whether or not the use of pensions was assisting servicemen or hindering their healing due to being "rewarded" for their disabilities.[215] Shell shock, which was a war wound that was documented to have been worthy of commendations in the form of wound chevrons were now being questioned based on their validity for access to pensions. Government policy was enacted to reeducate a population of disabled veterans so they could be members of the tax contributing society. The bias of a society was coming to the surface during the interwar period.

The 1927 edition of the *Manual of the Medical Department* correlates with multiple Marine Corps correspondence and inquiries of service men who died under questionable circumstances. Medical professionals were required to note their professional opinions if the suicide was due to a "mental abnormality."[216] This policy is presented in an inquiry of the suicide of Sergeant Robert R. Stock. This inquiry notes:

> suicide does not it of itself conclusively rebut the presumption of continuing sanity." Sergeant Stock was found to have committed suicide from a self-inflicted wound not in the line of duty and is the result of his own misconduct. Sergeant Stock had been complaining of feeling sick in days leading up to his suicide. Furthermore, the inquest notes the Sergeant Stock was crying in the courtyard in Nicaragua on the day in question.[217]

[215] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1927), 333.
[216] Inquest of the Death of Sergeant Robert Stock, HM-2007, box 9, Office of the Commandant: General Correspondence (1913-1932), National Archives, Washington, D.C.
[217] Inquest of the Death of Sergeant Robert Stock, HM-2007, box 9, Office of the Commandant: General Correspondence (1913-1932), National Archives, Washington, D.C.

A second endorsement is listed by medical officer, Lieutenant Commander Cochrane, indicates Sergeant Stock showed no signs of "mental derangement."[218] A court-martial further investigated the matter and agreed with the medical decision discussed. This individual's death and documentation surrounding the circumstances of his death illustrate how medical policy and military officers addressed suicide. Correspondences documented in the archival record note a back and forth discussion whether his suicide is the result of mental illness.[219]

The 1939 edition of *Manual of the Medical Department* further discusses the differences in treatment of commissioned and warrant officers compared to enlisted service men. Officers are given the opportunity to return to duty, if cleared, or allowed to retire.[220] Enlisted soldiers are reviewed and placed into one of three categories: men who can care for themselves and are not a menace to society, men who require discharge from service, and those who are discharged from service but require prolonged care in a hospital for the insane.[221] Previous editions make reference to misconduct, but the 1939 edition discusses misconduct through an entire chapter. Under this section, suicide is specifically listed as being the product of a mental condition for it not to be of one's own misconduct.

World War I resulted in modern approaches to the treatment of mental health while the interwar period witnessed the continuation of the debates over the validity of the diagnosis of "war neurosis" and what the role of the United States government as well as the Department of the Navy played in the lives of Marines who returned with psychological scars.

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[218] Inquest of the Death of Sergeant Robert Stock, HM-2007, box 9, Office of the Commandant: General Correspondence (1913-1932), National Archives, Washington, D.C.
[219] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1939), 231.
[220] *Manual of the Medical Department* (Washington: U.S. Navy Department, Bureau of Medicine and Surgery, 1939), 231.
[221] *The War of the Nations: Portfolio in Rotogravure Etchings* (The New York Times Company, 1919).

CHAPTER VII

CONCLUSION

My thesis is categorized as psychiatric history, new military history, and history of emotions. My thesis adds to the limited available literate focusing on the mental health and efforts taken by the military to treat shell shock in the Marine Corps during World War I. By analyzing the archival documentation completed by medical personnel and officers and the published manuals created by the military a more complete understanding of the perception of shell shock was identified. The military took steps to identify ways to prevent and treat shell shock, prior to entry. Furthermore, injuries of the mind were included in the medical manuals. However, the discrepancy and identification of the social perception was found in the documentation created by officers or lack thereof.

Future Research

There is currently a limited number of historiographic studies related to the treatment of mental health within the Marine Corps and the Department of the Navy. Ideally, my thesis could be expanded to encompass World War II. This expansion would allow for a more in-depth analysis of the change in treatment of shell shock and war neurosis. This would also allow for a study on the internalization of trauma, social stigma associated with trauma, and perception of trauma during the First World War, inter war period, and Second World War. This is due to the

multigenerational aspect of these wars: Fathers fought during the first war, and sons fought during the next. Various questions arise when considering this fact. Did the young men who fought in World War II idealize the perceived experiences of their fathers during the World War I? The study could also be expanded through the relative present to analyze the evolution of psychiatric treatment and care in the individual branches of the military while tying in the social perceptions, stigmas, and cultural movements which shaped perception.

Between 1917 in 1927, treatment of shell shock and War Neurosis as a war wound fluctuated between a valid casualty and a questionable disability. The social stigma resulted in a complex perspective and interpretation of mental health and sparked debate that resulted in changes to the treatment protocols.

Conversely, the thesis could expanded by taking a narrowed down approach; focusing on the inter war period and analyzing the social and economic effects on psychiatric treatment for veterans of the war. Observation and analysis of this interwar period would allow for a more thorough understanding of the changing political and social perception of mental health and allow for a more detailed view into the debates as to what the country should do with the large population of veterans with some form of War Neurosis. A narrow view of the time period could also shed light on the economic expenditure on psychiatric treatment, possibly shedding light on the additional reasons psychiatric patients where trained to return to the workforce.

Findings and Conclusions

The Marine Corps and the Department of the Navy, as an organization, treated shell shock cases as war wounds during World War I, even in the face of social stigma. However, archival material identified a clear disparity in the identification of shell shock cases between the 1st and 2nd battalions of the 5th Marines. The 1st Battalion was well documented within the

archival record and included a pages worth of shell shock casualties that were awarded a wound chevron. However, the same could not be said fort he 2nd Battalion. This could be as benign as poorly kept records and documentation. However, I argue this is due to the social stigma the 2nd battalion had for retreating from confrontations. Meaning, it was acceptable to be a shell shock case if you did not give way to fear by retreating.

It was not until the interwar period when the financial effects of military service pensions and disabled veterans became an issue that the Department of the Navy began questioning the country's plan for treating veterans with shell shock. These questions manifested in various inquiries as to the validity of shell shock and efforts to determine if the issue was a pre-existing condition or truly an injury sustained in the war. This issue manifested in inquiries over veteran suicides and veterans who were disabled due to the psychological damage of the war. The effects of which resulted in the Department of the Navy publishing a new medical manual in 1927 to include stricter and more detailed guidelines about self-inflicted injuries, suicide, and war neurosis.

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BIBLIOGRAPHIC SKETCH

Itzel Márquez has a background in History, earned her Bachelor of Art in History from the University of Texas Rio Grande Valley in December 2015. She subsequently earned a Master of Arts in History in May 2023. Ms. Márquez' areas of interest center around psychohistory, new military history, and the effects of culture and media of societal stigmas and norms.

Contact Information

3436 Sterling St. Brownsville, TX 78520

itzel.marquez.94@gmail.com