Life after Death

APPROACHES TO A CULTURAL AND SOCIAL HISTORY OF EUROPE DURING THE 1940s AND 1950s

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1

Post-Traumatic Stress Disorder and World War II

Can a Psychiatric Concept Help Us Understand Postwar Society?

ALICE FÖRSTER AND BIRGIT BECK

How far can the pervasive violence of World War II, which affected not only combatants but also civilians, help explain the nature of European societies in the 1950s? The research presented in this book spans several countries and approaches this question from a variety of disciplines. The specific point that this chapter proposes to address is whether the understanding of the individual's reaction to life-threatening violence can contribute usefully to the body of research on the German society of the 1950s. This chapter raises questions and generates new hypotheses or tools for future empirical research. The crucial question remains whether it is at all admissible to use medical concepts to generate hypotheses for historical research.

World War II exposed many individuals to extreme and prolonged violence, and works of fiction as well as historical essays and books attempt to describe the way in which ordinary Germans experienced the war. Wolfgang Borchert's play *Draussen vor der Tür* captured the atmosphere of the early postwar years.[1] When it was first broadcast on the radio on February 13, 1947, it elicited a tremendous response from listeners. The play describes the guilt, pain, nightmares, and finally suicide of a returned soldier confronted by various people, such as a former officer and the director of a cabaret, trying to forget the war and return to normality. Returning to "normality" was particularly important in the 1950s.[2] Here, the most important question is what lies beneath the surface of this normality and necessitates maintaining it at all costs.

1 Wolfgang Borchert, *Das Gesamtwerk* (Hamburg, 1993), 99–165, 341–3.

2 Ibid., 119–36. Besides Wolfgang Borchert, Heinrich Böll also vividly described the early years in postwar Germany in his tales and novels. See, e.g., "Die Botschaft" (1947), in Bernd Balzer, ed., *Heinrich Böll: Werke. Romane und Erzählungen I 1947–1952*, 3d ed. (Cologne, 1989), 30–5.

Because a great deal has been written about Holocaust survivors and their children, few of whom lived in postwar Germany, we will not deal with this particular aspect of the violence during World War II.[3] In recent years, children not only of perpetrators but also of ordinary Germans have begun talking about their childhood experiences of growing up in postwar Germany.[4] The experience of war and destruction deeply influenced their childhood.[5]

In this chapter, we provide an overview of the literature estimating the proportion of the German population that was exposed to violence in combat as well as in civilian life. According to psychiatric observation, certain traumatic experiences engender specific symptoms. We summarize relevant aspects of the psychiatric literature regarding reaction to combat, atrocities, rape, and life-threatening violence, and then attempt to describe the dimensions of the problem in Germany during World War II from a historical point of view. Moreover, we look at ways to investigate the impact of individual disturbance on the society of the 1950s. First, however, we define the concept of post-traumatic stress disorder (PTSD) before moving on to examine the experiences of people in Germany.

THE PSYCHIATRIC CONCEPT OF PTSD

Since as early as the seventeenth century, reactions to traumatic events have been described in works of fiction. However, medical acknowledgment of such a reaction came much later.[6] Both world wars and the Vietnam War

3 See, e.g., Dan Bar-On, "Children of Perpetrators of the Holocaust: Working through One's Own Moral Self," *Psychiatry* 53 (1990): 229–45; Norman Solkoff, "Children of Survivors of the Nazi Holocaust: A Critical Review of the Literature," *American Journal of Orthopsychiatry* 51 (1981): 29–41; Rachel Yehuda et al., "Vulnerability to Posttraumatic Stress Disorder in Adult Offspring of Holocaust Survivors," *American Journal of Psychiatry* 155 (1998): 1163–71.

4 Ingeborg Bruns, *Als Väter aus dem Krieg heimkehrte: Töchter erinnern sich* (Frankfurt am Main, 1991), and Dan Bar-On, *Die Last des Schweigens: Gespräche mit Kindern von Nazi-Tätern*, 2d ed. (Reinbek bei Hamburg, 1996).

5 Bruns, *Väter*, 52: "Mein Vater hat sich nie darüber geäussert, wie die Demütigungen und die Entbehrungen auf ihn gewirkt haben" ("My father never said anything about how the humiliations and privations affected him."); 82: "Als der Krieg kam und mein Vater Soldat werden musste, wurde alles anders. Er hatte kein grosses Interesse mehr an uns Kindern und seine Stimme klang hart" ("When the war began and my father had to become a soldier, everything changed. He no longer had much interest in us children, and his voice sounded harsh."); 89–90: "Ob mein Vater ohne den Krieg, ohne die schrecklichen Erfahrungen, die er doch als Arzt gewiss machen musste und von denen er nie gesprochen hat, ein anderer Vater, ein richtiger Vater hätte sein können? Das einzige was bei ihm sicher war, war, dass man nie sicher sein konnte ob er nicht plötzlich losschlagen oder losschreien würde." ("Could my father have been a different father, a proper father, without the war, without the horrible experiences that he must have had as a doctor and never spoke about? The only thing certain about him was that you could never be certain whether he might suddenly lash out or yell.")

6 Several articles and book chapters give historical reviews of the development of the concept of post-traumatic stress disorder. See L. Stephen O'Brien, *Traumatic Events and Mental Health* (Cambridge, 1998), 1–34; J. David Kinzie and Rupert R. Goetz, "A Century of Controversy Surrounding Post-Traumatic Stress Spectrum Syndromes: The Impact on DSM III and DSM IV," *Journal of Traumatic*

led to systematic research on the psychological reaction to combat. German psychiatric research following World War II focused mainly on the victims of the concentration camps, who were interviewed for compensation claims.[7] Triggered by the Vietnam War, psychiatric research on combat-related reactions to trauma mushroomed in the late 1960s and early 1970s, particularly in the United States. The term *post-traumatic stress disorder* was coined for the symptoms that developed following the experience of "an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone."[8]

The symptoms considered as typical of PTSD are:

- persistent *re-experiencing*, for example, dreams, intrusive recollections of the event, or intense distress at exposure to events that symbolize or resemble an aspect of the traumatic event;
- persistent *avoidance* of stimuli associated with the trauma or *numbing* of general responsiveness, for example, efforts to avoid thoughts, feelings, or activities associated with the trauma, inability to recall important aspects of the trauma, markedly diminished interest in significant activities, feelings of detachment or estrangement from others, restricted range of affect, or sense of foreshortened future; and
- persistent symptoms of *increased arousal*, for example, difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, or exaggerated startle response and physiological reactivity on exposure to events that symbolize or resemble an aspect of the traumatic event.[9]

To make a diagnosis of PTSD, at least one symptom of re-experiencing, three of avoidance and numbing, and two of hyperarousal lasting for at least one month are required.

Symptoms of depression and anxiety frequently occur in conjunction with PTSD.[10] Other disorders frequently seen following combat experience

Stress 9 (1996): 159–79; Bessel A. van der Kolk, Nan Herron, and Ann Hostetler, "The History of Trauma in Psychiatry," *Psychiatric Clinics of North America* 17 (1994): 583–600.

7 For a review of the German postwar literature on Holocaust survivors, see Klaus D. Hoppe, "Aftermath of Nazi Persecution Reflected in Recent Psychiatric Literature," *International Psychiatry Clinics* 8 (1971): 169–204.

8 This definition of the traumatic event was part of the diagnostic criteria for PTSD in the American Psychiatric Association, ed., *Diagnostic and Statistical Manual of Mental Disorder*, 3d rev. ed. (Washington, D.C., 1987).

9 The symptoms quoted in the text are also from the third revised edition. In the third edition of 1980, when PTSD was first included in the manual, survivors' guilt was also among the symptoms.

10 Susan M. Orsillo et al., "Current and Lifetime Psychiatric Disorder among Veterans with War Zone-Related Posttraumatic Stress Disorder," *Journal of Nervous and Mental Disease* 184 (1996): 307–13. The authors summarize critically the current research on the association of PTSD with other psychiatric disorders and then present their own results on 311 Vietnam veterans. Although lifetime rates for alcohol abuse or dependence were highest among the veterans, they did not differ between those with or without a diagnosis of PTSD.

include drug and alcohol problems, and physical symptoms that are not fully explained by a medical condition.[11] The relation between PTSD and alcohol abuse is complicated: Some view the abuse of alcohol as a consequence of PTSD symptoms, particularly sleep disturbance. However, alcohol and drug abuse can exacerbate symptoms of hyperarousal.

The severity of the trauma determines the percentage of traumatized individuals who will develop typical symptoms of PTSD. In medical research, no distinction is made between civilian and war-related trauma. An American epidemiological study reported a 1-percent history of PTSD in the general population and 3.5 percent in victims of physical attack.[12] Rape and threats to life both seem to increase the likelihood of developing PTSD. A study of 294 female crime victims in Charleston County, South Carolina, found 9.4 percent PTSD among those who experienced no rape, no death-threats, and no injury; among rape victims 28 percent showed evidence of PTSD, even if there had been no life-threat or injury; the percentage rose to 68.8 percent if the victim perceived a threat to life even if she was not injured; that figure rose to 78.6 percent if an injury also was experienced.[13] Rape, particularly when associated with death-threats and injury, elicits very high rates of PTSD. During World War II, rape was not an infrequent occurrence and was often combined with death-threats.

Several studies show that the experiences of prisoners of war (POWs) in Japan, which often involved beatings and/or torture and starvation, carried a particularly high risk of subsequent PTSD. One such study showed that starvation and beatings and/or torture during captivity were predictors of PTSD. Family histories of mental illness, preservice adjustment problems, and severe childhood trauma did not predict the occurrence of PTSD.[14] A retrospective American study that examined World War II Pacific-theater combat veterans found that 78 percent of those who had been POWs had a lifetime diagnosis of PTSD, compared with 29 percent of those with no such experience.[15] The POW experience, particularly in Japanese camps, involved life-threats and, in many cases, the witnessing of atrocities.[16]

11 The psychiatric term is somatoform disorder. For a review of the literature, see also O'Brien, *Traumatic Events*, 158–73.

12 John E. Helzer, L. N. Robins, and L. McEnvoy, "Post-Traumatic Stress Disorder in the General Population," *New England Journal of Medicine* 317 (1987): 1630–4.

13 Dean G. Kilpatrick et al., "Victim and Crime Factors Associated with the Development of Crime-Related Post-Traumatic Stress Disorder," *Behaviour Therapy* 20 (1989): 199–214.

14 Nancy Speed et al., "Posttraumatic Stress Disorder as a Consequence of the Prisoner of War Experience," *Journal of Mental and Nervous Disorder* 177 (1989): 147–53.

15 Patricia B. Sutker, Albert N. Allain, and Daniel K. Winstead, "Psychopathology and Psychiatric Diagnoses of World War II Pacific Theatre Prisoner of War Survivors and Combat Veterans," *American Journal of Psychiatry* 150 (1993): 240–5.

16 Brian E. Engdahl et al., "Posttraumatic Stress Disorder in a Community Group of Former Prisoners of War: A Normative Response to Severe Trauma," *American Journal of Psychiatry* 154 (1997): 1576–81.

All studies agree that the more severe the trauma, particularly the more that a person's life has been threatened, the higher the likelihood of developing PTSD. These research findings were incorporated into the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM IV*), leading to a change in the definition of trauma. The fourth edition of the *DSM* describes the trauma as follows: (1) "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others"; and (2) "the person's response involved intense fear, helplessness or horror. Note: In children this may be expressed instead by disorganized or agitated behavior."[17] According to some research, prolonged exposure or repeated exposure to stressors is more likely to cause symptoms.[18]

Some researchers consider participation in atrocities as crucial in the development of PTSD, whereas others regard the subjective appraisal of responsibility as more important in the development of symptoms. The diagnosis of PTSD does not involve a moral judgment, only the presence of certain symptoms following trauma. The concept underlying the definition is biological.[19]

A study of Vietnam veterans shows that, of a list of nine stressful events, participation in atrocities was the strongest predictor of PTSD. The other events included being subjected to enemy fire, being wounded, being attached to a unit in the South Vietnamese army, being surrounded by the enemy, being separated from one's unit, being on combat patrol, having a buddy killed in action, and witnessing atrocities. Statistical methods were used to control for the fact that stressful events often occurred in conjunction. Participation in atrocities increased the risk of PTSD by 42 percent, independent of having experienced any other stressful event. However, there also was a cumulative risk of PTSD with an increasing number of stressful events.[20]

In medical research, no distinction is made between victim and perpetrator as long as a stressor is present and leads to typical symptoms of PTSD. Recent research has focused on the subjective appraisal of traumatic events rather than objective factors.[21] Alan Fontana et al. presented a retrospective

17 American Psychiatric Association, ed., *Diagnostic and Statistical Manual of Mental Disorder*, 4th ed. (Washington, D.C., 1994).

18 Pamela J. Taylor, "Victims and Survivors," in John Gunn and Pamela J. Taylor, *Forensic Psychiatry: Clinical, Legal, and Ethical Issues* (Oxford 1993), 897–8.

19 Rachel Yehuda, "Neuroendocrinology of Trauma and Posttraumatic Stress Disorder," *Review of Psychiatry* 17 (1998): 97–131.

20 Naomi Breslau and Glenn C. Davis, "Posttraumatic Stress Disorder: The Etiologic Specificity of War-Time Stressors," *American Journal of Psychiatry* 144 (1987): 578–83.

21 Alan Fontana, Robert Rosenheck, and Elisabeth Brett, "War Zone Traumas and Posttraumatic Stress Disorder Symptomatology," *Journal of Nervous and Mental Disorder* 180 (1992): 749–55. The authors

study based on 1,709 Vietnam veterans who were treated in the PTSD Clinical Teams Program of the Department of Veterans' Affairs. The authors attempt to elucidate the relationship between the nature of the stressor and the ensuing symptoms. The traumatic experiences of the veterans were divided into four categories: (1) being the target of killing, (2) being the observer of killing or atrocities, (3) being the agent of killing or atrocities, and (4) failing to prevent killing. The two latter categories involved feeling responsible for the killing. The trauma experience itself was divided into high and low responsibility categories, and the symptoms were the number of suicide attempts, a general measure of psychiatric distress, and the three clusters of symptoms relevant for a diagnosis of PTSD (re-experiencing, hyperarousal, and numbing and avoidance).

The authors found that being the target of an attempt to kill was strongly related to a diagnosis of PTSD, particularly to symptoms of hyperarousal. The authors concluded that the subjective experience of being the target of an attempt to kill was associated most uniquely and strongly with PTSD. This is in keeping with the findings of the previously cited studies of war veterans and crime victims. The experience of being responsible for killing others or for failing to prevent harm to others was related to suicide and psychiatric symptoms not included in the classical definition of PTSD. Fontana et al. concluded: "Viewed in terms of our classification of personal responsibility, PTSD appears to be connected most specifically to traumas low in personal responsibility for their initiation, whereas psychiatric symptoms and suicide appear to be connected more specifically to traumas high in personal responsibility."[22] This might imply that the subjective appraisal of responsibility determines guilt feelings more strongly than do objective factors, such as actually participating in atrocities or being a witness. An earlier essay by William B. Gault, a Harvard psychiatrist who treated Vietnam veterans, lists six factors that in his opinion facilitate the occurrence of slaughter.[23] His definition of slaughter resembles the one given by Fontana et al. for atrocities. One of the factors is dilution of responsibility.

Recent data from a group of former World War II veterans who also had been POWs show that only a small minority ever received treatment for PTSD although over 50 percent had experienced PTSD during their

summarize up-to-date work on cognitive appraisal of danger and the role of moral conflict. They then present their own data on 1,709 Vietnam veterans.

22 Ibid., 753.

23 William B. Gault, "Some Remarks on Slaughter," *American Journal of Psychiatry* 128 (1971): 450–4. The six factors are: (1) the enemy is everywhere, (2) the enemy is not human, (3) dilution of responsibility, (4) the pressure to act, (5) the natural dominance of the psychopath, (6) firepower.

lives and 29 percent still met criteria for it forty to fifty years later. Among those who had been POWs in Japanese camps, 80 percent had a lifetime diagnosis of PTSD.[24] One veteran whose case is described in detail still suffers from intrusive recollections and sleep problems, and he feels distant and mistrustful of people outside his family. Most veterans in the study showed no significant occupational problems. However, a second veteran who was described in detail and still suffered from PTSD describes himself as underachieving at work due to his "personality." As a prisoner, he had survived the Bataan Death March and had witnessed senseless executions and death-threats. His weight had dropped from 150 to 80 pounds. After a long series of life-threatening episodes, he returned home, married, and raised three children with his wife. He was never promoted during thirty-six years at work. He suffered from daily intrusive recollections, frequent nightmares, hypervigilance, and survivor's guilt. His only social contacts outside the family were other POWs. He never had been treated for psychiatric problems prior to participating in the study.

The main conclusion that can be drawn from the work cited thus far is that following severe, life-threatening trauma, psychological problems, particularly PTSD, will develop in more than 50 percent of cases and can persist for long periods of time. Suicide attempts and guilt feelings are most likely to occur in individuals who felt subjectively responsible for killing others or for failing to prevent harm to others. However, only a minority of such traumatized individuals will seek treatment.

Moreover, PTSD affects not only the sufferers themselves but also their families. Zahava Solomon has reviewed the literature on the effect of PTSD on veterans' families.[25] She found that veterans must re-establish their role in the family when they return home, and some symptoms of PTSD can create problems in the process of reintegration. The symptoms she regarded as crucial are the "numbing of responsiveness and reduced involvement with the external world, as seen by diminished interest in significant activities, feelings of detachment or alienation, and constricted affect." Several studies show how Vietnam veterans had difficulties in maintaining close relationships. One study quoted in the review found that veterans who were involved in atrocities suffered from guilt and fear of their violent impulses. There also is some evidence of child-battering and wife-battering. One of the studies found that 50 percent of the couples seeking help reported

24 Engdahl et al., "Posttraumatic Stress Disorder," 1576–81.

25 Zahava Solomon, "The Effect of Combat-Related Posttraumatic Stress Disorder on the Family," *Psychiatry* 51 (1988): 323–9.

wife-battery. The incidents were particularly frightening and violent, and had led to professional consultation. Citing the President's Commission on Mental Health of 1978, the review notes that 38 percent of Vietnam veterans' marriages failed within six months of their return from combat. The author asserts that, in the marriages of PTSD sufferers that do not end in divorce, the wife often must bear an enormous psychological burden that can lead to depression and social isolation.[26] In her own study, Solomon found that the wife's mental health is seriously affected by the veteran's trauma-related psychopathology.[27] Moreover, the wife's social functioning also is impaired in several areas. The difficulties encountered by married couples with a spouse, usually the husband, suffering symptoms of PTSD are likely to affect children as well. In her review, Solomon remarks: "A veteran who engaged in actions against women and children may find the transition to the role of husband/father particularly difficult."[28] She also points out: "The natural exuberance and aggressiveness of a growing child, especially a son, may reawaken memories of wartime aggression and provoke excessive rage or guilt over sadistic impulses. The veteran's attempt to control his child's aggressiveness may be out of proportion."[29] Rosenheck and Fontana have investigated the effect of veterans' participation in abusive violence on their children's behavior.[30] Child behavior was assessed by means of a 122-item questionnaire. The main findings of the study were that child behavior was adversely affected by the father's participation in abusive violence and that

26 Ibid., 325–6.

27 Z. Solomon et al., "From Front Line to Home Front: A Study of Secondary Traumatisation," *Family Process* 31 (1992): 289–302.

28 Solomon, "Effect," 326.

29 Ibid., 325–6.

30 Robert Rosenheck and Alan Fontana, "Transgenerational Effects of Abusive Violence on the Children of Vietnam Combat Veterans," *Journal of Traumatic Stress* 11 (1998): 734. The authors have developed a questionnaire for combat exposure and abusive violence. The questions regarding abusive violence were as follows:

(1) Were you ever in a combat situation in (or around) Vietnam where you participated in any kind of injury or destruction that seemed necessary then, but that you would consider unnecessary now?

To what extent were you involved in:

(2) Terrorising, wounding, or killing civilians?

(3) Torturing, wounding, or killing hostages or prisoners of war?

(4) Mutilation of bodies of the enemy or civilians?

(5) In combat situations in (or around) Vietnam, women, children, and old people were sometimes seen by our side as the enemy. Were you ever (directly involved) in a situation in Vietnam where women, children, or old people were either injured or killed by American or South Vietnamese (ARVN) soldiers?

(6) In combat situations in (or around) Vietnam, Vietnamese prisoners or civilians were often injured because they were suspected of being enemy sympathisers, or to obtain information, or to avenge the death of American soldiers, or for other reasons. Were you ever (directly involved) in a situation where a Vietnamese prisoner was injured or killed for any reason?

the effect could not be explained fully by PTSD or a range of pre- and postmilitary factors.

In the literature mainly on veterans of the conflicts in Vietnam and Lebanon, there is evidence that the veterans' PTSD symptoms affected their marital relationships, the wives' mental health and social relations, and their children's behavior. Participation in abusive violence in particular seems to affect the behavior of the veterans' children years later, even if PTSD is not present. The questionnaire developed to assess the abusive violence of Vietnam veterans would have been pertinent in exploring the same phenomenon in German World War II veterans involved in partisan warfare or mass murder of Jews in the East.

THE EXPOSURE OF THE GERMAN POPULATION TO VIOLENCE DURING WORLD WAR II

This section discusses the portion of the German population exposed to multiple traumas that were low in personal responsibility, including bombing, rape, and combat situations in which they were the targets. Also addressed is that portion of the German population exposed to trauma high in responsibility, particularly on the eastern front, where a still undetermined number of Wehrmacht soldiers as well as soldiers of the Waffen-SS took part in or witnessed atrocities against Jews and other civilians. At home in Germany, the 1938 pogrom and deportation of Jewish and communist neighbors also exposed many Germans to the experience of witnessing cruelties. What remains unclear is the subjective experience: What proportion of Germans felt that they had failed to prevent a killing and thus experienced a trauma high in responsibility?

Diaries and interviews with children of Nazi perpetrators show evidence of avoidance and difficulties in expressing emotions.[31] Gitta Sereny quotes a railworker who described his wife's reaction to watching the transports to the camps: "There was a period in the beginning when my wife could not function at all, she could not cook, she could not play with the boy, she could not eat and hardly slept. This extreme condition lasted for about three weeks; she then became pathologically indifferent, she did everything like an automaton."[32]

Statistics on the exposure of German soldiers and civilians to violence or atrocities during the war are considered here. Obviously, the proportion of

31 Gitta Sereny, *Into that Darkness: From Mercy Killings to Mass Murder* (London, 1991), and Bar-On, *Last*.

32 Sereny, *Into that Darkness*, 150.

Germans who were exposed to violence cannot be calculated exactly. Here, historical methods differ from the often experimental design of research in the natural sciences.[33] As Rüdiger Overmans asserted in his remarks about the civilian and military losses of World War II, different methodological approaches have led to considerable variations in statistical estimates: "The main problem of all available statistics are the different definitions they use, thus not allowing an estimate about all losses."[34] Even a decade later, his statement remains valid and applies to most of the figures that follow. However, the figures can yield an impression of the extent of trauma encountered by German combatants and by civilians.

In 1939, the population of Germany proper was more than 69 million; add the people of Austria and the Sudetenland, and it rose to approximately 79 million.[35] A sizeable proportion of the German population was affected by the war over the following six years. The extent of exposure to traumatic events differed markedly in various subgroups of the population according to their rank in the military structure (for example, Wehrmacht soldiers and Waffen-SS) and the areas where they lived as civilians or fought as soldiers.

Wehrmacht soldiers who took part in the attack on Poland were the first to be involved both in combat and in perpetration of atrocities. At the beginning of September 1939, there were about 4.5 million men in the army, the air force, and the navy, and in 1944 the German armed forces totaled 10 million men.[36] Altogether, more than 17 million men spent time in the Wehrmacht during the Third Reich, and about 13 million of them survived the war.[37] Conscription into the army did not automatically imply front-line

33 Lutz Niethammer, "Fragen – Antworten – Fragen: Methodische Erfahrungen und Erwägungen zur Oral History," in Lutz Niethammer and Alexander von Plato, eds., *Lebensgeschichte und Sozialkultur im Ruhrgebiet 1930 bis 1960*, 3 vols. (Berlin, 1985), vol. 3: *"Wir kriegen jetzt andere Zeiten": Auf der Suche nach der Erfahrung des Volkes in nachfaschistischen Ländern*, 409–10.

34 Rüdiger Overmans, "Die Toten des Zweiten Weltkriegs in Deutschland. Bilanz der Forschung unter besonderer Berücksichtigung der Wehrmacht- und Vertreibungsverluste," in Wolfgang Michalka, ed., *Der Zweite Weltkrieg: Analysen, Grundzüge, Forschungsbilanz* (Munich, 1989), 869. Translation by the authors. Concerning the casualties of the German armed forces, Overmans recently published new statistical data. Rüdiger Overmans, *Deutsche militärische Verluste im Zweiten Weltkrieg* (Munich, 1999).

35 Länderrat des Amerikanischen Besatzungsgebiets, ed., *Statistisches Handbuch von Deutschland 1928–1944* (Munich, 1949), 18, table 4: "Development of the population 1850–1946." See also Peter Marschalck, *Bevölkerungsgeschichte Deutschlands im 19. und 20. Jahrhundert* (Frankfurt am Main, 1984), 149, table 1.7; Dietmar Petzina, Werner Abelshauser, and Anselm Faust, *Sozialgeschichtliches Arbeitsbuch III: Materialien zur Statistik des Deutschen Reiches 1914–1945*, 4 vols. (Munich 1978), 3:22; Bernhard R. Kroener, "Die personellen Ressourcen des Dritten Reiches im Spannungsfeld zwischen Wehrmacht, Bürokratie und Kriegswirtschaft 1939–1942," in Militärgeschichtliches Forschungsamt, ed., *Das Deutsche Reich und der Zweite Weltkrieg*, 6 vols. (Stuttgart, 1979–99), vol. 5/1: "Organisation und Mobilisierung des deutschen Machtbereichs," 750.

36 Rolf-Dieter Müller and Gerd R. Ueberschär, *Kriegsende 1945: Die Zerstörung des Deutschen Reiches* (Frankfurt am Main, 1994), 58, and Kroener, "Ressourcen," 726, 811.

37 Overmans, *Verluste*, 215, 294.

experience and involvement in combat. In fact, in 1939 only 1,131,000 men out of 4.5 million were on active duty, whereas the rest served in the reserves or belonged to the Wehrmacht staff who worked in barracks and factories.[38] It is of great significance for the extent of exposure to combat and atrocities to distinguish among the several fronts at which the soldiers saw action, because the circumstances were not identical with regard to physical and emotional demands. The attack on the Soviet Union on June 22, 1941, was the beginning of a brutal campaign that led to the greatest toll of casualties for the German army. The survivors of this campaign had had to contend with various hardships, including harsh weather conditions, logistical problems, and, more important, the atrocities and dangers of combat and partisan warfare. The average total troop strength of the German armed forces on the eastern front at any one time totaled 3.35 million men,[39] and it can be assumed that a majority of these soldiers were involved in brutal, life-threatening combat on a daily basis.

Surveys on the so-called *Kriegsneurotiker* (war neurotics) are worth mentioning here. Many show that large numbers of troops had previously suffered mental disturbance during the war. According to Karl Heinz Roth, who scrutinized the reports of the *Beratende Psychiater* (advising psychiatrists), before the attack on the Soviet Union in June 1941 suicides had become frequent and the first reports of self-mutilations had surfaced. During the winter of 1941–2, the number of shell-shocked soldiers rose further, and the number of suicides and cases of self-mutilation already exceeded those committed during World War I. After the Battle of Stalingrad, the number of shell-shock sufferers increased dramatically, and by 1944 the entire German army had reported about 20,000 to 30,000 *Kriegsneurotiker.* In the winter of 1944–5, military hospitals alone counted more than 100,000 shell-shock sufferers.[40]

In addition to ordinary forces, the members of the combat units of the SS, the so-called Waffen-SS, and the so-called *Einsatzgruppen* (operation teams) took part not only in the campaigns against Poland and the Soviet Union, but

38 Kroener, "Ressourcen," 731.

39 Bernd Wegner, "Der Krieg gegen die Sowjetunion 1942/1943," in Militärgeschichtliches Forschungsamt, ed., *Das Deutsche Reich und der Zweite Weltkrieg*, vol. 6: Horst Boog, *Der globale Krieg. Die Ausweitung zum Weltkrieg und der Wechsel der Initiative 1941–1943* (Stuttgart, 1990), 778.

40 Karl Heinz Roth, "Die Modernisierung der Folter in den beiden Weltkriegen: Der Konflikt der Psychotherapeuten und Schulpsychiater um die deutschen 'Kriegsneurotiker' 1915–1945," *1999: Zeitschrift für Sozialgeschichte des 20. und 21. Jahrhunderts* 3 (1987): 8–75, see esp. 41, 49, 72. His research is based on material from the Bundesarchiv Militärarchiv at Freiburg im Breisgau. See also Gerhard Berger, *Die Beratenden Psychiater des deutschen Heeres 1939 bis 1945* (Frankfurt am Main, 1998), 107–30, 172–7, 238.

also in the mass extermination of Jews in the east. In the summer of 1942, the number of troops in the Waffen-SS totaled 190,000 men,[41] and by the end of the war another 800,000 to 900,000 Germans and men from the Baltic region, Romania, and Hungary had joined these units.[42] Five *Einsatzgruppen*, totaling 2,700 men, operated in the campaign against Poland. After the attack on the Soviet Union, four *Einsatzgruppen* of 600 to 1,000 men each were formed; a total of 4,000 men thus went into action in the Baltic, in Belorussia, Ukraine, Bessarabia, Crimea, and the Caucasus.[43] The members of the Waffen-SS and the *Einsatzgruppen* were the main perpetrators of the mass shootings of men, women, and children. Most participated in or witnessed atrocities. Although many of the perpetrators were deeply influenced by Nazi ideology and were therefore convinced of the necessity of their deeds, there are reports that some could stand participating in such atrocities only under the influence of alcohol.[44] There is no research available showing whether the members of these special units suffered different rates of PTSD or other psychiatric illness or suicide than did the ordinary soldiers of the Wehrmacht. However, according to the American literature on Vietnam veterans, one would expect the highest rates of PTSD in combatants particularly if they took part in atrocities. Perpetrators who qualify for trauma high in responsibility generally have high rates of suicide. However, personal acceptance of responsibility is crucial.[45] There may be a significant difference in this respect between postwar Germany and the post-Vietnam United States.

Not only men served on the western and eastern fronts: A large number of women worked as *Wehrmachtshelferinnen* (female military aides), for example, as secretaries or anti-aircraft auxiliaries. Depending on the circumstances, many of these mainly young women were exposed to combat; however, there is no research on how they coped with their experiences. In the summer of 1944, about 50,000 women and girls were deployed as anti-aircraft auxiliaries, and at the beginning of 1945 the total number of

41 Kroener, "Ressourcen," 959, table: Stärkeentwicklung der Wehrmachtteile und der Waffen-SS vom 1. September 1939 bis 1. Juli 1942.

42 Bernd Wegner, "Anmerkungen zur Geschichte der Waffen-SS aus organisations- und funktionsgeschichtlicher Sicht," in Rolf-Dieter Müller and Hans-Erich Volkmann, eds., *Die Wehrmacht: Mythos und Realität* (Munich, 1999), 406n3. See also Overmans, *Verluste*, 215.

43 Helmut Krausnick and Hans-Heinrich Wilhelm, *Die Truppe des Weltanschauungskrieges: Die Einsatzgruppen der Sicherheitspolizei und des SD 1938–1942* (Stuttgart, 1981), 34, 147.

44 A massacre is described by Christopher R. Browning, *Ordinary Men: Reserve Police Battalion 101 and the Final Solution in Poland* (New York, 1993), 55–70; on the significance of alcohol, see 61, 69, 100. Browning also mentions the case of an *SS-Hauptsturmführer* who became ill during the killing activities of his battalion, 114–20.

45 See the section "The Psychiatric Concept of PTSD" at the beginning of this chapter.

auxiliaries for the Wehrmacht amounted to about half a million.[46] Five percent of all internees in the Soviet Union were alleged to be women, and one survey estimates that in 1949, 25,000 women were still held prisoner in Soviet camps.[47]

By the end of 1945, a total of 18.2 million men had been called up to the Wehrmacht and Waffen-SS; out of these, 4.5 million were killed, more than half of them on the eastern front.[48] Eleven million German soldiers and members of the Wehrmacht were captured; of these, more than 3 million were POWs in the Soviet Union and only 2 million returned.[49] One should remember that all these estimates depend on the definition of the status of a POW; indeed, it is unclear who counted as a prisoner of war in these statistics. For instance, women of the Wehrmacht retinue did not have the status of combatants and therefore did not count as POWs when they were captured. Moreover, the place of captivity is not insignificant, as prisoners in the Soviet Union were often bundled off to labor camps where men had to toil in quarries and often were threatened with death or serious injury. One of the long-term consequences of malnutrition was dystrophy, from which many of the POWs in Soviet camps suffered.[50] However, the majority of German soldiers were captured by the Western Allies.[51] The problems encountered by repatriated POWs from the Western Allies have not been examined in detail, as noted in a recent collection edited by Annette Kaminsky.[52] Nevertheless, it is known that long-term separation from their families and the harsh conditions in the labor camps traumatized the POWs and made their reintegration into civilian life difficult. In 1953, there were more than 1.4 million war invalids, half of them seriously disabled. However, the figures do not give us a description of the injuries sustained. Moreover, there is no information on the contribution of psychological factors to the degree of invalidity.[53]

Far more than in World War I, German civilians in World War II were exposed to life-threatening violence. From 1942 onward, the intensified

46 Müller and Ueberschär, *Kriegsende*, 31. Also Kroener, "Ressourcen," 726, 811.

47 Stefan Karner, *Im Archipel GUPVI: Kriegsgefangenschaft und Internierung in der Sowjetunion 1941–1956* (Vienna, 1995), 14–15.

48 Overmans, *Verluste*, 293–6.

49 Beate Ihme-Tuchel, "Zwischen Tabu und Propaganda. Hintergründe und Probleme der ostdeutsch-sowjetischen Heimkehrerverhandlungen," in Annette Kaminsky, ed., *Heimkehr 1948* (Munich, 1998), 40, and lower figures in Müller and Ueberschär, *Kriegsende*, 112. See also Overmans, *Verluste*, 286, 292.

50 Karner, *Archipel*, 63–75, 86–94. H. Paul, *Charakterveränderungen durch Kriegsgefangenschaft und Dystrophie* (Bad Godesberg, 1959).

51 Sibylle Meyer and Eva Schulze, *Von Liebe sprach damals keiner: Familienalltag in der Nachkriegszeit* (Munich, 1985), 253, table 5.

52 Kaminsky, *Heimkehr*, 7.

53 Meyer and Schulze, *Liebe*, 257, table 7.

bombing of German cities by Allied forces led to the large-scale destruction of housing and increasingly influenced life on the home front, particularly in the cities. In 1945, a total of 4 million homes had been destroyed in Germany alone. The air raids had killed 600,000 civilians; 900,000 were wounded, and 7.5 million had been made homeless. Some of the people who were bombed out had to live in temporary shelters for years.[54] The areas most severely affected by the bombing were Berlin and the Ruhr area. For instance, in Cologne 70 percent of the housing stock – a total of 176,000 apartments – was destroyed, and in Dortmund and Duisburg more than half of the prewar dwellings were completely annihilated.[55] In Berlin, which had the highest number of casualties, 50,000 died as a result of air raids.[56] In July 1943, in an operation called *Gomorrha*, 3,000 Allied bombers dropped more than 9,000 tons of firebombs and explosive devices on Hamburg within ten days, leaving 40,000 people dead. Sixty-one percent of the city's housing stock was destroyed, and one million people were left homeless.[57] In the last months of the war, Germans in some areas were exposed daily – sometimes several times a day – to air raids, which constituted life-threatening events with low responsibility.[58]

What did daily bombing mean for the residents of a town? It meant blackouts in the evening, a ban on going out, and huddling for hours in air-raid shelters with old and sick people and with screaming children. In some cases, women had to give birth without medical help while the building burned around them and detonations made a terrible noise heralding death.[59] These experiences would fully qualify as traumatic events as defined in *DSM IV*, particularly because many people also witnessed the death or serious injury of their next of kin. There are reports of women who considered suicide because they felt hopeless but did not kill themselves because of the children.[60] An opinion poll in October 1948 documented long-term effects of the bombing. Eight-hundred West Germans over age 18 were

54 Bernd J. Wendt, *Deutschland 1933–1945: Das "Dritte Reich." Handbuch zur Geschichte* (Hannover, 1995), 538, and Müller and Ueberschär, *Kriegsende*, 41.

55 Christian Engeli, "Krieg und Kriegsfolgen in Berlin im Vergleich zu anderen Städten," in Wolfgang Ribbe and Jürgen Schmädeke, eds., *Berlin im Europa der Neuzeit: Ein Tagungsbericht* (Berlin, 1990), 406, table 3.

56 Ibid., 402–3.

57 Ursula Koser-Oppermann, "Evakuiert, umquartiert, einquartiert. Wohnen in der zerstörten Stadt," in Ulrike Jureit and Beate Meyer, eds., *Verletzungen: Lebensgeschichtliche Verarbeitung von Kriegserfahrungen* (Hamburg, 1994), 176.

58 Olaf Groehler, *Bombenkrieg gegen Deutschland* (Berlin, 1990), 259, 319.

59 Sibylle Meyer and Eva Schulze, " 'Als wir wieder zusammen waren, ging der Krieg im Kleinen weiter': Frauen, Männer und Familien im Berlin der vierziger Jahre," in Niethammer and von Plato, *Andere Zeiten*, 309.

60 Ibid., 308.